UNIVERSITY OF BIRMINGHAM

Mental Health Policy Commission

INVESTING IN A RESILIENT GENERATION

Keys to a Mentally Prosperous Nation

> "The 2019 Spending Review presents a perfect opportunity to implement these ideas."

Lord Gus O'Donnell
Former Cabinet Secretary and Head of the Civil Service, 2005–2011

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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 be 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

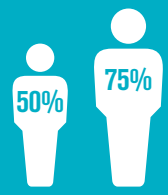
CONTENTS

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 condition[1]

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 problem[5]

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 ago[6]

10 YEARS

There is on average a **ten-year delay** between young people experiencing their first symptoms and receiving help[7]

7 pence in every **£** the NHS spends is on children's mental health and just over 1p of this is spent on early intervention[8]

3 IN 4 CHILDREN with a diagnosable mental health condition **do not get** access to the **support** that they need[9]

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]

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

Social exclusion and social disadvantage increase the risk of all types of mental health difficulties in children and young people, from depression to psychosis[11]

Adverse childhood experience (particularly sexual and psychological abuse, and being exposed to domestic violence or bullying) substantially increases the risk of poor mental health[12]

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)[13]. 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 problems[14]. 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 2004[15], 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:

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 Concordat[16] 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 Challenge[17] 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 interventions[18] 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)[19] 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[20]	Six years
Enhanced ***perinatal support*** with a specific focus on the mental health of mothers and infants[21]	
Whole-school ***Social and Emotional Learning*** programmes that are universal but can offer additional support for more vulnerable children[22]	Three years
Whole-school approach to addressing ***harmful behaviour*** such as ***bullying***[23, 24]	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 Commission[25]. 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 nation[26].

> 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 prosperity[27].

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)[28], 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[29, 30, 31].

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

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.

Common mental health problems often begin in childhood: one in ten children have a mental health disorder[32], 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[33, 34]. The frequency of mental health problems in children and young people is increasing[35] and differences in mental well-being between population groups can be seen at an early age[36]. 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.

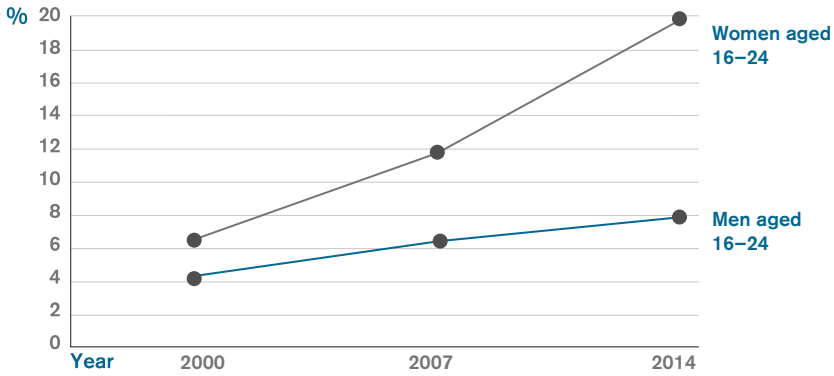


Figure 2: Rates of reporting of self-harm in young people[37]

> To neglect mental illness in young people is not only morally unacceptable, but also an enormous economic mistake[38].

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 breakdown[39].

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'[40]. 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[41, 42, 43, 44]

WHILE ONE IN TEN CHILDREN EXPERIENCE POOR MENTAL HEALTH, ONLY ONE IN FOUR OF THESE HAVE ACCESS TO MENTAL HEALTH SERVICES[45].

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 2020–2021[46]. 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 people[47]

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 treatment[48]. 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 potential[49]. 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 billion[50].

THE PREVENTION GAP

The 'treatment gap' is the difference between those who may need treatment and those who actually receive it. The Commission proposes that, for maximum long-term impact, we need to focus instead on the ***'prevention gap'*** between those who would derive benefit from preventative activity and the current extent of that activity.

A focus on the prevention gap is crucial for two reasons:
(a) to maximise well-being and productivity at a population level; and
(b) to reduce the demand for mental health services across the life-course.

The Commission believes that this needs to be the focus for a primary and secondary prevention strategy that will promote population mental health, although the benefits of some of the interventions may take a generation to realise.

Primary prevention
Aims to reduce the likelihood of people experiencing poor mental health in the future.

Secondary prevention
Responds to early signs of poor mental health in ways that minimise people's need for treatment and maximise their subsequent life chances.

Both involve addressing the various life challenges that may be contributing to their mental distress, and building their social, personal, and economic resources.

Figure 3: Primary and secondary preventions

There is strong evidence that both of these aspects of prevention are relevant to mental health. We know that trauma, adversity, and stress are contributory factors that increase the likelihood of all forms of mental ill-health. We know that early and inclusive ways of responding can have a substantial impact on reducing both the intensity and duration of mental distress, and its negative impact on social, educational, and economic participation. We know that rates of long-term recovery from mental distress varies substantially both over time and between countries – and the greatest part of this variation is due to factors within people's wider social, family, economic, and cultural environments[51, 52].

Some preventative activity may be ***universal*** – seeking to bring benefit to everyone – and some may be more ***targeted*** towards those who are identified as having greater need or being at greater risk. Some of the most effective preventative strategies combine elements of both. The principle of ***'proportionate universalism'*** proposes a gradation of intensity of activity, within a universal provision, towards those who may potentially benefit most. Such an approach may often be more acceptable as it can reduce the possibility of feeling singled-out or stigmatised, and it can reduce the possibility of 'falling through the net' of services.

Evidence that childhood circumstances and early experiences play a major role in influencing susceptibility to mental health difficulties in later life[53, 54, 55, 56, 57] has led the Commission to conclude that there is a strong logic for a specific focus on preventative activity for children, young people, their families, communities, places of education, and employers.

THE EARLY YEARS ARE A TIME OF RAPID BRAIN DEVELOPMENT AND 'PLASTICITY', WHERE SUCCESSFUL SUPPORT AND INTERVENTIONS CAN RESULT IN LIFE-LONG POSITIVE IMPACTS[58, 59].

Complex mechanisms involving interactions between social experiences, personal responses and adaptations, and physiological changes[60] are the subject of research in neuroscience and epigenetics. This is demonstrating how difficult family relationships and adverse childhood experiences can have a direct impact on brain development and metabolic and neural functioning – for example, in relation to the on-going release of stress hormones, information processing, recognising others' emotions, and the ability (or otherwise) to develop effective self-regulatory mechanisms[61]. They can also be a major contributing factor in determining how people are able to deal with subsequent life challenges, and hence their risk of developing mental health difficulties.

It is not just the early years that are important. Adolescence and early adulthood is also a period of 'brain plasticity', where adverse and damaging experiences can have a lasting impact[62], but conversely where there is an opportunity to redress the physiological impact of earlier difficulties through exposure to positive relational experiences and psychologically informed environments[63].

Effective preventative activity requires a twin-track focus on:

- **Maximising resilience** – factors that increase the capacity for individuals, families, and communities to thrive and to deal effectively with challenges to mental health
- **Minimising vulnerabilities** – factors that increase the likelihood or potential severity of mental ill-health, including socio-economic determinants and risk-taking behaviours

Much of the evidence received by the Commission stressed the importance of moving beyond a 'deficit model' (just focusing on potential vulnerabilities) towards a positive focus on resilience. We know that not all people who experience adversity in their lives go on to develop mental health problems[64]. A recent report from Public Health Wales has highlighted how those with high childhood resilience are less than half as likely to experience mental illness as adults than those who have only developed low resilience as children[65].

Maximising Resilience

Resilience reflects the ability to mobilise personal, relational, and socio-economic resources or 'capital' to deal with specific challenges and to thrive or flourish more generally. Resilience capital not only underpins positive well-being, it also enables people to buffer themselves against, or overcome, challenges to their mental health. This approach enables us to broaden our vision beyond a narrower focus on the individual and takes account of their wider social circumstances. Resilience and recovery from adversity may be seen to depend on the following forms of capital:

PERSONAL (OR MENTAL) CAPITAL

OUR COGNITIVE AND EMOTIONAL RESOURCES, INCLUDING EMOTIONAL INTELLIGENCE, SOCIAL SKILLS, AND ABILITIES TO COPE WITH STRESS

RELATIONSHIP CAPITAL

OUR CLOSER PERSONAL AND FAMILY RELATIONSHIPS AND WHETHER THESE OFFER TRUST, ACCEPTANCE, AND THE POTENTIAL FOR MUTUALITY

ECONOMIC CAPITAL

FINANCIAL RESOURCES THAT ENABLE US TO COPE WITHOUT EXCESSIVE STRESS ON A DAY-TO-DAY BASIS AND TO ACHIEVE OUR ASPIRATIONS

IDENTITY CAPITAL

POSITIVE PERSONAL AND SOCIAL IDENTITIES GIVE US 'CURRENCY' IN RELATION TO WIDER SOCIAL PARTICIPATION AND ACCESSING SOCIAL CAPITAL – AND HELP TO BUFFER US FROM THREATS OR CHALLENGES

SOCIAL CAPITAL

BEING PART OF DURABLE FORMAL OR INFORMAL SOCIAL NETWORKS

Figure 4: Forms of capital that contribute to resilience[66]

> "It is during our childhood and adolescence that the greatest opportunities exist to develop our resilience."

An absence of one or more forms of resilience capital may increase vulnerability to mental ill-health – or to the adverse experiences that may contribute to this. Conversely, an episode of poor mental health can result in a sudden and rapid loss of relationships and social capital. People with mental health difficulties may find that they take on negatively valued and potentially stigmatising identities associated with diagnosis, and this may substantially impair their opportunities to re-integrate into work, community, or educational settings, and to re-build their stock of social and economic capital.

It is during our childhood and adolescence that the greatest opportunities exist to develop our resilience. One factor that can be particularly influential is having trusted relationships with adults[67]. Resilience is not advanced by over-protectiveness – opportunities for challenge, experimentation, and risk-taking may be important, but so too may be the provision of effective 'safety nets' so as to mitigate potentially damaging consequences. For many young people, it may be important that, if they 'mess up', they have the opportunity for a 'second chance' to recover a positive life trajectory, rather than becoming labelled as problematic within educational, health, or social systems. We need to minimise the risks to mental health by minimising exclusion.

Key life transitions can have major implications for resilience. On the one hand, we may easily lose access to social, relationship, identity, and other forms of capital that have hitherto sustained us. On the other hand, we may have opportunities to develop and access new forms of capital. Significant points of transition in earlier life include starting school, moving from primary school to secondary school, and then moving on to further education and work, perhaps coupled with moving away from family and/or locally based friendship networks.

Minimising Vulnerabilities

Inequalities, Discrimination, and Exclusion

It is clear that the risks of poor mental health are not evenly distributed across society[68] – those that face disadvantage or exclusion on the basis of income, race, gender, culture, sexual orientation, or disability are far more likely to experience mental health difficulties[69]. Overall, mental ill-health is more common in more unequal societies[70].

Social exclusion and disadvantage are associated with enhanced risk of all types of mental health difficulties, from depression[71] to psychosis[72]. Findings from the Millennium Cohort study indicate that children from low-income backgrounds are four times more likely to experience mental health problems than those from high-income backgrounds[73]. 17 per cent of 11-year-olds from families living in the bottom fifth of income distribution have severe mental health problems compared with only four per cent among those families in the top fifth[74]. This income-related gradient appears to have become steeper in recent years and is much steeper among children than adults[75]. There are important gender differences, with women in the bottom fifth of income distribution nearly three times as likely to have a diagnosed mental health condition as men in the top fifth of income distribution[76]. Similarly, suicide rates are much higher for men living in poorer socio-economic circumstances[77].

> "The needs of young people from particular communities are not being recognised and are going unaddressed."

Other factors – such as sexism, racism, and homophobia – can be equally 'toxic', and these are often associated with socio-economic disadvantage. For example, men of African Caribbean heritage are up to nine times more likely to receive a diagnosis of psychosis[78]. A recent inquiry identified a pattern of exclusion, including educational disadvantage and racism, as contributory factors[79]. The prevalence of poor mental health among socially excluded groups can be extremely high, with common mental health problems four to 15 times higher for homeless people and 50 to 100 times higher for people who are street homeless[80].

The mechanisms for the relationships between inequalities, discrimination, and mental ill-health are complex. There are three factors that the Commission has identified as a focus for intervention.

- First, stress affects biological regulatory systems and thus such inequalities start before birth by mothers being exposed to stressful events and life circumstances, which include violence and abuse, poverty, and poor housing.
- Second, it is evident that the experience and duration of stressful experiences, and the extent to which they are buffered by social supports in the early years, plays a critical role in our subsequent resilience. Children living in households of lower socio-economic status were less likely to have access to the buffers and support to mitigate the effects of poor mental health[81].
- Third, poverty, debt, homelessness, unemployment, and the related stress not only affect individuals and families directly, they also have a long-term inter-generational impact[82, 83].

These factors have implications for health-related behaviours and can affect parenting skills and the management of household finances[84]. It underscores the importance of addressing the social determinants of poor mental health and the necessity of a systemic and systematic approach that is across government at a national and local level and at a local level in partnership with the third sector organisations, the business sector, and communities. A central element of such a strategy must be on preventing all forms of exclusion, including those in relation to economic and educational opportunity, employment, and housing.

Adverse Childhood Experiences (ACEs)

Alongside socio-economic factors, there is a compelling body of evidence that exposure to specific adverse childhood experiences (ACEs) can be a major contributory factor towards emotional, behavioural, and mental health issues among young people, including self-harm, substance misuse, and the full range of mental health difficulties (including psychosis)[85, 86, 87, 88, 89]. ACEs can also greatly increase the risk of physical health problems such as obesity, heart disease, and cancer – making the economic case for investment in prevention and early support and intervention very strong[90].

The evidence of impact for some ACEs is stronger than for others. Physical abuse, sexual abuse, and psychological abuse[91] have been shown to have major adverse consequences for mental health, whereas the impact of parental criminality and imprisonment on mental health outcomes is inconclusive[92].

Adverse childhood experiences identified in original ACEs study[93]	Other childhood experiences linking to adverse mental health outcomes
☐ Psychological abuse ☐ Physical abuse ☐ Sexual abuse ☐ Substance misuse within household ☐ Household mental illness ☐ Domestic violence/abuse ☐ Criminal behaviour within household	☐ Poor attachment with primary caregivers ☐ Difficult relationships with parents – especially low warmth/high control ☐ Physical and/or emotional neglect ☐ Bullying ☐ Homelessness ☐ Being an unsupported young carer ☐ (Unrealistic) pressure to achieve

Table 5: Adverse childhood experiences that impact on health outcomes

Children who experience an ACE are often exposed to more than one: violence in the home is highly correlated with physical maltreatment and psychological abuse, and all forms of adversity correlate with economic deprivation. In Wales, a recent study found that more than half the population reported one ACE and one in seven reported four or more ACEs[94]. Both the level of exposure to a particular ACE and exposure to multiple ACEs are correlated with increasing incidence and severity of adverse outcomes[95, 96, 97, 98].

However, current ACE categories have been criticised for not taking sufficient account of other childhood experiences, notably economic disadvantage, discrimination, and racism – which, as discussed earlier, have a major impact on subsequent mental health.

What is needed is a more integrated understanding of what makes young people vulnerable to mental health difficulties: it is likely to involve a combination of wider social factors and specific adverse experiences, with the possibility of strong inter-relationships between them. While more research on ACEs is needed[99], concerted efforts that address those factors that have greatest impact on the incidence of mental illness across the life-course[100] are justified.

Adverse Childhood Experience	Increased likelihood of developing serious mental health difficulties
Physical, sexual, or psychological abuse[101] ☐ Moderate ☐ Severe	 11x 48x
Taken into care[102]	11x
Bullying[103]	3x
Violence in the home[104]	9x
Deprived economic backgrounds as children[105]	7x

Table 6: A summary of research studies linking ACEs with an increased risk of mental ill-health

> Physical abuse, sexual abuse, and psychological abuse have been shown to have major adverse consequences for mental health, whereas the impact of parental criminality and imprisonment on mental health outcomes is inconclusive.

CLOSING THE PREVENTION GAP:
THE PARADIGM SHIFT TO WHOLE-SYSTEM CHANGE

Given that those who have a high level of resilience in childhood and adulthood are 50 per cent less likely to have a mental illness in later life[106], there are strong grounds for a focus on building resilience in and around young people.

> "Mental health is a right not a gift."

The Commission has identified four building blocks that influence young people's resilience, each of which needs to provide a focus for policy development and intervention.

Figure 5: The four building blocks that influence young people's resilience

Closing the Prevention Gap: Enhancing Family and Community Relationships

Parental Health and Well-being

The foundations for a resilient generation rest on the well-being of their parents, which is influenced by a range of social determinants, wider social networks, and the places in which they live. Universal 'family-friendly' policies that are designed to create the conditions in which a 'secure base' can be provided, including secure housing, financial benefits, provision for maternity and paternity leave, and measures to encourage work/life balance, also play a role.

In 2017, there were 19 million families in the UK, a 15 per cent increase from 1996[107]. 25 per cent of families with dependant children are single-parent families, 90 per cent of which are headed by women[108], and 21 per cent of single parents are from a Black, Asian, and Minority Ethnic (BAME) background[109]. Just under half (47 per cent) of children in single-parent families live in relative poverty, around twice the risk faced by children in couple families[110], indicating that welfare measures to improve this situation form an important strand of a strategic approach to building a resilient generation. Furthermore, although there have been significant improvements in terms of maternity and, particularly, paternity provision in recent years in the UK, there is still a need for a culture shift towards men taking an active role in parenting. Additional support needs in relation to poor mental health and/or alcohol or substance abuse also need to be recognised and appropriate support made available.

Perinatal Support

Between ten per cent and 20 per cent of women develop a mental health problem during the perinatal period and this has been recognised as a public health problem[111] because of the negative effects on the mother and the potentially long-term consequences for the healthy emotional, cognitive, and physical development of the child. This is a critical area for early intervention for women, but one that has only been recently recognised[112].

- Universally provided parent education and infant sleep interventions
- Screening and collaborative care, involving midwives to identify and intervene early
- Mother-infant (as part of wider) support for women with elevated symptoms of perinatal depression
- A range of different support for women with moderate to severe symptoms, including offering exercise, yoga, online support, intensive psychological support, and multi-disciplinary support

Figure 6: Promoting positive mental health in the perinatal before and after birth[113]

Support for Parents and Families

Family relationships are important determinants of mental health outcomes, both in terms of parent-child bonding[114, 115], and in terms of the wider context of family interactions, particularly those between parents[116]. Although mothers tend to be the primary focus of parenting, relationships with fathers are also predictive of differences in subsequent mental health outcomes[117].

CREATING AN EFFECTIVE 'SECURE BASE' FOR GROWING UP DEPENDS ON A RANGE OF FACTORS – BOTH MATERIAL AND EMOTIONAL.

Central to this can be opportunities for secure psychological attachment, and this may be threatened by traumatic or abusive experiences taking place within the context of family life. Family interactions characterised by affectional bonds and encouragement of autonomy can protect against mental health difficulties in adulthood – both in terms of enabling the development of personal resilience and in providing a secure base from which to develop wider social and relationship capital[118]. Conversely, parent-child interactions characterised by lack of emotional warmth and intrusive control or over-protection are predictors of greater risk of subsequent mental health difficulties[119, 120]. Particular issues arise where children, including those as young as five, take on a caring role due to parental disability or ill-health – and this may often go unrecognised. Such children may miss out on opportunities to develop *as children* rather than as carers – and they may miss school and have lower educational attainment as a consequence[121]. Difficulties in family relationships are by far the largest reason for referral to CAMHS[122].

Both in the UK and internationally, there has been investment in a range of programmes that have sought to enhance parenting capability and family relationships – usually targeted to some degree towards those families seen as in greatest need of such support.

Usually situated in disadvantaged communities, Sure Start Children's Centres aim to offer social and professional support in a non-stigmatising way to families with pre-school age children. Although much of what is on offer can be primarily focused on mothers, this can nevertheless achieve positive outcomes in terms of enhancing family relationships and functioning – as well as enabling significant improvements in mothers' mental health. However, the positive benefits may not be sufficient to fully compensate for the adverse effects of economic and social disadvantage[123].

Figure 7: Sure Start/Children's Centres

Parenting Programmes

Internationally recognised parenting programmes, such as Triple P and Incredible Years, have a strong evidence base in terms of child behaviour outcomes[124], although the evidence suggests that such interventions, which are directed primarily at the parent, may not have significant long-term impact on mental health outcomes[125]. Potentially more serious ACEs, such as the prevention of domestic violence, are outside the remit of most programmes – and they may not always be very successful in engaging with fathers/partners[126]. The Early Intervention Foundation (EIF) has concluded that a more holistic whole-family approach is necessary if there is to be real impact on the sorts of ACEs that influence subsequent mental health[127]. In particular, a greater focus needs to be given to those programmes that actively engage with both parents and their relationships with each other, as well as with their children (whether or not they are currently in a partner relationship).

Promising approaches are the Supporting Father's Involvement programme in the USA[128] and the Cowans programme[129] which has been rolled out by Tavistock Relationships and which has been funded by the Government to increase the provision of parenting programmes to couples.

Figure 8: Involving fathers

Family Interventions

Taking an inclusive whole-family approach (with potentially greater involvement of fathers), Family Intervention Projects have achieved impressive results in the UK[130] – although they typically saw less success when parents had existing mental health or other health difficulties[131]. The Troubled Families programme has attempted to scale-up this approach on a national scale, but a national evaluation of Phase 1 did not find positive results overall compared to matched controls. Although there were 'some beacons of good practice', there were concerns that the scaling-up had resulted in some sacrificing of the quality of family intervention practice[132]. The Commission hopes that these implementation and training issues will be better addressed in Phase 2 of the roll-out of the programme.

A particularly promising approach to family intervention is the Family Recovery Project model in which mental health and substance misuse specialists are embedded within the core team. This has demonstrated positive outcomes for families where parental mental health or substance misuse are issues[133] – thereby tackling two of the identified ACEs that may otherwise be predictors of subsequent mental health difficulties.

Figure 9: Family Recovery Projects

Overall, there is evidence that existing programmes can have positive impacts on family life. A consistent theme that emerges is the need for more of a whole-system approach that engages fathers and wider family, rather than focusing on mothers in isolation – and one where there is specific expertise in relation to key issues such as mental health and substance/alcohol abuse.

Investing in Healthy and Sustainable Communities

We have long known the value of social capital and of ensuring that potentially excluded groups have access to this. In a recent report, the World Health Organization (WHO) argued that:

> Supporting action to create cohesion and resilience at local level is essential. It requires a 'whole-of-society' approach that encourages local-level partnerships between those affected by inequity and exclusionary processes and a range of civic actors – civil society and other partners[134].

The Commission believes that this is best summed-up as investing in social infrastructure. Critical elements of this infrastructure are the built and green environment; housing and employment are known to be critical to good mental health and conversely to poor mental health and widening inequalities[135, 136]. Local government has a key role to play in influencing the social infrastructure of our communities.

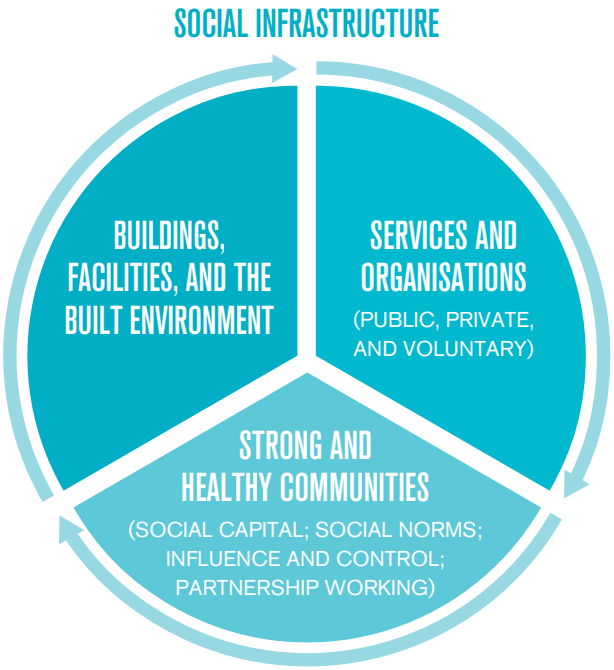


Figure 10: Dimensions of social infrastructure[137]

Promising approaches to developing social infrastructure, which are being implemented by local government and health partners, include Asset-Based Community Development[138] and Local Area Coordination[139]. However, the focus has so far tended to be on the needs of vulnerable and socially isolated adults and older people, rather than on those of young people.

Local Area Coordination is an evidence-based approach to support people as valued members of their communities. It enables people to pursue their vision for a good life and to stay safe, strong, connected, healthy, and in control.

Local Area Coordination works to:

- provide an accessible point of contact and networking in the local community;
- help people build their own assets and community connections; and
- build trusting relationships with individuals, wider community members, and workers in organisations.

Originally developed in Western Australia where it has been used to support the resilience and safety of both adults and young people, it is currently being implemented in over 11 UK local authorities – but generally just with a focus on vulnerable adults.

Figure 11: Local Area Coordination

The Commission believes that community engagement activity needs to be re-focused on the perspective of young people – recognising that many young people are seeking opportunities for meeting and connecting within safe community spaces.

Critical to strong social infrastructure is empowerment and co-production.

> Where activities are co-produced... both services and neighbourhoods become far more effective agents of change[140].

INCREASING THE CONTROL PEOPLE EXERCISE OVER RESOURCES AND THE ACCESS THEY HAVE TO SOCIAL INFRASTRUCTURE CAN BOLSTER SOCIAL SUPPORT, SELF-ESTEEM, AND SELF-EFFICANCY, WHICH ACT AS A BUFFER TO THE ADVERSE EFFECTS OF SOCIO-ECONOMIC AND FAMILIAL STRESSORS.

The Commission believes that co-production should become an organising principle in public services' engagement with communities and the young people within them. By looking to the capabilities and strengths of individuals and communities, a new paradigm for mental health would seek to build on these assets, as illustrated by the Black Thrive initiative in Lambeth.

Black Thrive aims to tackle the range of deeply entrenched and complex societal issues, including racism, that contribute to significantly poorer outcomes for African and Caribbean people with respect to their mental well-being. Black Thrive recognises that a systematic approach to address deeply systemic issues is required. It is a five-year partnership between local services and the community centred around a shared vision that all Black people thrive, experience good mental health and well-being, and are supported by relevant accessible services, which provide the same excellent quality of support for all people regardless of their race. In recognition that no single action or intervention can independently achieve change of this scale, Black Thrive provides the governance, infrastructure, and resources for organisations and individuals to collaborate, co-design, and co-ordinate activities in order to meet shared objectives. Parity of voice is central to this vision, and so members of the local communities are equally represented at all decision-making levels, sitting alongside statutory organisations to set priorities for the system.

Figure 12: Black Thrive as an example of co-production in mental health

It is important to recognise that some communities are divided on the basis of income, ethnicity, or other factors, and minority groups may sometimes feel excluded from an otherwise cohesive community – with a consequent detrimental impact on their mental health[141]. While the Commission welcomes the focus on community cohesion in the Government's recent *Integrated Communities Strategy Green Paper*[142], we are concerned that the approach proposed does not fully reflect the complexities of processes of inclusion and exclusion – and hence how to build communities that create resilience capital.

The Commission received many examples of community-based preventative interventions that have improved quality of life and mental well-being and that have also demonstrated system benefits, such as reduced healthcare utilisation[143, 144]. However, despite documented success, they struggle to become established because mainstream programmes tend to be funded by local authorities and the NHS as pilots and as part of discretionary spending.

The Commission believes that an agreed definition of social infrastructure and how to measure it would help to underpin the shift of paradigm by increasing transparency and accountability. The ONS already measures some aspects of social infrastructure and adding more effective measures of social and relationship capital would further strengthen the current data collection.

Closing the Prevention Gap: Minimising Adverse Experiences and Exclusions

Impact of Inequalities

The Marmot Review[145] advocated six policy objectives as necessary to reduce inequality; these have been endorsed more recently by PHE and the Institute for Health Equity at University College London (UCL)[146]. The Commission also wishes to endorse these as a benchmark for policy and strategy development at a national and local level.

1. Give every child the best start in life
2. Enable all children, young people, and adults to maximise their capabilities and to have control over their lives
3. Create fair employment and good work for all
4. Ensure a healthy standard of living for all
5. Create and develop healthy and sustainable places and communities
6. Strengthen the role and impact of ill-health prevention

Figure 13: Recommendations from the Marmot Review

To be able to provide a secure base for their children, families need to have an adequate and secure income, access to health care, education, and employment, and, perhaps most importantly, decent housing. Addressing these requires scrutiny and review across a range of government policy – with an awareness that an investment in ensuring the basic living conditions in which children will thrive can potentially save the Exchequer substantial sums in the long run.

Alongside such a universalist emphasis, there can be value in more targeted initiatives to help those most vulnerable or at risk. Community engagement and asset-based community approaches are critical to addressing inequality and social exclusion because they open up opportunities to harness local initiative, mobilise local resources, and ensure that marginalised or disadvantaged families are better networked into the mainstream. Accessible debt and welfare advice may also be of great value in preventing extremes of financial exclusion.

An equally important priority is to ensure secure and stable housing and to support families and young people at risk of homelessness. Approaches to reducing evictions of families is an important upstream intervention and should be prioritised by national and local government. In addition, Housing First – an evidence-based approach to enable potentially vulnerable people to have a settled home with intensive support to address personal, social, and health issues – is an important element of preventative action to reducing homelessness[147].

Responding to Adverse Experiences

Making Children Safer: Innovative Approaches

In England, local authority children's services have tended to be reactive rather than proactive, with little explicit focus on long-term mental health outcomes – even though children who experience abuse and Looked After Children have an elevated risk of subsequent mental health difficulties. However, in response to Munro's critique of child protection practice[148], and supported by the Department for Education Innovation Fund, some local authorities have promoted more proactive and holistic practice frameworks for engagement with families[149]. These promote earlier resolution of issues of harm and risk[150].

Using such approaches, innovators such as Hackney and Leeds have demonstrated an ability to make a substantial reduction in the number of children coming into the care system – with a potential long-term gain in terms of a lower incidence of mental health difficulties.

Restorative Practice is a whole-system approach that can include schools and other services that engage with young people. Using the mantra of 'high challenge/high support', it has a strong focus on working positively with families and peer groups to address issues of harm at an early stage, using approaches such as Family Group Conferencing, which gives power back to members of social networks to come up with sustainable solutions that provide safety and nurturing. Restorative Practice provides the basis for 'bottom-up' family and community-based approaches to minimise both the incidence and impact of ACEs, such as physical and sexual abuse and domestic violence, and can underpin a whole-system approach that includes schools and other services that engage with young people. It needs to be located within a wider educational approach to changing cultural and social norms to abuse and violence.

Linked to Restorative Practice, *Family Group Conferencing* is an approach to family-based planning and decision-making that is now being increasingly used as an alternative to professionally dominated forums in situations where children are seen to be in need or at risk. This can be particularly effective in engaging fathers and extended family in the support of children, thereby enabling more effective systems of support and protection that may or may not involve significant on-going input from professional services. When Family Group Conferencing was implemented in Kent, it was found that, in the majority of cases, positive solutions were found, which averted the need for children to enter the care system[151].

Figure 14: Restorative Practice and Family Group Conferencing

Tackling Domestic Violence and Abuse

The Government is consulting on improving the response to domestic violence, with the aim of preventing domestic violence by challenging the acceptability of abuse and addressing underlying attitudes[152]. Overwhelmingly, it is women who are the victims and survivors, and men who are the perpetrators, of domestic violence[153, 154], with a profound impact on children.

The National Society for the Prevention of Cruelty to Children (NSPCC) has evaluated a group intervention programme for mothers affected by domestic violence, known as DART (Domestic Abuse, Recovering Together), which shows promising results. The programme aims to help mothers support their children by helping them understand how they have been affected by the abuse and supports the mother's recovery[155]. A reduction in emotional and behavioural difficulties shown by the children and the improvement of mothers' self-esteem were maintained six months after the programme concluded[156].

Figure 15: DART (Domestic Abuse, Recovering Together)

There has, understandably, been a focus on interventions and programmes for victims and/or perpetrators of domestic violence, but relatively little attention has been paid to prevention.

CHANGING ATTITUDES AND BEHAVIOURS THROUGH EDUCATION AND AWARENESS-RAISING IS KEY FOR CHILDREN AND YOUNG PEOPLE TO LEARN WHAT IS ACCEPTABLE AND TO SHIFT SOCIAL NORMS WITHIN PEER GROUPS[157].

There is reasonable evidence for pre-school school-based education programmes for both the prevention of child sexual abuse[158] and domestic violence[159]. However, this is reliant on the readiness of schools to implement this and will require training and support from specialist domestic violence staff[160].

A review of programmes addressing domestic abuse reinforced the value of a whole-family focus in services rather than focusing on vulnerable women or vulnerable children in isolation[161]. In Leeds, where a restorative approach has been rolled out in children's services, there is some evidence of a reduction in rates of re-referrals for domestic violence[162]. Internationally, the Supporting Father's Involvement programme has targeted families experiencing high levels of conflict and shows promise in relation to both reducing violent behaviour and increasing fathers' involvement in domestic life.

Community-Level Initiatives

Internationally, an ambitious whole-system approach to enhancing community capacity and preventing and mitigating the effects of ACEs has been undertaken in Washington State, USA[163]. Using locally based community partnership approaches, programmes embraced universal and targeted prevention activities aimed at increasing individual and collective resilience and trauma informed programmes to provide remediation or recovery services to young people with multiple ACEs. They all included a focus on:

- child abuse prevention and family support;
- school climate and student success;
- risk behaviour reduction and healthy youth development; and
- community development.

The conclusion of the evaluation was that those sites that were most effective in addressing ACEs and building resilience were those that had effective strategies for achieving change through building community capacity and networks.

Closing the Prevention Gap: Mentally Friendly Education and Employment

Schools

Schools play an important role both in promoting mental health and well-being and responding to mental health needs that may not be picked up by or voiced to parents[164]. Around 60 per cent of schools in England have a plan or policy about promoting the mental health and well-being of all pupils or report that the promotion of positive mental health and well-being is integrated into the school day[165]. Support groups and peer support can be offered – but only by around 40 per cent of schools. Around 60 per cent offer counselling services, but of these less than half offer more than five hours per week in total for the entire school population – indicating that this is not a generally available service for pupils who may be facing difficulties. Typically, this has to be funded out of stretched school budgets.

The Government's recent Green Paper[166] recognises the important role that schools can play in relation to mental health and proposes funding for schools to establish new mental health support teams – and it is hoped that around one in four schools in England will have this provision in place by 2022.

Social and Emotional Learning

There is strong international evidence for school-based Social and Emotional Learning programmes that aim to promote capabilities for resilience, healthy and respectful relationships, and good mental health. Some also specifically target bullying and other potentially adverse experiences. Although bullying is recognised as relatively widespread and having a negative effect on mental health, recent findings highlight the potential for resilience in children exposed to bullying, and the importance of supporting the resilience of children and young people as they recover from bullying[167].

Most programmes are delivered on a universal basis, often with targeted input for those needing additional support. Research shows that all children can derive some benefit in terms of self-esteem, well-being, and reduced incidence of mental health problems, with those more at risk showing 'a more dramatic effect'[168, 169]. Universal approaches can provide a more inclusive, and less stigmatising, way of working with young people of greater concern. By contrast, some purely targeted interventions, for example, programmes for children who were identified as exhibiting aggressive or bullying behaviour, can be less effective and even produce negative outcomes[170].

Whole-System Approaches

Within Leeds, under the slogan 'Making Leeds a child friendly city', Restorative Practice has been rolled out in schools, as well as children's social care services and other sites of engagement with young people. At the core of this is the facilitation of 'restorative conversations' involving all those involved in, or affected by, incidents of harm or abuse – including young people, teachers, and family members. The aim is to provide an ethos of high challenge and high support in which difficult feelings can be expressed and potentially harmful issues resolved. In turn, bringing such issues out into the open can lead to a broader culture change in which abuse is less likely to occur and social networks are likely to be more protective.

The effectiveness of programmes can depend on the wider school and community context in which they are delivered. In isolation, behavioural-based programmes may not be effective[171] – whereas programmes that infuse the whole school culture have much greater impact[172, 173].

Experience in the USA suggests that:

a) multi-year programmes are more likely to foster enduring benefits than short-term interventions;
b) prevention programmes that focus on multiple domains (eg, individual, school, and family) are more effective than those that focus only on the child;
c) for school-age children, the school ecology and climate should be a central focus of intervention; and
d) programme success is enhanced by combining emphases on changing children's behaviours, teacher and family behaviour, home-school relationships, and school and neighbourhood support for healthy, competent behaviour.

Figure 16: Evidence on whole-school approaches[174]

Where the involvement of parents and families can be achieved, school-based programmes can bring about significant positive changes at the family and community level with potentially large effects[175, 176, 177, 178].

Schools have been rightly identified by government as crucial sites for promoting the positive mental health and well-being of young people. Social and Emotional Learning programmes are an important part of this, but they can only be effective if they become central to the ethos of the whole school, rather than being marginalised into specific parts of the curriculum – and undervalued in relation to academic achievement. It is also important for schools to look outwards and engage with parents and the wider community around this agenda. An underdeveloped area in some schools is the provision of support groups, peer mentoring, and counselling.

Supporting Successful Transitions in Education and into Employment

Through embedding personal, social, health, and economic education (PSHE), schools can help equip students with the necessary practical skills and resilience capital that can enable them to make successful transitions from primary school to secondary school, and subsequently to college, university, and/or employment. The Big Lottery is currently investing £75 million in the Headstart programme to develop and evaluate models to support young people through the primary/secondary transition. Important areas to cover are not just social and emotional learning; practical skills, including managing finances and healthy eating, are also important. This is particularly important for the onward transition from school. However, such learning may not currently be sufficiently prioritised and may be seen as a lower priority than academic learning.

Universities

The transition to university can be daunting for young people who are insufficiently prepared and who often experience loneliness, financial problems, and stress[179]. This can result in alcohol/substance abuse, financial crisis, and mental distress[180]. A 2016 YouGov survey reported that 27 per cent of university students experience mental distress[181] and there have been increasing numbers of student suicides.

UNIVERSITIES HAVE SEEN AN UNPRECEDENTED 94% INCREASE IN DEMAND FOR COUNSELLING SERVICES[182].

Many universities do not yet have effective strategies for supporting the mental health of students and there is significant variation in the type of, level of, and speed of access to services[183]. In response to this, IPPR[184] and Universities UK[185] are recommending a 'step-change' in terms of a 'whole-university' approach, which would ensure that prevention and early intervention strategies are at the heart of student mental health provision. The Commission wishes to endorse this approach.

Closing the Prevention Gap: Well-being at Work

Getting into Employment

Getting into employment can be a challenge for young people but more so for those experiencing mental health difficulties. A Cochrane review of 14 randomised control trials (RCTs)[186] found that supported employment and Individual Placement and Support (IPS) are better than other approaches in enabling people to find jobs quicker and be in employment for longer. Success is not dependent on diagnosis but on motivation – and the majority of those who wish to work are placed successfully. Research also shows that people accessing employment through IPS find that their mental health and social functioning also increase in comparison with matched controls[187]. Originally developed for people with more severe mental health difficulties, IPS is now being rolled out in the West Midlands for people experiencing common mental health problems and this is currently being evaluated.

Staying in Employment: Implications for Employers

Work is changing and so is health and safety at work. Mental ill-health and stress are now the largest causes of sickness absence, accounting for 49 per cent of all days lost due to ill-health[188]. But the cost of sickness absence is dwarfed by the cost of 'presenteeism', which is estimated to amount to between £16.8 billion and £26.4 billion[189]. The cost of poor mental health to the UK economy has been estimated at £33 billion to £42 billion.

49% OF SICKNESS ABSENCES ARE DUE TO MENTAL ILL-HEALTH AND STRESS.

Research suggests that focusing on well-being can give a 12 per cent productivity gain[190] – while failure to address mental health problems in the workplace, whatever the cause, has a direct impact on business performance and productivity.

In October 2017, the review *Thriving at Work*[191], commissioned by the Prime Minister, made 40 recommendations. The review's authors, Lord Stevenson and Paul Farmer, summed-up their approach: *'the correct way to view mental health is that we all have it and we fluctuate between thriving, struggling and being ill and possibly off work'.*

The report makes a strong case for action by businesses, regulators, government, and employees themselves in establishing mental health standards in workplaces.

The Commission strongly believes that implementing these standards would result in more high-performing British businesses. To do this, there is a need for greater transparency and consistency in the public reporting of company policies and action to promote and protect the well-being and mental health of their employees. This should take the form of narrative discussion and metric-based reporting to facilitate understanding.

There is already a well-defined set of public reporting guidelines developed by Business in the Community[192]. Benchmarking of the FTSE 100 against these guidelines has found that companies that have robust arrangements for reporting on employee engagement and well-being out-perform the rest of the FTSE 100 by ten per cent[193].

The Commission believes that there are clear business and societal benefits from including measures of employee health and well-being within the wider reporting by companies of their 'human capital' – the knowledge, skills, and abilities of their workforce[194]. Given the particular value of this reporting for investors, the FCA should consider making such reporting mandatory. Alternatively, the Government could follow the precedent it set in April 2017 with the introduction of regulations[195] for the collection and publication of gender pay gap data by employers with 250 or more employees.

Core mental health standards	Enhanced mental health standards
Produce, implement, and communicate a mental health at work plan that encourages and promotes good mental health of all staff and an open organisational culture	Increase transparency and accountability through internal and external reporting
Develop mental health awareness among employees	Demonstrate accountability by nominating a health and well-being lead at Board or Senior Leadership level
Encourage open conversations about mental health and the support available when employees are struggling	Improve the disclosure process
Provide your employees with good working conditions	Ensure provision of tailored in-house mental health support
Promote effective people management	
Routinely monitor employee mental health and well-being	

Table 7: Core and enhanced mental health at work standards[196]

Closing the Prevention Gap: Responding Early and Responding Well to First Signs of Distress

There is strong evidence that offering an early and appropriate response to young people at the point that they are first showing signs of emotional or mental health difficulties can substantially reduce its severity and long-term impact. The case has been made particularly strongly in terms of anxiety and behavioural issues that may be precursors of more serious and enduring mental health difficulties. Responding early and responding well may also be important in minimising any consequent impact on family life, education, employment, and peer relationships.

Accessing Appropriate Support

We heard from young people that when they first started to experience difficulty, they did not always receive the sort of support that would have been most helpful for them. For many, the issues that were challenging for them were seen as part of a wider 'life crisis', perhaps involving relationship difficulties (with peers or family), identity issues, bullying, academic expectations, and/or other factors. There was typically no obvious place to go for help with these concerns, and they are not necessarily seen as the province of mental health services. From the point of view of family members, friends, or even their GP, it was similarly unclear as to how to access early and appropriate support.

> "We are human beings with human emotions and need to be treated as such."

Young people expressed the view that they would have wished for more choice in terms of the support that could be offered, not always feeling that a clinically focused response, and being labelled with a mental health diagnosis, was what would have been most helpful, at least in the first instance. A timely and 'joined-up' response to the young person's social, emotional, and mental health difficulties is badly compromised by the lack of integration between local authority children and family services, school-based counselling and support services, and NHS-provided mental health services. Many services have waiting lists and eligibility criteria that manage demand in such a way as to reduce the possibility of an early and preventative response and instead only offer support and intervention when a situation has become much more serious and entrenched – potentially requiring a more costly trajectory of service use.

Given that the onset of first difficulties are typically between the ages of 12 and 25, organisational splits between CAMHS and adult mental services in the ages between 16 and 18 can be particularly unhelpful – as is the distinction between early intervention services for psychosis, typically located within adult mental health services but potentially taking referrals for younger adolescents, and CAMHS for young people of the same age who are not (yet) displaying definitive signs of psychosis. All of this combines to militate against the provision of a coherent and well-understood point of access for young people who may be in need of an early response to difficulties that could easily escalate into more serious mental health issues.

One promising model being implemented by a growing number of CAMHS is known as THRIVE. The THRIVE framework[197] is a multi-agency, person-centred and population health approach to deliver mental health services for children, young people, and families. It aims to replace the tiered model of children's mental health care with an emphasis on a whole-system approach. It emphasises need in five categories: Thriving, Getting Advice and Signposting, Getting Help, Getting More Help, and Getting Risk Support. Prevention and the promotion of mental health and well-being is emphasised along with a clearer distinction between treatment and support. Children, young people, and their families are empowered through active involvement in decisions about their care through shared decision-making, which is fundamental to the approach.

The model was first developed in Camden by the Tavistock and Portman NHS Foundation Trust and is now being implemented in a number of other places in England, including the whole of the Greater Manchester Combined Authority area.

Figure 17: The THRIVE Framework

Digital Technology

Digital channels and services are increasingly being used to promote self-management and as a way of extending the reach of healthcare professionals, widening access to appropriate support, and meeting people's preferences. The internet and smartphones offer quick access to support and can offer solutions to overcoming the barriers to appropriate and effective support for those who require/seek support. These technologies can be divided into those that deliver mental health services and those that offer 'self-help' via apps or online. It also allows for scarce professional resources to provide the right intervention at the right time.

THE ROYAL FOUNDATION OF THE DUKE AND DUCHESS OF CAMBRIDGE AND PRINCE HARRY, IN COLLABORATION WITH HEADS TOGETHER, HAS RECENTLY INVESTED £2 MILLION TO ESTABLISH A NEW START-UP TO DEVELOP NEW DIGITAL TOOLS TO ENCOURAGE DISCUSSIONS ABOUT MENTAL HEALTH.

The Commission learnt of two pilot RCTs, the e-couch anxiety and worry program in schools[198] and the GoodNight Study[199], that demonstrate how e-health services may have value in preventing and reducing mental distress via fully automated services. Other digitally delivered and technology-based services have also demonstrated some benefits and successes, such as computerised cognitive behavioural therapy (cCBT) programs[200, 201] and SMS-based programs[202].

Although some of the current evidence is promising, there is a need for greater clarity in terms of what technologies work for whom and in what circumstances. We do not yet have more detailed evidence from larger-scale trials and there is currently limited evidence outside the clinical environment[203] – and the extent to which children and young people effectively engage with these services is unclear[204, 205].

Based on the evidence provided to the Commission, digital technology has not yet demonstrated that it should be the channel of choice for overcoming barriers to mental health care nor as an alternative to relational encounters with mental health services. However, the Commission recognises that digitally delivered mental health services have a role to play in addressing the prevention gap.

> "Digital channels and interventions have a place but they can also create risk of isolation. We need to have a human on the other end."

Early Detection and Support for At-Risk Groups

However accessible services may be, there is still the likelihood that some young people – particularly those who may be the most vulnerable – may not take the step of asking for help when they first need it. Particular at-risk groups may include:

- Looked After Children (especially those leaving care);
- victims of assault or abuse – and those for whom there have been safeguarding concerns;
- young offenders;
- homeless young people;
- young people not in employment, education, or training;
- young people with parents who have had mental health or substance/alcohol abuse problems; and
- recent migrants/asylum seekers – and particularly unaccompanied minors.

While there is little evidence to support the idea of universal screening/intervention programmes for young people, there is a stronger argument for systematic alertness to indications of emerging mental distress within identifiable higher-risk groups. Most such young people should already be known to services and should, in many instances, be in regular contact with a professional or support worker. The EIF has highlighted the importance of, and characteristics of, a trusted relationship – and how a range of factors can make this easier or harder to stay alongside vulnerable young people[206]. Public Health Wales has shown how having trusted relationships with adults is a key component of childhood resilience, with a major impact in terms of reducing the likelihood of mental health difficulties in adulthood[207].

> "There needs to be easy access to support and services so that everyone is welcome."

In addition to ensuring organisational support for trusted relationships, mental health and well-being should be a consistent and explicit part of the agenda, so that early signs of mental health difficulty – for example, anxiety, poor concentration, and low mood – may be picked up. Such early identification would need to be backed-up by appropriate mental health training for practitioners so that appropriate support can be offered.

Characteristics of a Prevention-Focused Early Response

Building resilience and offering treatment should not be seen as either/or, but as both/and – some CAMHS, such as THRIVE and Early Intervention for Psychosis services, embrace practices that help young people and their families to build on personal, social, relationship, and identity forms of capital, alongside providing immediate treatment and care.

What is required in service specifications is explicit recognition of the importance of secondary preventative activity at a time when young people are at great risk of rapidly losing a substantial part of their social and relationship capital, as well as much of their identity capital. Alongside this, if they drop out of education or employment and their return is not properly supported, they stand to lose a significant part of their personal capital and their (potential) economic capital.

Models of Inclusive and Accessible Early Response Services

Accessibility, acceptability, and appropriateness are core principles that should underpin all forms of mental health support. However, mental health services are not always well designed to meet the needs of young people, who may be reluctant to discuss their difficulties, or their families. They may fail to take account of their needs and preferences in respect of gender, race, sexuality, or disability, or the evidence that young people and families facing severe social disadvantage are much less likely to seek support.

> "The experience of young people needs to be heard. This means both having a voice and having an impact on research and practice."

A key message from our consultations with young people and adults with lived experience of mental distress was that they wanted to have a voice in how services are designed and delivered. Indeed, we heard from young people about the misplaced assumptions that were made by services about their needs and the underestimation of their willingness or capacity to contribute. Therefore, the Commission endorses co-production as central to re-designing current provision.

There have been significant developments over the past 15 years in early intervention for young people experiencing psychotic symptoms[208]. The Commission heard from Professor Patrick McGorry about developments in an Australian context with the introduction of Headspace. Headspace is underpinned by the principle that support has to be readily available and the barriers to access addressed. The approach recognises the developmental nature of adolescence and is underpinned by the principle that support has to be readily available. Barriers to access have to be addressed, for example through co-location with sexual health and employment services.

> "Medication is the standard offer and while helpful for some it can leave us feeling drugged-up. Psychological therapies and social support need to be routinely available."

An independent evaluation of Headspace concluded that 'large numbers of young people would not access services or would access them at a much later stage in the development of their disorders, potentially incurring significant costs to the Government as well as difficulties for the young people and their families'[209]. However, one of the challenges now faced by Headspace is that some young people require additional support, but this is not readily available.

Headspace was developed between 2006 and 2009 to address mild to moderate mental health issues for young people between the ages of 12 and 25. Headspace has since grown to a network of 110 centres across metropolitan, regional, and rural areas of Australia, with the aim of creating a new culture and way of engaging with young people around their mental health.

The Headspace model was built from scratch rather than by reforming or adding to existing CAMHS. The underpinning philosophy of Headspace is engaging with and maximising life chances for young people. The model is a primary care model with a mix of different services and pathways. Designed with input from young people so they do not have the same look or feel as other clinical services, the centres are there to help people access health workers – whether it's a GP, psychologist, social worker, alcohol and drug worker, counsellor, vocational worker, or youth worker.

Headspace operates a 'soft access' or 'no wrong door' policy. The aim is to make every contact count – because it may be the only time a young person engages with a service.

Figure 18: Headspace as a model for accessible mental health support for young people

Another comprehensive first-response approach is that of Open Dialogue, which has been developed in Finland and is now being trialled in the UK. Although time-intensive in its early stages, this approach has shown considerable success in averting the need for hospital admissions, reducing the need for on-going medication and treatment, and maximising the chances of full and long-term recovery – with around 80 per cent of those presenting with the early stages of serious mental illness being fully recovered and re-integrated into family, education, and employment within two years[210].

Developed in Finland over the last 20 years, the Open Dialogue approach offers a rapid whole-system-based response to people when they first experience a mental health difficulty. Instead of offering an individualised programme of treatment and care, the first response is to convene a series of network meetings involving the person's family and friends, together with any significant others with an interest in their welfare, such as teachers or employers. The purpose of these meetings is to gain a deeper understanding of the challenges and difficulties that may underlie the mental health issue(s) and how these are understood by the person and those who are around them.

The approach is currently being trialled in a number of NHS Trusts in England and is the subject of a national research study funded by the National Institute for Health Research.

Figure 19: Open Dialogue[211] as a model for whole-system mental health support for young people

Investing in a Resilient Generation: What Now Needs to Happen to Close the Prevention Gap?

In the Commission's view, implementing piecemeal programmes will have limited impact on building young people's resilience or reducing their risk of exposure to circumstances or experiences that make them more vulnerable to mental health difficulties. The lack of integration between different programmes at national and local levels serves as a major obstacle to progress.

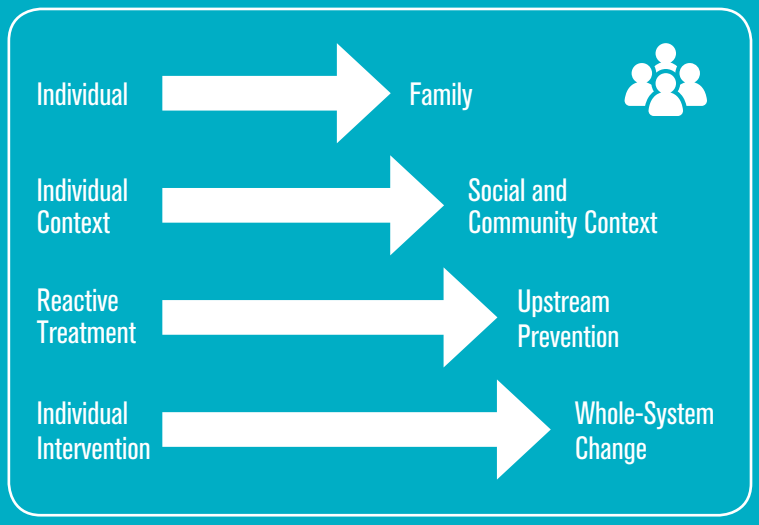


Figure 20: The Paradigm Shift

What is required is whole-system change and ownership of the mental health and resilience agenda across national and local government and across non-statutory agencies and communities; no single grouping can achieve the necessary shift on their own. This entails a 'step-change' shift in our thinking from downstream to upstream, from the individual in isolation to the wider social and community context, and from separate programmes or interventions to more joined-up changes in policies, cultures, and practices.

The Commission's Call to Action is designed to support this shift.

Successful innovation requires both creating the context and mechanisms through which such change is possible ('changing the rules of the game') and stimulating substantive local initiatives that can test-out more effective ways of supporting young people in their families and communities. There is also a need for rapid research and evaluation to be built-in as part of each initiative so that we can learn from what works.

Changing the 'Rules of the Game'

At the heart of the Commission's case for change is the evidence of the life-long consequences of failing to put in place the right support at the right time, especially during childhood. During the Commission's evidence sessions we heard how the EIF has estimated that the cost of 'late action' in the early years of life and childhood, even in the short-run, amounts to nearly £17 billion[212].

CURRENTLY, THERE IS NO SYSTEMATIC APPROACH TO CLASSIFYING WHERE PUBLIC EXPENDITURE IS PREVENTATIVE. IN ITS ABSENCE, THERE CAN CONTINUE TO BE AN INVISIBLE INSTITUTIONAL BIAS AGAINST EARLY ACTION, WHICH IS UNDERPINNED BY THE WAY IN WHICH RESOURCES ARE ALLOCATED AT ALL LEVELS OF GOVERNMENT.

Although unintended, this means that programmes that aim to prevent need arising in the first place tend not to be funded or are the first to be cut.

The next Spending Review, expected in 2019, offers the opportunity to change the default from spending on late action – on consequences – to spending on early action – on causes. An essential foundation for this shift of paradigm is how we account for public expenditure on early action. Building on the work of the National Audit Office (NAO)[213], and more recently the Chartered Institute of Public Finance and Accountancy (CIPFA) and PHE, it should be possible for the ONS to start a process of classifying spending on early action. Part of this work would include developing and consistently applying definitions of early action and social infrastructure. Adopting this approach would increase transparency and aid accountability for decisions on preventative versus reactive spending.

In our evidence-taking, we were struck by the idea that spending on early action should be recognised as a category of capital investment. Capital projects are already planned on a ten-year basis and social infrastructure and early action should be too.

Making Visible the Cost of Failing to Act Early

The approach proposed by the Commission builds on the most recent revisions to the Treasury's Green Book[214]. There have been a number of subtle but important changes giving greater emphasis to the individual and societal well-being. In particular, the valuation of costs and benefits section states that subjective well-being can be particularly useful in certain policy areas, for example community cohesion, children and families. By applying appraisal techniques to look at social, financial, and economic cost-benefit over the long-term, the 2019 Spending Review could identify opportunities for investing in early action and social infrastructure.

Were this re-classification of public expenditure to be undertaken, its value could be increased further by widening the remit of the OBR to report as part of its annual Fiscal Sustainability Report on the sustainability of acting too late.

The OBR's fiscal sustainability reports central projections have consistently pointed to an unsustainable fiscal position over the long-term, with the trend getting worse year-on-year. By making the build-up of untenable future spending liabilities more visible, it would also bring into focus whether preventative investment is at a level sufficient to improve long-term financial sustainability, crystallising the policy and spending choice for government.

Of course, one of the challenges facing public sector leaders, even when they accept the case for early action, is financing the upstream action long enough for its effect to be felt downstream. It is not an option to cut spending on those in need today.

However, during a Spending Review, government can take a longer view about spending priorities. It can decide to re-allocate a share of anticipated increased spending on late action by the end of a Spending Review period to start investing in early action programmes at the beginning of a spending period. In combination with the re-classification of spending described above, public spending could be shifted towards early action.

Just as a Spending Review is the moment to start shifting resources, it is also the moment to set clear accountability in government for driving early action. The Commission believes that HM Treasury is best-placed to take on this responsibility, especially navigating the stumbling block that spending on early action by one agency rarely leads to a saving landing in that agency.

'Best Buys' for a Spending Review Investment in Prevention

When the Mental Health Task Force consulted with service users about the priorities for mental health, access to and choice of treatment emerged as the top two choices, but next came prevention. The resulting *Five Year Forward View for Mental Health* called for a Prevention Concordat to be developed, modelled on the Crisis Care Concordat. This also included an updated economic modelling of the return on investing in a range of interventions[215].

Based on the evidence gathered by the Commission and the economic modelling by the LSE for PHE[216], the Commission believes the interventions set out in Table 3 offer the prospect of 'best buys' with long-term impact for children, young people, and families. These comprise:

- debt and welfare services;
- universal and targeted provision for perinatal mental health problems;
- whole-school anti-bullying programmes;
- social and emotional learning in schools;
- parenting programmes addressing conduct disorder;
- well-being programmes in the workplace;
- stress prevention in the workplace; and
- suicide prevention.

The Commission believes that these eight well-evidenced interventions should be commonplace and that they offer 'quick wins' for closing the prevention gap. In launching the Investing in a Resilient Generation Grand Challenge, the Commission recommends that the Government uses the 2019 Spending Review to pump-prime these eight interventions while the more ambitious Grand Challenge programme is mobilised.

Investing in a Resilient Generation: A Grand Challenge

To address the prevention gap will require sustained commitment and dedicated resources at a national and local level. The evidence gathered by the Commission supports the view that a shift towards prevention will lead to improvements in population health and savings to public sector budgets, and will boost the prosperity of the country. However, some of the actions will take time to achieve. It is vital, therefore, that sufficient time is given to enable these benefits to be realised, and that the process of change is dynamic in nature, realising the opportunities for innovation and learning.

Building the capacity at a local level to shift the system to one that is focused on prevention will require knowledge exchange and transfer. The Commission believes that in making the case for closing the prevention gap, the benefits should be viewed through the lens of increased productivity and prosperity. If health in all policies is to have meaning, it must be a feature of the Government's Industrial Strategy too.

Published in November 2017, the Industrial Strategy[217] sets out four Grand Challenges. They are to:

- put the UK at the forefront of the artificial intelligence and data revolution;
- maximise the advantages for UK industry from the global shift to clean growth;
- become a world leader in shaping the future of mobility; and
- harness the power of innovation to help meet the needs of an ageing society.

Each challenge will explore how to make the most of the global opportunity and how to respond to it. The Commission believes that closing the prevention gap should be framed as a fifth Grand Challenge: Investing in a Resilient Generation. This would have the goal of halving the number of people living with life-long mental health problems within a generation.

As the Government's executive agency for the public's health, PHE should work with Innovate UK to shape this Grand Challenge. Funding would be available to consortia of local government, education, business, community and voluntary organisations, and academia to implement real-world experiments that would impact on young people's mental health through effecting systemic change across a complex interlocking 'system of systems'. To be successful, any bid would need to demonstrate how it would engage with all four of the building blocks of resilience outlined in this report:

- positive family and community relationships;
- mentally-friendly education and employment;
- minimising adverse experiences and exclusions; and
- responding early and responding well to first signs of distress.

Consortia bidding for funding would have to demonstrate how they would work across these interlocking systems and make use of administrative and other data to support rapid cycle evaluation and mutual system accountability.

Research and Evaluation

Innovation on the scale envisaged by the Investing in a Resilient Generation Grand Challenge requires a framework for evaluating the outcomes of the complex interactions involved in whole-system change. Complex factors, imprecise measures, and long time-frames for assessment can all work together to inhibit research and the development of a strong evidence-base for policy decisions. The Commission heard different views on what constitutes strong evidence on which to base policy recommendations.

> "Communication between research and practice is needed. They are currently out of step so that the services provided are not taking account of the latest research."

1. Evidence is derived from empirical studies with the traditional hierarchy of evidence accepted, placing meta-synthesis of studies at the pinnacle and the supremacy of RCT designs evident in establishing rigour. The focus for studies is often on well-defined interventions (eg, CBT) and their outcomes, measured in terms of individual-level functioning, and the outcomes are often defined by academic researchers and capture data that can be measured.

2. The world is complex and systems thinking is needed, with evidence generated through learning from pilots and evaluating the implementation of initiatives in real-time. This is exemplified by Theory of Change approaches to evaluation 'bringing together science and practice' to ensure that practice promoted by policy fits local communities.

3. A rights-based approach, compatible with the notions of capabilities and aligned with promoting positive health and rights to health. People, families, and communities are centre-stage in this approach and their knowledge, preferences, and outcomes are essential in shaping policy objectives. Strong proponents of this approach emphasise the value of participatory research and of co-designing initiatives with communities.

Figure 21: Competing views on the nature of evidence to underpin a shift to prevention

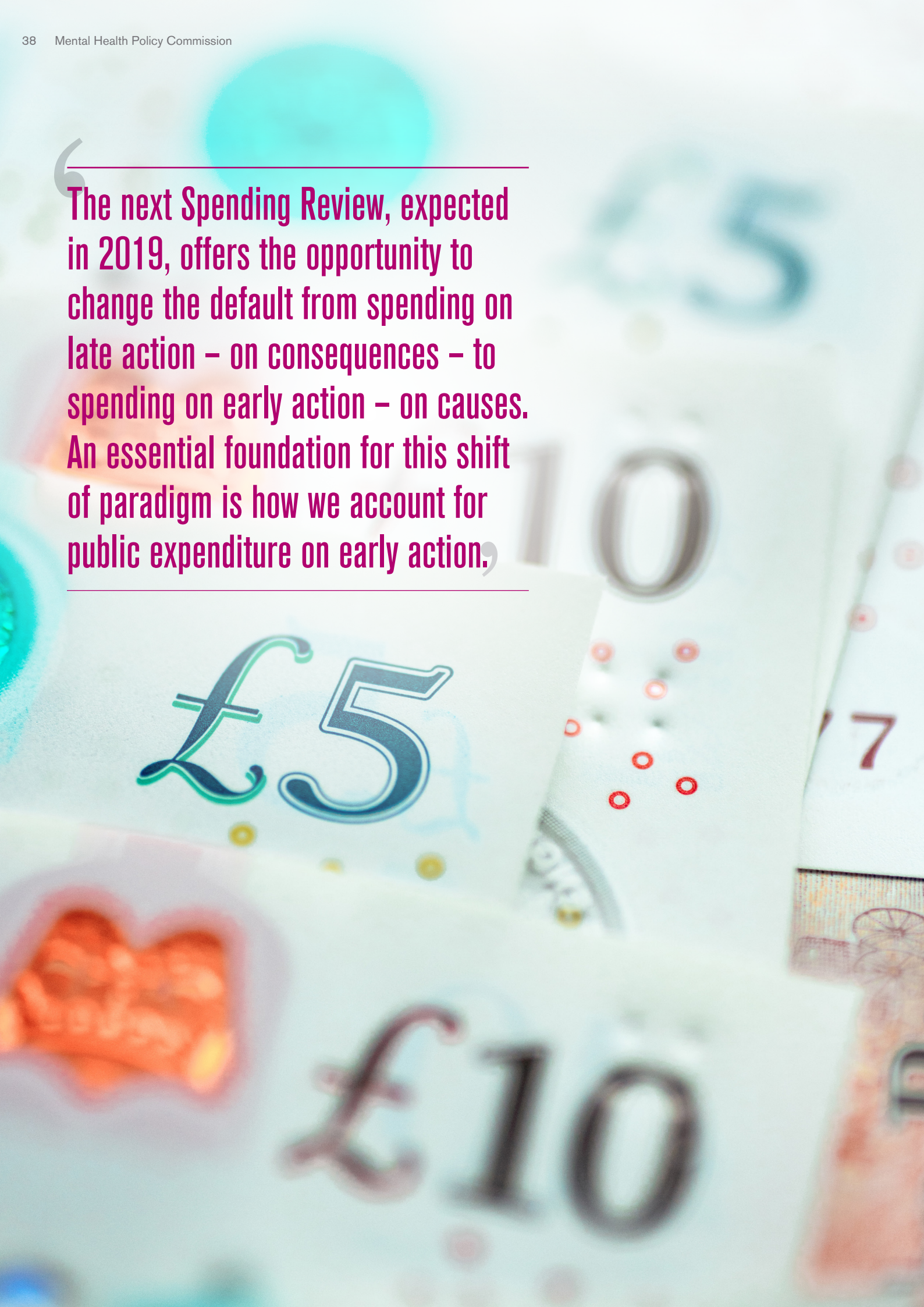
It is time to move beyond the turf wars and promoting a narrow view to what constitutes evidence. The Commission's view is that it is the integration of these three different approaches that is needed. The key questions are, therefore:

a. Has the initiative been the focus for systematic data gathering and analysis ('proof of concept')?
b. Has the initiative been tested in the real world through piloting and trialling to investigate the role of contextual factors and system-wide effects ('proof of scalability')?
c. Has the initiative been designed or tested with people experiencing mental distress, with their families, and with their communities to differentiate pathways and preferences ('proof of concept and scalability')?

Work on agreeing outcomes and the appropriate measures to demonstrate impact is needed as a matter of priority and should be an early task for the Grand Challenge consortia. This should have four aims:

- to learn more about how service systems interact and how to improve them to benefit people at risk of mental health problems;
- to identify the most promising interventions in terms of agreed outcomes and their costs and benefits;
- to track the impact of new policies across government departments and systems; and
- to identify areas for change to improve quality and outcomes within systems.

A wide range of methods are required, and the Investing in a Resilient Generation Grand Challenge should take advantage of national investment in big data studies as well as invest in a national programme of rapid evaluation of projects that can feed back learning into the system in terms of what is and is not working effectively, and in what contexts.



> The next Spending Review, expected in 2019, offers the opportunity to change the default from spending on late action – on consequences – to spending on early action – on causes. An essential foundation for this shift of paradigm is how we account for public expenditure on early action.

ABOUT THE COMMISSION

The Commission was established to explore and make the case for a paradigm shift from the treatment of mental illness to its prevention. At the outset, the Commission sought to understand the extent of the mental health treatment gap and efforts to close it set out in the *Five Year Forward View for Mental Health*. As this report documents, the Commission decided that the best way forward was to re-frame the challenge of closing the treatment gap to 'how do we close the prevention gap?'

During the course of the Commission's work it became clear that for the prevention gap to be closed, prevention has to underpin all government policies and has to start early in life. The Commission has, therefore, focused on primary prevention and early intervention for children and young people through promoting the conditions for good mental health.

The key lines of inquiry for the Commission can be found along with further details on the Commission's website at: **www.birmingham.ac.uk/mhpc**

The Commission's methods included:

- reviewing a diverse body of literature, including the evidence for interventions, descriptions of positive practice and key policies focused on reducing mental ill-health;
- an international call for evidence;
- witness sessions, hearing from internationally renowned experts in the field of mental health, particularly youth mental health;
- interviews and discussions with international experts; and
- a series of roundtable discussions at which the emerging findings were discussed and explored with targeted audiences, including young people and people with lived experience of poor mental health to ensure that their perspectives informed the Commission's work.

TERMINOLOGY

The Commission recognises the contested nature of the terms associated with mental health and has endeavoured to employ terms and phrases whose definitions are broad, recognisable, and do not privilege a particular knowledge basis. The terms mental wealth, mental capital, mental health difficulties, mental ill-health, poor mental health, mental distress, and mental illness have been used interchangeably to reflect the context.

ACE	Adverse Childhood Experience
CAMHS	Child and Adolescent Mental Health Services
CYP	Children and young people
EIF	Early Intervention Foundation
FCA	Financial Conduct Authority
GDP	Gross domestic product
GP	General Practitioner
IPS	Individual Placement and Support
LSE	London School of Economics and Political Science
NHS	National Health Service
OBR	Office for Budget Responsibility
ONS	Office for National Statistics
PHE	Public Health England
RCT	Randomised controlled trial
WTE	Whole-time equivalent

> 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.

> The costs of failing to marshal the necessary resources and implement large-scale programmes are huge. The time for small-scale pilots is over.

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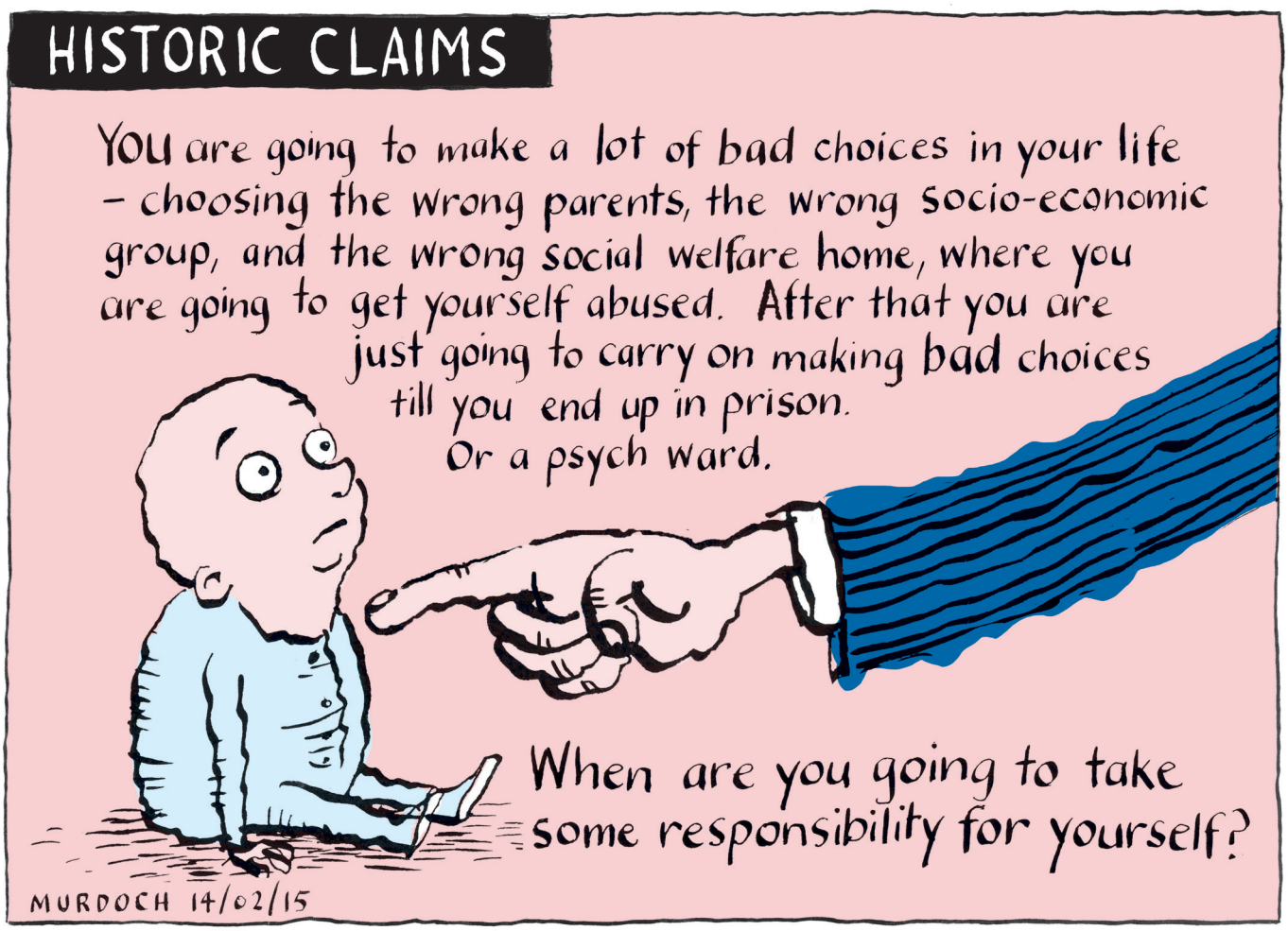

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NO SINGLE ACTION OR SINGLE AGENCY, IN ISOLATION, CAN ENSURE THAT THE CAUSES OF POOR MENTAL HEALTH ARE MINIMISED.

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.

UNIVERSITY OF BIRMINGHAM | institute for mental health

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.

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