Building a Preventative Mental Health System for Children and Young People

A report prepared for the Child of the North All-Party Parliamentary Group

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Foreword

Emma Lewell MP
Chair of the Child of the North
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Across the UK, increasing numbers of children and young people are experiencing poor mental health and wellbeing, and emotional distress; and nowhere has this strain been seen more than in the North. Demand for support has risen sharply over the last decade, doubling since 2011, and services continue to face growing pressures and long waiting times. For too many children and families, help only arrives when at crisis point.

Whether in my time as a children's social worker, as youth mentor, or local councillor, working with children from my area, or now as MP for South Shields, I have come face-to-face with the challenges so many children and young people face. But I have also seen the immense potential that can be unlocked when communities are strengthened, services are supported and barriers are removed.

Our children deserve to be supported throughout their lives. Mental health expands beyond clinical services and individual vulnerability; it is shaped by security of housing, stability of family life, experiences of poverty, relationships at school, feelings of safety. For children and young people growing up in the North of England, these factors are far more likely to come together, while they also have to bear the brunt of disproportionate service and funding cuts.

This report highlights the importance of place-based and preventative approaches, of which there are already great examples in communities across the North. But importantly, this report challenges us to think differently about what supports children and young peoples' mental health. The challenge is not simply to tackle issues when they emerge, but to create the conditions in which fewer children and young people reach crisis point in the first place. Building a genuine, future-proofed preventative mental health system will require long-term investment, cross-sector collaboration, and a renewed commitment to children, families, and communities - this is the key to ensuring our young people will thrive.

Executive summary

Children and young people's mental health has become one of the defining public health and social policy challenges facing the UK. Rates of anxiety, depression, emotional distress, and self-harm among children and young people have risen substantially over the last decade, with further deterioration following the COVID-19 pandemic. Demand for support continues to outpace capacity across mental health services, while many children and young people experience long waiting times, unmet need, or escalating difficulties before receiving help.

This report argues that current approaches remain too heavily focused on responding to crisis after difficulties have already become severe. While specialist mental health services remain essential, the evidence reviewed throughout this report demonstrates that improving child and adolescent mental health requires a broader preventative approach that addresses the social, relational, and structural conditions shaping wellbeing across childhood and adolescence.

60-second Summary: Key Insights

Children and young people's mental health difficulties are rising. Rates of anxiety, depression, emotional distress, and self-harm have increased substantially over the last decade, with further deterioration following the COVID-19 pandemic.

Mental health inequalities are strongly linked to poverty and place. Children and young people growing up in disadvantaged communities, particularly across parts of the North of England, are more likely to experience cumulative adversity, poorer wellbeing, and reduced access to support.

Demand for services now exceeds capacity. Specialist mental health services remain under significant pressure, with many children and young people facing long waits, rejected referrals, or support only once difficulties have escalated.

Loneliness and weak belonging are important risk factors. Increasing evidence shows that social isolation, exclusion, and lack of connection contribute directly to poor mental health across childhood and adolescence.

Community infrastructure acts as mental health infrastructure. Youth services, sports clubs, libraries, arts activities, voluntary organisations, family hubs, and safe community spaces can strengthen belonging, social connection, resilience, and early help-seeking.

Trusted relationships are one of the strongest protective factors for mental health. Supportive relationships with parents, peers, teachers, youth workers, mentors, and other trusted adults consistently predict better emotional wellbeing and resilience.

Prevention begins early and must be relational. Parental wellbeing, strong early relationships, emotionally supportive schools, and opportunities for participation and belonging all shape long-term mental health trajectories.

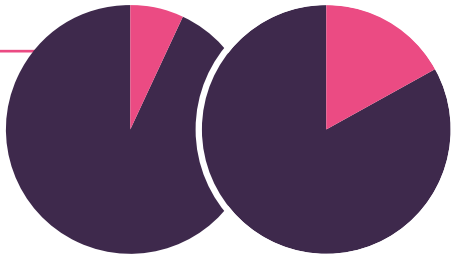
Improving child mental health requires a shift toward prevention. Effective policy must go beyond treatment alone and invest in the social, relational, and community conditions that help children and young people thrive before difficulties reach crisis point.

Nearly 1 in 5 primary school children now have a probable mental health disorder

Almost **400,000** children are still waiting for mental health support

One-third of adolescent mental health problems could potentially be prevented through action on child poverty

The proportion of 10–15-year-olds with a probable mental health disorder increased from around 7% in 2011 to approximately 16–17% by 2024.



Mental health inequalities are socially and geographically patterned

Mental health difficulties are not distributed evenly across the population. Children and young people living in disadvantaged communities are more likely to experience many of the risk factors associated with poor mental health, including poverty, insecure housing, food insecurity, educational exclusion, family stress, social isolation, discrimination, and reduced access to supportive community environments.

Those inequalities are particularly pronounced across parts of the North of England, where many communities experience persistently higher levels of deprivation alongside reduced access to preventative infrastructure and support. The report highlights evidence showing that inequalities in mental health are closely connected to inequalities in access to safe public spaces, extracurricular activities, youth provision, trusted adults, transport, and opportunities for social participation and belonging.

Population-based studies reviewed in this report also demonstrate widening inequalities in self-harm and crisis presentation following the COVID-19 pandemic, particularly among young people living in the most deprived communities.

Loneliness, belonging, and relationships matter

The report highlights growing evidence that loneliness, weak social connection, exclusion, and lack of belonging are important pathways into poor mental health across childhood and adolescence. Conversely, supportive relationships with parents, peers, teachers, youth workers, mentors, coaches, and other trusted adults can strengthen resilience and protect wellbeing. Opportunities for participation in sport, arts, volunteering, youth organisations, and community activities are associated with improved emotional wellbeing, social competence, and reduced loneliness.

Increasingly, loneliness is being understood not solely as an individual experience, but as a social and structural issue shaped by unequal access to supportive relationships, safe environments, and opportunities for participation and belonging.

Prevention begins early

The report demonstrates that many of the foundations for mental health are established during pregnancy, infancy, and early childhood. Parental mental health, early caregiving relationships, social support, and early relational experiences all shape children's emotional development and later mental health trajectories. Socioeconomic disadvantage increases the likelihood that children experience multiple and cumulative forms of adversity from the earliest stages of life.

Evidence reviewed throughout the report suggests that early prevention is most effective when it is relational, community-based, accessible and non-stigmatising, responsive to inequality, and focused on strengthening supportive relationships and social connection.

Community infrastructure is mental health infrastructure

A central finding of this report is that community environments function as an important form of mental health prevention infrastructure. Youth services, voluntary organisations, libraries, sports clubs, arts activities, family hubs, parks, mentoring schemes, and safe community spaces can all provide opportunities for belonging, participation, trusted relationships, and early support before difficulties escalate.

The report presents multiple examples of innovative practice across the North of England, including community gyms and youth hubs, social prescribing models, parenting programmes, peer support initiatives, nature-based interventions, and place-based system transformation approaches. Although those approaches differ in scale and delivery model, the evidence suggests that effective prevention consistently depends on trusted relationships, psychologically safe and accessible environments, opportunities for belonging and participation, community embeddedness, and integration with wider systems of support. However, the report also highlights substantial inequalities in access to community infrastructure. Many of the areas with the greatest levels of need have experienced long-term reductions in youth provision, local authority funding, and voluntary sector capacity.

Prevention cannot sit within health services alone

The evidence reviewed throughout this report suggests that improving child and adolescent mental health requires coordinated action across multiple sectors rather than reliance on healthcare services alone. Mental health policy must move beyond a predominantly treatment-focused model toward one that places greater emphasis on prevention, relationships, belonging, and the social conditions shaping wellbeing.

The report argues that prevention should include reducing child poverty and socioeconomic inequality, strengthening family support, improving school belonging and inclusion, rebuilding youth and community infrastructure, increasing access to trusted adults and safe spaces, improving early intervention pathways, and supporting community-based and place-based approaches.

A record

850,000

children accessed NHS mental health support in 2025

27.5%

of parents in the North East experienced a perinatal mental health condition

compared with

24.6%

in the South East.

Teenage mental health problems have more than doubled since 2011

One in four children referred for specialist mental health support are rejected

Children in the North are significantly more likely to experience mental health difficulties than children in the South, with rates approaching one in five in some northern regions

The North East has the highest levels of school-based mental health referrals in England

Children in northern England had higher rates of attendance at mental health appointments than children elsewhere in England.

The North East experienced some of the largest reductions in mental health funding between 2010 and 2018 and was also the region that experienced the greatest decline in children's mental health.

Four in ten adolescent behavioural difficulties are linked to poverty and poor parental mental health

12.6% of children with a probable mental health disorder missed more than 15 days of school compared with 4% overall.

Key policy implications

The report identifies several priorities for policymakers:

1. **Rebalance the system toward prevention:** Investment in prevention and early intervention should be prioritised alongside specialist treatment provision.
2. **Address structural inequalities:** Policies aimed at reducing poverty, housing insecurity, educational exclusion, and discrimination should be understood as mental health policies.
3. **Invest in community infrastructure:** Youth services, voluntary organisations, family hubs, libraries, sports, arts provision, and safe public spaces should be recognised as part of the mental health prevention system.
4. **Strengthen relational support across childhood:** Trusted relationships and opportunities for belonging are fundamental protective factors for mental health and should be embedded across schools, services, and communities.
5. **Prioritise place-based approaches:** Prevention strategies should be responsive to local need and inequalities, particularly in disadvantaged communities across the North of England.
6. **Improve cross-sector integration:** Healthcare, education, local government, voluntary organisations, and community services need stronger coordination and shared accountability for children and young people's wellbeing.

Conclusion

This report argues that improving children and young people's mental health requires a shift from a predominantly reactive system toward one that strengthens the conditions that enable children and young people to thrive. The challenge is not simply expanding access to treatment after difficulties emerge, but creating the social, relational, and community conditions in which fewer children and young people reach crisis point in the first place. Children and young people need more than access to services, but they also need supportive families, inclusive schools, trusted adults, safe community spaces, opportunities for participation, and communities in which they feel connected, valued, and able to belong.

1 What is happening to children and young people's mental health?

"It would help a lot of kids if the government focused on mental health and not just put it to one side"
Young person, YPAG focus group for this APPG report

1.1 Trends in child and adolescent mental health

There is clear evidence that child and adolescent mental health is worsening in the UK[1, 2]. Analysis of data from Understanding Society (a large and state-of-the-art representative household survey) indicates that mental distress has risen substantially since 2011 in both children (those 5 to 10 years of age) and adolescents (10 to 15 years), measured using the Strengths and Difficulties Questionnaire [Figure 1]. For children, that increase appears to have steepened in the years following 2020 and the COVID-19 pandemic; for adolescents, the steepening is less pronounced and pre-dates the pandemic. Recent work by academics at the University of Manchester and UCL for Youth Futures Foundation[2] demonstrated that the rise cannot be explained by rising awareness and reduced stigma in relation to mental health: it has been accompanied by a real rise in symptoms of distress and increased clinical service use. The authors also concluded that the evidence did not suggest that the pandemic was to blame for this rise. That suggests that the deterioration in child and adolescent mental health reflects broader structural and societal changes rather than a temporary post-pandemic effect.

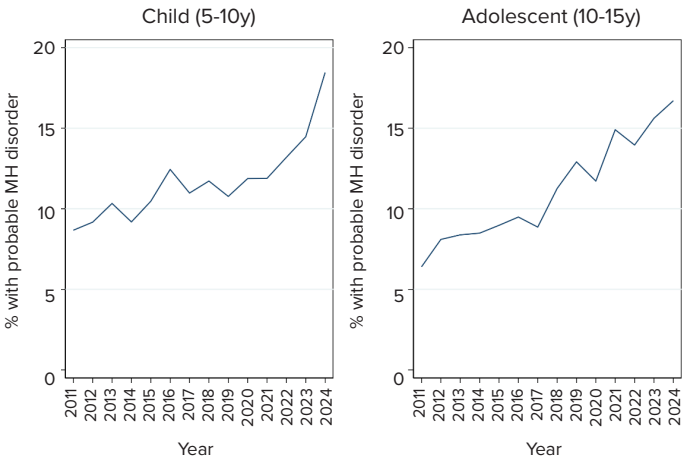
Similar trends are evident internationally. Analysis from the Global Burden of Disease study across 31 European countries showed that mental disorders, substance use disorders, and self-harm represent an increasing source of disability and premature mortality among young people ages 10–24 years[3]. The study concluded that the burden associated with mental disorders among young people had increased substantially over the previous decade, with further acceleration during the COVID-19 pandemic. Across Europe in 2019, an estimated 13.6 million young people ages 10–24 years were living with mental disorders[3].

The trends shown in Figure 1 are not equally spread across all children and young people in the UK. There are clear geographic disparities in mental health for children and young people[4]. In Figure 2, we see that in England, rates of distress are generally higher in the North and the Midlands than in the South, particularly for children. The post-2020 worsening of child mental health is also more pronounced in the North and Midlands. Those regional patterns are likely to reflect broader social and economic inequalities, including differences in poverty, employment, housing, and access to local services.

The data also shows some sex differences. Among children, males tended to have higher rates of distress compared to females, although rates of increase have been similar to that of females [Figure 3]. Conversely, there were higher rates of distress for adolescent females than males. There has also been a particularly marked post-2020 rise in distress among adolescent females, suggesting growing vulnerability during this period.

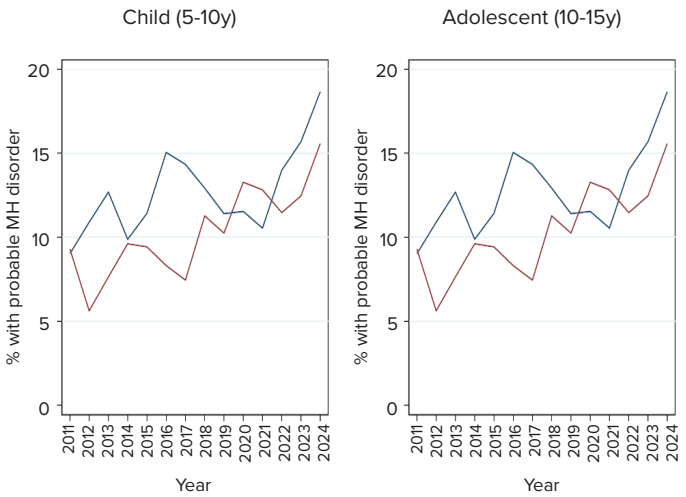
Using data collected over time for individuals followed up from childhood to adolescence helps to understand the emergence of mental health problems. In the UK-wide Millennium Cohort Study [Figure 4], externalising problems comprising hyperactivity and conduct problems (assessed using the Strengths and Difficulties Questionnaire) were high from early childhood and remained persistently high across childhood[5]. In contrast, internalising problems, comprising peer and emotional problems, increased over childhood and adolescence. Males experienced persistently higher levels of externalising difficulties compared to females, while females showed a steeper increase in

Figure 1. Percentage of children (a) and adolescents (b) with a probable mental health disorder by year[116]



Source: Understanding Society.
'Probable mental health disorder' defined as SDQ total difficulties score > 17. (Goodman et al., 1998)

Figure 2. Percentage of children (a) and adolescents (b) in England with a probable mental health disorder by year and region[116]



Source: Understanding Society.
'Probable mental health disorder' defined as SDQ total difficulties score > 17. (Goodman et al., 1998).

internalising difficulties in adolescence.

Analyses using routine primary and secondary care contacts from the Welsh SAIL databank, a population-wide data linkage, supports the findings from the Millennium Cohort Study. Analyses show incidence rates of autism, ADHD, and conduct disorder peak in childhood, and are higher for males compared to females. For both males and females, incidence rates of depression and anxiety, self-harm, and eating disorders increase steeply after puberty. Depression and anxiety, which are the most common across all psychiatric conditions, were twice as high in females than males by 17 years.

1.2 Service demand, access, and unmet need

The worsening of child and adolescent mental health is increasingly reflected in rising demand for NHS services. Over the past decade, there has been a substantial increase in the number of children and young people accessing mental health support, alongside growing waiting lists and evidence of unmet need.

According to NHS data[6], by the end of 2025, more than 850,000 children and young people were in contact with mental health services in the past year in England. This represents a sustained rise in the number of children and young people in contact with services [Figure 5]. By the end of 2025, more than 850,000 children and young people were in contact with services in the past year in England, representing a marked increase compared to pre-pandemic levels. Referrals to Children and Young People's Mental Health Services (CYPMHS) have also risen substantially, reflecting increasing demand across the system.

The increase in demand has placed considerable pressure on services [Table 1]. Despite more children and young people accessing support, waiting lists remain high. The Children's Commissioner for England[8] estimated that more than 320,000 children and young people were waiting for mental health support after being referred to NHS services in 2023–24. More recent estimates from the British Medical Association[9] suggest that over 385,000 children and young people were still waiting for a first community mental health appointment in the year to March 2025.

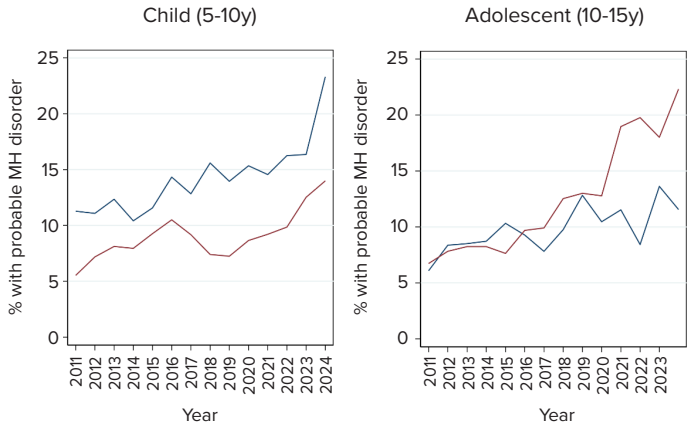
Delays in accessing support are common. NHS benchmarking data suggest that only around one-third of children and young people begin treatment within four weeks of referral, while many wait several months for support. Long waits can lead to worsening symptoms, increased pressure on schools and families, and greater likelihood of children reaching crisis point before receiving help.

Evidence also suggests increasing severity of distress and crisis presentation among some groups of young people following the COVID-19 pandemic. Systematic review evidence reported substantial increases in self-harm and suicidal ideation presentations among children and young people following the pandemic, particularly among adolescent females ages 13–17 years[10], as well as increases in suicide-related outcomes and emergency presentations[11].

High levels of unmet need are also evident in referral rejection rates. Research from the Education Policy Institute[12] found that approximately one in four referrals to specialist CYPMHS in England were rejected. This means that many children and young people identified as needing support are not accepted into specialist care, often because thresholds for intervention are high and services are overstretched. As a result, many children receive support only once difficulties have escalated to crisis point.

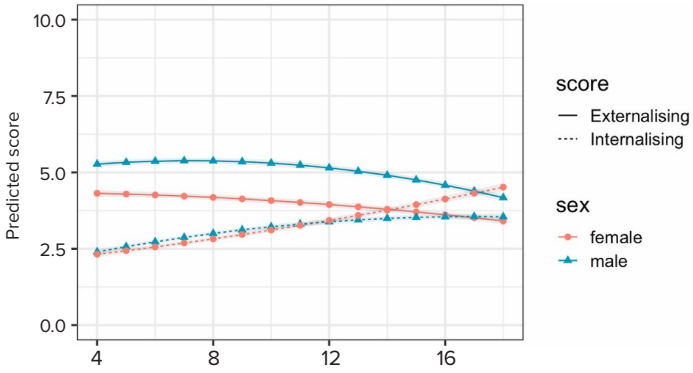
Pressure on services is particularly acute for children with complex or severe needs. Workforce shortages and insufficient community provision continue to contribute to difficulties accessing timely care, and some children are still placed far from home for inpatient treatment due to shortages in local provision[13]. When children do access services they describe deficits in care, including high staff turnover, treatment feeling rushed and being discharged before they feel medically ready[14].

Figure 3. Percentage of children (a) and adolescents (b) with a probable mental health disorder by year and sex[116]



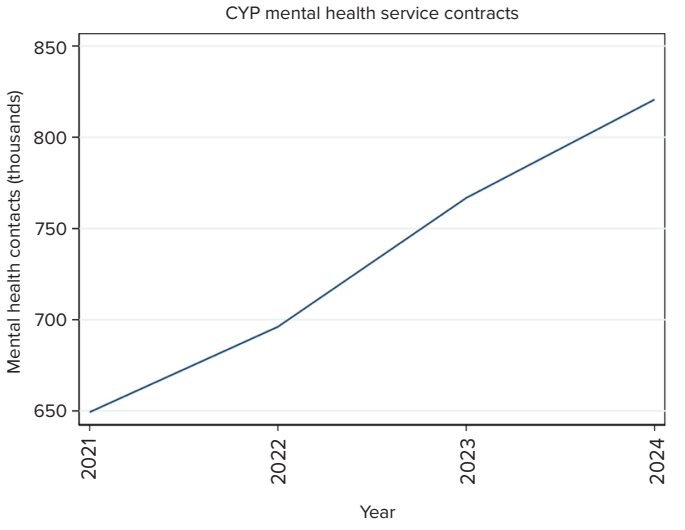
Source: Understanding Society.
'Probable mental health disorder' defined as SDQ total difficulties score > 17 (Goodman et al., 1998).

Figure 4. Predicted externalising (solid) and internalising (dotted line) scores for males (triangles) and females (circles)



Source: UK Millennium Cohort Study.
Predicted score was the modelled average trend by age and gender, in externalising and internalising problems assessed using the Strengths and Difficulties Questionnaire

Figure 5. Number of children and adolescents accessing NHS mental health services over time (monthly rolling average)



Source: NHS Mental Health Services Monthly Statistics

"There's not that many support places really… like there's places, but they're all quite far away."

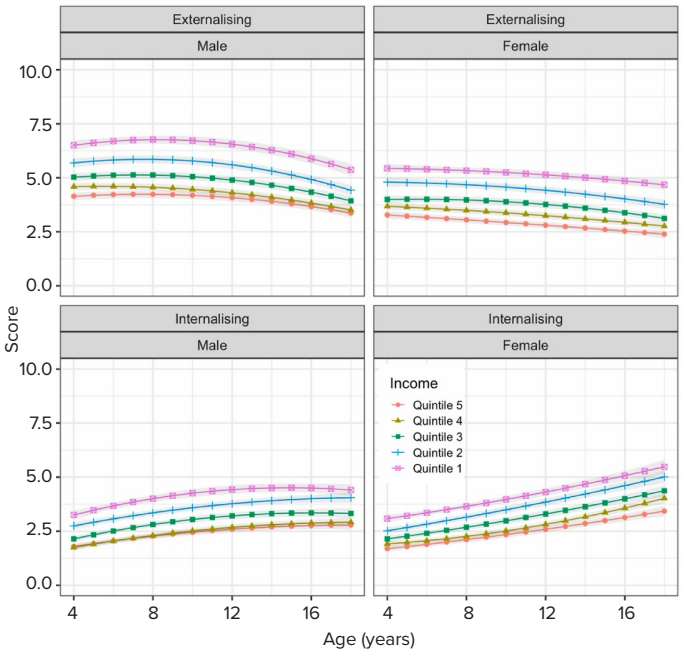
Young person, YPAG focus group for this APPG report

Together, the findings suggest that rising levels of mental distress among children and young people are now translating into sustained and escalating pressure across the mental health system. While improving access to specialist NHS services remains essential, the scale of current demand highlights the need for stronger prevention and early intervention approaches delivered through schools, families, communities, and wider public services.

Table 1. Indicators of pressure on children and young people's mental health services in England

Indicator	Latest estimate	Source
Children and young people in contact with NHS mental health services in the past year	>850,000	NHS Mental Health Services Monthly Statistics[6]
Children waiting for mental health support after referral	>320,000	Children's Commissioner for England: Children's mental health services 2023-24[8]
Children waiting for first community mental health appointment	>385,000	British Medical Association: Children and young people's mental health services in England[9]
Referrals to specialist CYPMHS rejected	~25%	Education Policy Institute: Access to child and adolescent mental health services[12]
Children starting treatment within 4 weeks	~30%	Centre for Mental Health: NHS bench marking survey findings[7]

Figure 6. Predicted mean externalising and internalising difficulties scores by childhood socioeconomic conditions (proxied by household income, Quintile 5 to Quintile 1)



Source: UK Millennium Cohort Study.
Predicted score was the modelled average trend by age and gender, in externalising and internalising problems assessed using the Strengths and Difficulties Questionnaire. Quintile 5 [households with highest income] to Quintile 1 [households with lowest income].

1.3 Inequalities and place

The rise in child and adolescent mental health difficulties is not experienced equally across the population. There is a clear link between socioeconomic disadvantage and mental health difficulties in childhood and adolescence[5]. Figure 6 shows that children and adolescents from lower-income families, or those whose mothers had lower levels of education, are more likely to experience mental health difficulties than those from the highest-income families or whose mothers had degree-level education.

Population-based linkage analyses from Cheshire and Merseyside further demonstrate strong inequalities in mental health need and crisis presentation among children and young people[15]. Analyses involving 567,676 individuals ages 10–24 years between 2018 and 2022 found substantial increases in emergency department attendance related to self-harm following the COVID-19 pandemic, with attendance rates increasing from approximately 3 to 6 per 1,000 people annually. The highest increases were observed among young people living in the most deprived communities, particularly adolescent girls ages 15–19 years and young men ages 20–24 years. Graphical analyses demonstrated widening inequalities over time by deprivation quintile, with the steepest post-pandemic increases concentrated among the most deprived groups [Figures 7–8].

The same analyses also identified evidence of unmet need, with boys, younger secondary school pupils, and children and young people living in the most deprived communities less likely to access support despite evidence of mental health difficulties. Similarly, data on primary and secondary mental health contacts in the Welsh population show that across 0 to 17 years, the incidence of almost all mental health conditions (except eating disorders and Tics) increases with greater socioeconomic deprivation.

There is substantial variation in the rates of mental health problems and service use across regions in England. Analysis of secondary school-based referrals to NHS-funded mental health services between 2012-2022 showed the highest rates of referral in the North East and lowest in London, with area-level deprivation and free school meals predicting higher referrals[16]. Between 2016-2023, children in Northern England had higher rates of attendance to mental health appointments compared to other regions[17]. These regional inequalities appear to be related not only to deprivation, but also funding and access to services; when mental health services in the North East saw some of the biggest reductions in funding across the country in 2010-2018, this was also the region that saw the greatest decline in children's mental health[4].

1.4 Summary: Why upstream/community prevention is now essential

Poor mental health in childhood and adolescence is associated with lower educational attainment, reduced employment opportunities, poorer physical health, and increased demand on public services across the life course[18, 19]. The evidence presented in this chapter shows that child and adolescent mental health difficulties are increasing across the UK, with particularly concerning trends among adolescent females and children living in the North and Midlands. The patterns cannot be explained solely by greater awareness of mental health problems or by the COVID-19 pandemic. Instead, they reflect a genuine and sustained rise in distress among children and young people. Mental health difficulties are also not evenly distributed across society. Children and young people growing up in socioeconomic disadvantage experience substantially higher levels of emotional and behavioural difficulties than their more advantaged peers. Similar inequalities are evident across regions, with poorer mental health outcomes concentrated in more deprived communities.

At the same time, demand for NHS mental health services has risen sharply, placing increasing pressure on already stretched services. While improving access to specialist support remains essential, the scale and

persistence of these trends make clear that treatment alone cannot reverse the current trajectory.

These findings point to the urgent need for earlier, community-based approaches to prevention and support. Improving child and adolescent mental health will require action beyond healthcare alone, including investment in early years support, schools, families, youth services, community infrastructure, and reducing child poverty and inequality. Preventative approaches that strengthen social relationships, resilience, and supportive environments are likely to deliver long-term benefits for both mental health and wider life outcomes.

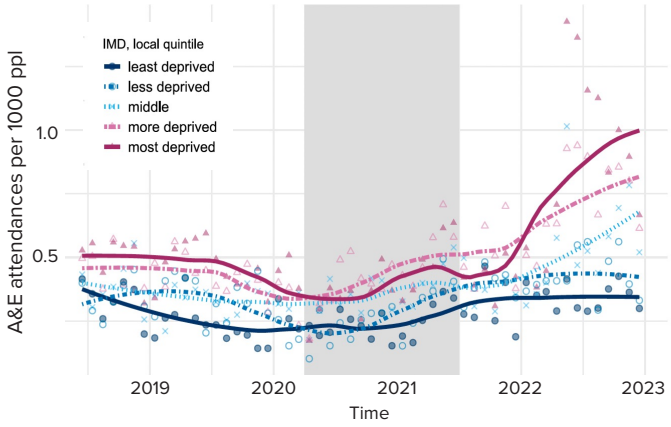
1.5. Why "Child of the North" matters

The evidence reviewed in this chapter demonstrates that child and adolescent mental health difficulties are not distributed evenly across the population. Inequalities in mental health are strongly shaped by place, with children and young people living in more disadvantaged communities experiencing higher exposure to many of the social and structural risks associated with poor mental health outcomes.

Such inequalities are particularly important in the North of England, where many communities experience persistently higher levels of child poverty, insecure employment, housing insecurity, educational disadvantage, and poorer physical health outcomes than the national average[20]. Children and young people growing up in these contexts are more likely to experience multiple and cumulative forms of adversity across childhood and adolescence.

Importantly, inequalities are not only concentrated geographically in terms of risk exposure, but also in relation to access to protective resources and support. Many of the factors identified throughout this report as important for protecting mental health, including safe community spaces, youth provision, extracurricular activities, trusted adults, accessible transport, voluntary sector infrastructure, and opportunities for participation and belonging, are themselves unevenly distributed across places.
Over the last decade, reductions in youth services, local authority budgets, community provision, and preventative support have disproportionately affected some of the most disadvantaged communities[4]. As a result, areas with the greatest levels of need may also have the weakest preventative infrastructure available to children and young people.

Figure 7. Trends in emergency department attendance related to self-harm by quintile of deprivation, Cheshire and Merseyside, 2018–2022

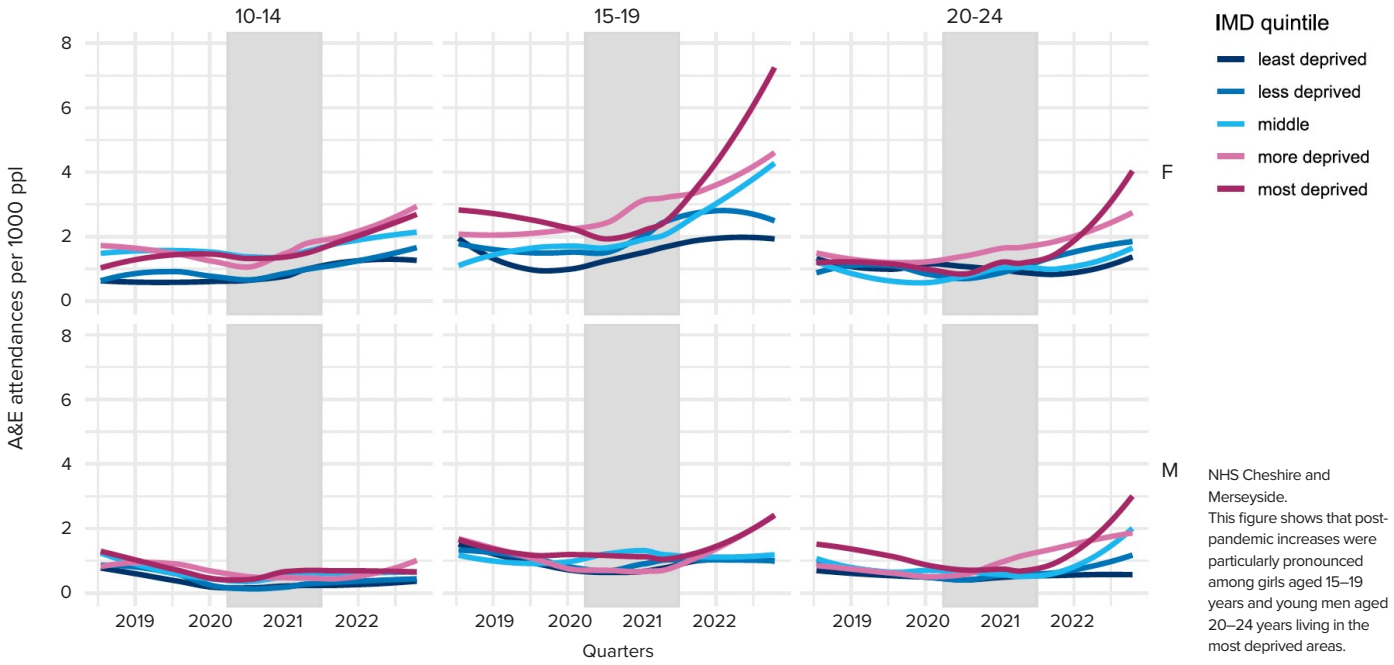


Source: NHS Cheshire and Merseyside.
This figure illustrates widening inequalities in self-harm-related emergency department attendance across deprivation quintiles following the COVID-19 pandemic, with the highest rates observed in the most deprived communities.

This has important implications for mental health policy. If the drivers of poor mental health are partly social and structural, then prevention must also be understood as place-based. Improving outcomes for children and young people requires attention not only to individuals, but to the environments in which they grow up, learn, socialise, and seek support. A place-based approach recognises that schools, families, neighbourhoods, community organisations, and local services interact together to shape children and young people's wellbeing. It also recognises that effective prevention depends on strong local relationships, trusted institutions, and accessible community infrastructure.

The North, therefore, matters not only because of higher levels of disadvantage, but because it illustrates how inequalities in social and community infrastructure can become inequalities in mental health outcomes. Understanding and addressing those spatial inequalities is essential for building a more preventative and equitable mental health system for children and young people.

Figure 8. Trends in emergency department attendance related to self-harm by quintile of deprivation, Cheshire and Merseyside, 2018–2022



NHS Cheshire and Merseyside.
This figure shows that post-pandemic increases were particularly pronounced among girls aged 15–19 years and young men aged 20–24 years living in the most deprived areas.

2 What drives poor child and adolescent mental health outcomes?

2.1 Why environment matters

Child and adolescent mental health is shaped not only by individual vulnerability, but by the environments in which children grow up. Evidence consistently shows that risks accumulate across childhood through poverty, family stress, housing insecurity, school experiences, peer relationships, and community conditions. Those factors interact over time, meaning that inequalities in mental health emerge early and widen across development. Understanding these drivers is essential for designing effective prevention strategies.

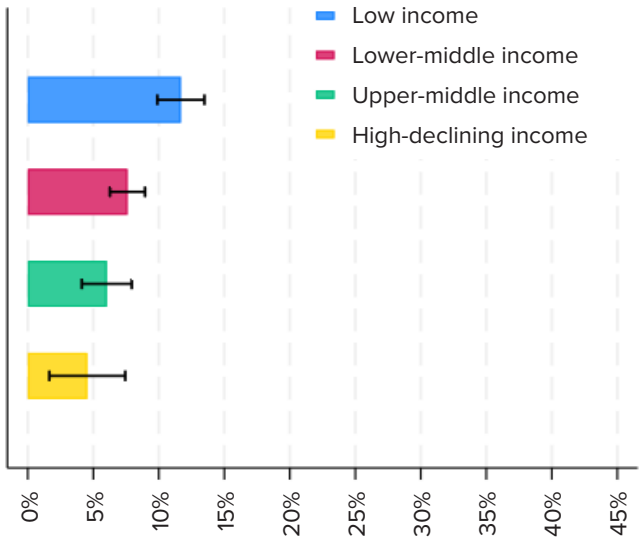
The evidence reviewed in this chapter highlights that mental health difficulties are socially patterned and developmentally embedded. Children exposed to persistent disadvantage, instability, or adversity are substantially more likely to experience emotional and behavioural difficulties during adolescence. At the same time, supportive relationships within families, schools, peer groups, and communities can protect against poor outcomes and strengthen resilience.

2.2 Structural and economic conditions

Poverty and persistent disadvantage

There is strong evidence that persistent socioeconomic disadvantage is associated with poorer mental health across childhood and adolescence. Data from the UK Millennium Cohort Study shows that of the four family income trajectories across childhood (low, lower-middle, upper-middle, and high-declining income trajectories), those adolescents exposed to persistently low income over time (the low-income trajectory) had approximately twice the probability of socioemotional behavioural difficulties at age 17 years compared to those experiencing stable upper-middle income trajectories, even after accounting for early-life and family characteristics [Figure 9].

Figure 9. Average predicted probability of socioemotional behavioural problems (aged 17 years) for each income trajectory



Source: UK Millennium Cohort Study.
Estimates are shown with 95% confidence intervals. This figure shows inequalities in adolescent socioemotional behavioural problems by childhood family income trajectory.

The analyses suggest that approximately one-third of socioemotional behavioural problems in adolescence could potentially have been prevented if all children had experienced more favourable income trajectories across childhood; around 27% of cases were attributable to persistent low-income exposure alone[21].

Socioeconomic inequalities are also embedded within children's developmental trajectories from early childhood onwards. Black et al.,[22] found that around one in four children follow adverse socioemotional developmental trajectories characterised by persistent, late-emerging, or early emotional and behavioural difficulties between ages 3 and 14 years. Socioeconomic disadvantage, including lower maternal education, area deprivation, and maternal mental health difficulties, substantially increases the likelihood of these trajectories. Children experiencing persistent or late-emerging difficulties face two to three times higher odds of clinically significant mental ill health by adolescence.
Together, the findings suggest that socioeconomic disadvantage does not simply coincide with poorer mental health outcomes, but contributes to developmental pathways that increase vulnerability across childhood and adolescence.

Housing insecurity and instability

Housing insecurity, including frequent moves, temporary accommodation, overcrowding, and poor-quality housing, also has significant consequences for children and young people's mental health and wellbeing[23]. Housing instability creates persistent anxiety and uncertainty for children and families. Many children report worrying about safety, moving home, disrupted friendships, and financial strain, contributing to stress, sleep disruption, and difficulty settling. Over time, those experiences can diminish children's sense of stability, security, and hope for the future[24, 25].

Poor housing conditions are also associated with emotional and behavioural difficulties[25, 26]. Children living in insecure or overcrowded environments may experience irritability, attention difficulties, social withdrawal, nightmares, or emotional dysregulation. Parents frequently describe how overcrowding and instability disrupt routines and make it harder to maintain supportive family relationships and consistent boundaries.

Housing insecurity can additionally contribute to shame, stigma, and social isolation. Children may avoid inviting friends home or disengage from social relationships because of embarrassment about their living conditions. Frequent relocations can disrupt access to schools, healthcare, and peer networks, weakening key sources of emotional support and belonging[24] and increasing loneliness[27, 28].
Evidence also highlights important protective factors. Supportive relationships, continuity in education, maintained peer connections, and coordinated local authority support can help reduce some of the negative impacts of housing insecurity on mental wellbeing.

2.2 Family relationships and caregiving

Family environments play a central role in shaping child and adolescent mental health. Evidence consistently shows that supportive parent-child relationships protect mental health, while persistent family stress and adversity increase risk.

Research using the UK Millennium Cohort Study[5] found that interventions

targeting aspects of the early childhood environment could reduce around one-third of socioeconomic inequalities in mental health at both age 5 and age 17 years. Parent-child relationships were identified as one of the most important pathways explaining these inequalities across development.

Parenting, of course, does not occur in isolation. The quality of parent-child relationships is influenced by wider social and environmental conditions, including poverty, housing quality, neighbourhood conditions, psychosocial stress, and access to social support. That highlights the importance of supporting families as part of prevention strategies to address mental health inequalities.

Cumulative adversity and caregiver mental health

Children are often exposed to multiple forms of adversity simultaneously. Approximately one in four children grow up with a parent experiencing mental health difficulties, increasing exposure to adversity, instability, and emotional stress across childhood[29,30]. Analyses of the six distinct childhood trajectories of family adversity and poverty from infancy to adolescence identified in the Millennium Cohort Study showed that only 43% of children experienced consistently low adversity across childhood[31]. The remainder experienced one or more persistent forms of adversity, including poverty, poor parental mental health, parental alcohol use, or domestic violence and abuse.

More than half of UK children are persistently exposed to either caregiver mental ill-health, family poverty, or both at some point during childhood. Children exposed to persistent poverty alongside persistent poor parental mental health consistently experienced the poorest outcomes at ages 14 years and 17 years, including substantially higher rates of socioemotional behavioural difficulties[31]. Around one in ten children experience both persistent poverty and persistent caregiver mental ill-health simultaneously[32]. These cumulative adversities have major implications for adolescent mental health. Analyses suggest that approximately 40% of socioemotional behavioural problems, 24% of cognitive difficulties, and 22% of adolescent mental health problems at age 17 years are attributable to persistent caregiver mental ill-health and poverty across childhood.

Persistent family adversity is also associated with the most severe adolescent mental health outcomes. Research by Chen et al.[33] shows that by age 17 years, around 22% of adolescents in the Millennium Cohort Study reported self-harm in the past year, and around 7% reported a suicide attempt. Adolescents exposed to persistent poverty, poor parental mental health, or domestic violence and abuse were substantially more likely to report both outcomes. The highest risks were observed among those exposed to persistent poverty combined with persistent poor parental mental health.

Family adversity has an intergenerational impact on mental health as mental health difficulties often disrupt education and co-occur with other difficulties. Researchers have developed an indicator of Positive Adulthood Transition using data from the Millennium Cohort Study, to assess good socioemotional wellbeing (absence of mental health difficulties as assessed on the Strengths and Difficulties Questionnaire), alongside GCSE educational attainment, good physical health, healthy weight, and absence of criminal justice involvement. Adolescents exposed to persistent poverty and poor parental mental health had the lowest likelihood of achieving Positive Adulthood Transition - 17.9%, compared to 48.7% of adolescents not exposed to adversity[34].

Therefore, addressing family adversity is a crucial pathway in addressing mental health inequalities, to break the cycle of disadvantage.
Family adversity can also erode emotional support within the home. Adolescents growing up with persistent poverty and poor parental mental health are substantially more likely to report low perceived emotional support from family members[35]. Importantly, emotional support appeared particularly protective for children exposed to the greatest adversity[36]. These findings suggest that persistent family stress not only directly harms children's mental health, but also weakens the relationships that would otherwise help protect against poor outcomes.
Together, this evidence highlights the importance of coordinated approaches that address child poverty, caregiver mental health, and family relationships simultaneously.

2.3 Schools as protective and risk environments

Schools play a crucial role in supporting child and adolescent mental health. Beyond education, schools provide structure, social connection, emotional support, and opportunities for belonging. Experiences within school environments can therefore either protect or undermine mental wellbeing.

Evidence from 40 countries following the COVID-19 pandemic found that adolescent wellbeing declined substantially after school closures[37]. Young people reported feeling less supported, experiencing greater academic pressure, and demonstrating poorer educational outcomes, particularly among disadvantaged groups. These findings reinforced the broader role of schools in promoting wellbeing, social connection, and emotional development.

> *"A lot of your stresses come from the school environment where you are for most days a week."*
> **Young person, YPAG focus group for this APPG report**

Attendance and exclusion

Recent Department for Education data[38] show that suspensions and permanent exclusions in England remain substantially higher than pre-pandemic levels. Those patterns are not evenly distributed across the population[39]. Rates of suspension are around five times higher among pupils eligible for free school meals and those with identified special educational needs compared with their peers. Permanent exclusion rates are also substantially higher among disadvantaged pupils and those requiring additional support. Persistent and severe school absence show similar inequalities. Children receiving free school meals are around twice as likely to be persistently absent and four times more likely to be severely absent than their peers. Children with Education, Health and Care Plans are around seven times more likely to experience severe absence.

Mental health difficulties are strongly linked with school disengagement. In 2022, around 4% of children ages 7–16 missed more than 15 days of school, rising to 12.6% among children with a probable mental health disorder[40]. Qualitative evidence[41] also suggests that mental health difficulties are a common reason for disengagement from school, while parental mental health problems can create additional barriers to attendance.

There is also growing evidence of bidirectional relationships between mental health problems and school exclusion[42, 43]. Children experiencing mental health difficulties are more likely to be excluded, while exclusion itself can worsen emotional wellbeing, school belonging, and relationships with staff. Qualitative studies describe exclusion as contributing to anxiety, low mood, loss of confidence, and hopelessness among young people and families.

The effects may persist into adulthood. Children who experience exclusion or chronic absence are more likely to experience poorer mental health, lower educational attainment, unemployment, and involvement in violence or crime later in life[44-48].

School belonging and connection

Feelings of school belonging appear to be an important protective factor for adolescent mental health. Analysis from the #BeeWell study in Greater Manchester found that adolescents reporting stronger school belonging experienced lower levels of emotional difficulties [Figure 10]. These findings suggest that schools can play an important preventative role by fostering supportive relationships, inclusion, emotional safety, and connectedness alongside academic achievement.

2.4 Peer relationships and social connection

Peer relationships and social connection are central to mental health and wellbeing during adolescence[49]. Supportive friendships can protect against stress, strengthen self-esteem, and promote resilience, while peer difficulties can contribute to emotional distress and social isolation. UK evidence consistently shows that loneliness, peer victimisation, and weak social relationships are associated with poorer mental health outcomes among children and young people[50, 51].

Positive peer support and strong social relationships can buffer the effects of adversity experienced elsewhere in children's lives, including within families and schools[2]. Supportive social environments, opportunities for connection, and feelings of belonging are increasingly recognised as important protective factors for young people's wellbeing.

2.5 Summary: What matters most for prevention?

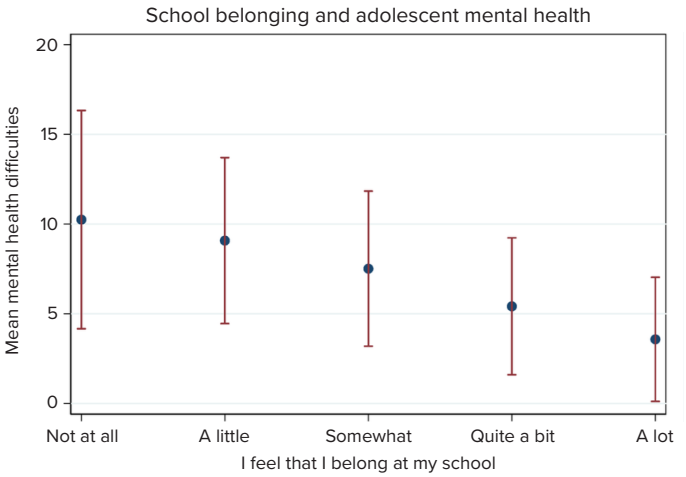
The evidence presented in this chapter demonstrates that child and adolescent mental health is shaped by the cumulative influence of social, economic, family, school, and peer environments across childhood. Several factors consistently emerge as particularly important drivers of poor mental health outcomes:

- persistent poverty and socioeconomic disadvantage
- caregiver mental ill-health
- cumulative family adversity
- housing insecurity and instability
- school disengagement, exclusion, and absence
- weak social connection and belonging

Importantly, many of these factors are potentially modifiable through policy and prevention. The findings suggest that improving child and adolescent mental health requires action beyond healthcare alone. Effective prevention is likely to require coordinated investment across multiple sectors, including poverty reduction, housing, family support, schools, youth services, and community infrastructure.

The evidence also highlights the importance of protective relationships. Supportive families, positive school environments, strong peer relationships, and connected communities can help buffer the effects of adversity and strengthen resilience. Policies that strengthen these relational and community resources are therefore likely to play an important role in improving child and adolescent mental health and reducing inequalities over the life course.

Figure 10. Levels of emotional difficulties by reported school belonging



Source: #BeeWell.
95% confidence intervals shown. 'Emotional problems' measured using the Me and My Feelings questionnaire.

These findings also suggest that mental health support cannot be understood solely as the responsibility of specialist services. The environments in which children and young people spend their time, including schools, neighbourhoods, youth organisations, sports clubs, libraries, and community groups, may all contribute to prevention by creating opportunities for belonging, supportive relationships, and social connection. Chapter 4, therefore, examines the role of community environments and social infrastructure in protecting child and adolescent mental health.

> *"A good group of friends that you can talk to is, like, really important. It can obviously, like, help you and you can tell them what you're going through."*
>
> **Young person, YPAG focus group for this APPG report**

3 Prevention begins early: perinatal mental health, families, and early relational support

The previous chapter demonstrated that child and adolescent mental health is shaped by the cumulative influence of poverty, housing insecurity, family adversity, caregiver mental health, school experiences, and social connection across childhood and adolescence. However, many of the foundations for emotional wellbeing and mental health are established much earlier in life.

Increasing evidence shows that experiences during pregnancy, infancy, and early childhood shape emotional development, stress regulation, relationships, and later mental health across the life course. Early relationships are, therefore, not simply important for immediate wellbeing; they form part of the prevention infrastructure that supports children's long-term emotional and developmental trajectories.

Chapter 3 examines the role of parental mental health, infant mental health, and early relational support in shaping child outcomes. It argues that prevention begins long before children and young people reach specialist mental health services and that supporting families, caregivers, and early relationships is a critical component of any preventative mental health system.

3.1 Why early relationships matter for mental health

A growing body of evidence demonstrates that parental mental health is one of the strongest predictors of children's emotional, behavioural, and developmental outcomes. These relationships operate through multiple biological, psychological, social, and relational pathways beginning before birth and continuing across childhood.

Maternal distress during pregnancy and the postnatal period, including anxiety and depression, is associated with poorer socioemotional, cognitive, and adaptive behavioural outcomes in children[52]. Paternal mental distress during the postnatal period is also associated with children's socioemotional, cognitive, and physical development[53]. Evidence suggests that persistent or compounding parental mental health difficulties across the antenatal and postnatal periods may be particularly important for later emotional difficulties among children and adolescents[54,55].

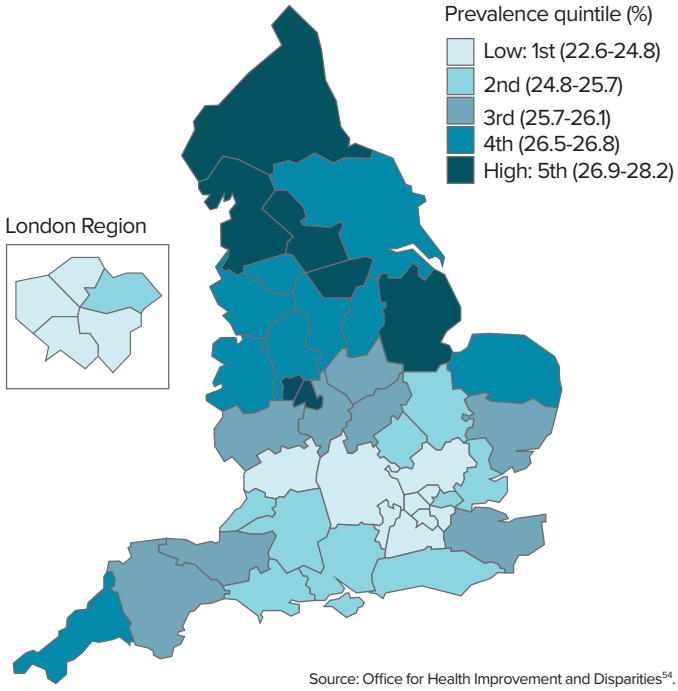
The evidence increasingly suggests that parental wellbeing cannot be separated from the wider social and structural conditions in which families live. Inequalities in poverty, housing, social support, and community infrastructure are also inequalities in early relational health and child development.

3.2 Parental mental health, inequality, and cumulative risk

As with children's mental health more broadly, parental mental health difficulties are socially patterned and unequally distributed across the population. The prevalence of perinatal mental health conditions in England is estimated at 25.8%, with regional analyses demonstrating higher prevalence in the North compared to the South [Figure 11][56]. For example, 27.5% of parents in the North-East who gave birth in 2019 experienced a perinatal mental health condition, compared with 24.6% in the South-East.

Socioeconomic disadvantage substantially increases the likelihood that children will experience cumulative forms of adversity during early development. Findings from the Wirral Child Health and Development Study[57] showed that children whose mothers experienced greater

Figure 11. Prevalence of perinatal mental health conditions by Integrated Care Board area, England, 2019



Source: Office for Health Improvement and Disparities[54].

socioeconomic disadvantage during pregnancy demonstrated higher levels of externalising difficulties by age 4-5 years, with maternal prenatal depressive symptoms partially mediating this relationship. Simultaneous exposure to poverty and poor parental mental health appears to produce particularly elevated levels of risk. Children exposed to both persistent poverty and family adversity are approximately six times more likely to experience socioemotional and behavioural difficulties during adolescence than children growing up in more advantaged circumstances[31]. Importantly, these relationships are often transactional rather than one-directional. Child emotional and behavioural difficulties may themselves increase parental stress, exhaustion, and depressive symptoms over time, reinforcing cycles of relational and emotional difficulty within families[58].

Those findings support a cumulative risk model in which poverty, caregiver mental health difficulties, housing insecurity, and social adversity interact across development rather than operating independently. Structural inequalities, therefore, function as upstream determinants of both parental wellbeing and child mental health outcomes[59]. This is particularly important in the North of England, where higher levels of deprivation, poorer health outcomes, housing insecurity, and reduced access to preventative support may increase cumulative exposure to risk across generations.

Addressing parental mental health, therefore, requires more than clinical treatment alone. It also requires attention to poverty reduction, social support, housing security, accessible community provision, and the wider social conditions shaping family wellbeing.

3.3 Infant mental health and the first 1001 days

Increasing evidence demonstrates that developmental pathways linked to mental health begin before birth. During pregnancy, the foetal brain undergoes rapid development and is highly sensitive to environmental influences, including parental stress and mental health difficulties. For example, there is evidence that maternal stress during pregnancy may influence the development of stress regulation systems associated with later emotional regulation and mental health[60]. Parental mental health difficulties before and during pregnancy are also associated with adverse birth outcomes including preterm birth and low birth weight, which themselves increase the likelihood of later neurodevelopmental and psychiatric difficulties[61]. However, outcomes vary substantially depending on the timing, severity, duration, and wider social context of adversity[62].

Although biological pathways are important, the evidence reviewed throughout this report suggests that relationships remain central to prevention. During the first 1001 days, from conception to age two, relationships with caregivers help shape stress regulation systems, emotional security, social development, and later resilience[63, 64]. Sensitive and responsive caregiving supports infants to feel safe enough to explore, play, learn, and develop relationships[65]. These early experiences help build the foundations for emotional regulation, social competence, wellbeing, and later mental health.

Conversely, poverty, housing insecurity, social isolation, parental stress, and parental mental health difficulties can reduce emotional availability within caregiving relationships and disrupt opportunities for connection, play, and emotional attunement[66]. Early disruptions in caregiving relationships may, therefore, reverberate across development and contribute to intergenerational cycles of disadvantage and relational difficulty[67]. This highlights why infant mental health should not be understood narrowly as an individual clinical issue. Infant mental health is relational, developmental, and socially shaped.

Investment in infant mental health, therefore, represents a preventative strategy with potential long-term benefits across education, wellbeing, social development, and later service demand[68]. Perinatal mental health services, maternity care, health visiting, family hubs, early years services, and parent–infant mental health services all contribute to this wider prevention system. Sustained investment in infant mental health and early relational support is not an optional enhancement to services, but a core part of reducing inequalities and improving long-term mental health outcomes.

3.4 What works in early prevention?

The evidence for perinatal and early-years interventions is increasingly promising. Across the literature, interventions appear most effective when they combine emotional support, practical help, relationship-building, and opportunities for social connection within accessible and trusted settings. Systematic reviews suggest that interventions supporting both parental mental health and the parent–child relationship may improve outcomes for parents and children simultaneously[69-71]. Parenting support programmes also appear beneficial for improving children's socioemotional outcomes even where effects on parental mental health are smaller or less consistent[72].

Several features emerge repeatedly across promising approaches as follows:

Relational and emotionally supportive approaches. Interventions appear most effective when they create trusting, non-judgemental relationships and provide parents with opportunities to feel heard, supported, and emotionally safe.

Community-based and non-stigmatising delivery. Interventions that are delivered within community settings such as family hubs, children's centres, community organisations, and local groups may improve engagement and reduce barriers to participation compared with more formal clinical environments[73].

Social connection and peer support. Many successful interventions strengthen social support and reduce parental isolation. Social support is consistently associated with improvements in parental wellbeing, stress, depression, anxiety, and parent–child relationships[74]. Conversely, loneliness and social isolation are associated with poorer perinatal mental health and poorer socioemotional outcomes for children[57,75].

Flexible and practical support. Transport, childcare, culturally responsive delivery, home visits, language accessibility, and proactive outreach all appear important for reducing barriers to engagement, particularly for families experiencing disadvantage[76].

Trusted and sustained relationships. The evidence also suggests that continuity and sustained engagement matter. Superficial or short-term support may be less effective than approaches that foster ongoing trusted relationships and community connection[77].

At the same time, the effectiveness of preventative support depends heavily on wider community infrastructure and workforce capacity. For example, although health visiting can reduce parental isolation and support early intervention[78], cuts to public health funding have substantially reduced workforce capacity. Since 2015, the health visiting workforce in England has fallen by approximately 40%, limiting opportunities for sustained preventative work[79].

Taken together, the evidence suggests that early prevention is most effective when it is relational, community-based, flexible, and responsive to inequality. Supporting parental wellbeing, reducing isolation, strengthening relationships, and improving access to trusted support should therefore be understood as central components of child mental health prevention.

3.5 Case studies: Early relational and community-based prevention

The evidence reviewed throughout this chapter suggests that prevention begins long before children and young people reach specialist mental health services. Early relationships, parental wellbeing, emotional support, and opportunities for social connection during pregnancy, infancy, and early childhood all contribute to later mental health trajectories.

The following case studies illustrate how community-based and relational approaches can support parents, strengthen parent–child relationships, reduce isolation, and improve wellbeing during the perinatal and early years period. Although the interventions differ substantially in setting and delivery model, several common features emerge consistently:

- trusted relationships
- flexible and non-stigmatising support
- opportunities for peer connection
- practical and emotional support combined
- community embeddedness
- responsiveness to inequality and adversity.

Together, the case studies demonstrate that prevention in the early years is not confined to clinical services. Parenting programmes, voluntary organisations, peer support, public spaces, and community networks can all contribute to the relational foundations that support lifelong mental health.

Case Study 1: Kids Matter in Merseyside

What this illustrates: How peer-led parenting programmes embedded within trusted community settings can strengthen parental confidence, reduce isolation, and support family wellbeing for parents from low-income backgrounds.

Kids Matter is a structured community-based parenting programme designed to improve parental self-efficacy, wellbeing, and parenting confidence among parents of children aged 0–10 years. The programme aims to reduce behavioural, social, and emotional difficulties among children by strengthening parent–child relationships and supporting authoritative parenting approaches.

The six-week programme is delivered within familiar community environments including schools, nurseries, churches, and community centres. It is targeted at parents in the bottom 20% of the socioeconomic bracket, seeking to address the additional risks for children raised in low-income and low-support households. Sessions are free of charge and include crèche provision to reduce barriers to participation.

A distinctive feature of Kids Matter is its peer-led model. Facilitators are often local parents or community members who receive training and ongoing supervision. Sessions are informal and discussion-based, creating psychologically safe environments where parents can share experiences without fear of judgement. Facilitators maintain contact with parents after programme completion through texts, calls, home visits, and signposting to local activities and services.

Routine evaluation data using validated measures including TOPSE and WEMWBS indicate improvements in parental self-efficacy and wellbeing sustained at three-month follow-up[80]. The programme has developed strong partnerships across Merseyside with schools, churches, charities, and local authorities[81].

Case Study 2: Nature-based parent wellbeing support in Hull

What this illustrates: How nature-based and community-centred approaches can support parental wellbeing, social connection, and parent–child relationships in accessible public spaces.

Phoenix Families Community Interest Company developed a nature-based intervention for parents and children under five in Hull[82]. Sessions take place within an urban green space connected to a local museum and involve flexible nature-based activities including crafts, sensory play, and outdoor exploration.

The intervention emphasises parental wellbeing alongside opportunities for positive parent–child interaction. Parents consistently described the groups as emotionally supportive, socially welcoming, and less formal than other services they had previously accessed.

Research involving interviews, observation, and workshops found that the programme promoted relaxation, social connection, confidence, and opportunities for playful interaction between parents and children[82]. Participants particularly valued the calm atmosphere, facilitator support, and flexibility of the sessions.

The programme also illustrates the potential role of public institutions such as museums and green spaces in supporting community mental health prevention. Partnership working between Phoenix Families and Hull Museums generated mutual benefits for participating families and local organisations.

Case Study 3: Baby Steps in Better Start Bradford

What this illustrates: How proactive, relationship-based, holistic perinatal support delivered through trusted systems and community settings can reduce stigma, increase engagement and strengthen parental wellbeing and early relationships.

The Better Start Bradford Innovation Hub was a ten-year collaboration involving Born in Bradford and the University of York established to evaluate early-life interventions across three disadvantaged inner-city Bradford wards. Baby Steps is an antenatal and postnatal group intervention developed by the NSPCC and delivered within Better Start Bradford by Action for Children. The programme aims to strengthen parental emotional wellbeing, confidence, and sensitivity during pregnancy and early infancy.

The intervention combines home visits, online group sessions, proactive outreach, and ongoing psychosocial and practical support from practitioners before and after birth. Parents are introduced to the programme through maternity services, allowing support to be embedded within trusted care pathways.

Baby Steps has successfully engaged ethnically diverse families living in areas of high socioeconomic disadvantage in Bradford[83]. The programme uses flexible and culturally responsive delivery approaches including multilingual staff, practical support, transport assistance, and proactive relationship-building. By offering parents a voluntary opportunity to participate in universal support, Baby Steps reduced the stigma associated with services perceived as mandatory or only for 'vulnerable' families.

Preliminary evaluation findings suggest small reductions in maternal depressive symptoms, particularly among women with high antenatal symptoms, alongside qualitative evidence of improved confidence, emotional reassurance, reduced isolation, and stronger responsiveness to infant cues[83, 84].

Importantly, Baby Steps demonstrates how early prevention may be strengthened through universal and non-stigmatising approaches embedded within wider systems of family and community support.

4 Community as prevention infrastructure: social connection, belonging and access to "third spaces"

"Even if you don't have any sort of mental health problems going on, it's quite important to know that you still have that sort of security… If one day your mental health wasn't the best, you still have somewhere to go."
Young person, YPAG focus group for this APPG report

4.1 Community infrastructure, belonging, and mental health

Children growing up in disadvantaged contexts are less likely to have access to safe public spaces, structured extracurricular opportunities, and supportive local social networks[85, 86]. Those inequalities matter because they reduce opportunities for social interaction, belonging, and supportive relationships, all of which are important for emotional development and wellbeing; the inequalities increase the likelihood of loneliness, which is linked to worsening mental health and well-being. Conversely, positive childhood experiences, including participation in groups, volunteering, physical activity, and supportive relationships with adults outside the family, are associated with better mental health and resilience across development[87, 88]. Many of those experiences are enabled through neighbourhoods and community settings rather than formal mental health services.

Community environments can, therefore, function as protective systems, particularly where family-level resources are limited. Supportive local environments may help maintain regular social contact, reduce isolation, and provide alternative routes to emotional support and belonging[89, 90].

Young people consistently identify three features of supportive community environments as important for wellbeing[91]:

- psychological safety (feeling accepted and not judged)
- consistency (regular and predictable access)
- opportunities to build meaningful relationships with peers and trusted adults

Community settings such as youth organisations, sports programmes, libraries, voluntary groups, and arts activities are often effective because they combine all three of those things. Participation in such organised community activities is associated with improved emotional wellbeing, social competence, and lower levels of internalising difficulties[92, 93].

Community participation can also increase access to supportive non-parental adults, including youth workers, coaches, volunteers, and mentors[94, 95]. Those relationships may provide emotional support, guidance, and early identification of difficulties before problems escalate to specialist services.

"The sports and community things add like a sense of belonging to the individual. Like they think they are part of something bigger than just themselves… they can make more connections with different people and build that sense of community with people they can talk to."
Young person, YPAG focus group for this APPG report

4.2 Loneliness, belonging, and mental health

Loneliness is increasingly understood as a relational and environmental issue rather than as an individual deficit[96]. A growing body of evidence demonstrates consistent associations between loneliness (loneliness is a subjective and distressing experience that arises when a person's social relationships do not meet their emotional or social needs for connection, belonging, and support) and poorer mental health outcomes across childhood and adolescence.

Systematic review evidence shows that loneliness is associated with higher levels of anxiety and depression among children and adolescents, including those with pre-existing mental health difficulties[97].

Longitudinal evidence[97, 98] also suggests bidirectional relationships, where loneliness increases vulnerability to psychological distress, while mental health difficulties further reduce social participation and increase isolation. Loneliness is also associated with lower wellbeing, including reduced life satisfaction, diminished psychological wellbeing, and fewer positive emotions[93, 99]. Together, this evidence suggests that loneliness affects both mental ill-health and broader wellbeing.

Young people frequently describe loneliness as being connected to exclusion, bullying, social anxiety, and difficulties maintaining friendships[50, 100]. Experiences of loneliness may also discourage help-seeking and reduce confidence in social relationships[49].
Feelings of belonging appear particularly important for protecting wellbeing. Research consistently shows that supportive peer relationships, opportunities for participation, and emotionally safe environments can help reduce loneliness and strengthen resilience[28, 51]. Loneliness has also, more recently, been framed as a social justice issue[101]: it is shaped by inequality, exclusion, limited access to supportive environments, and weak social infrastructure.

"Unfortunately, I'm off for this whole week [from school] because I just feel so lonely and depressed and can't bear to go in…"
Female, 16 years old[100]

4.3 Third spaces, trusted adults, and prevention

Community "third spaces" (settings outside home and school) provide important opportunities for voluntary participation, relationship building, and identity development. These include youth clubs, libraries, sports organisations, arts programmes, faith groups, and community organisations.

Recent evidence suggests that programmes creating sustained opportunities for shared activity and repeated social interaction

are among the most promising approaches for reducing loneliness among young people[102]. Shared activities and regular participation support friendship formation, strengthen social belonging, and create opportunities for young people to explore identity outside formal educational settings. Systematic reviews also consistently report positive associations between participation in organised community activities and improved wellbeing, social connectedness, empowerment, and lower symptoms of anxiety and depression[92, 103, 104].

Young people often describe community spaces as important because they provide environments where they feel accepted, understood, and able to seek support without stigma.

Participation in community activities also broadens access to trusted adults outside the family[91]. Relationships with youth workers, coaches, volunteers, and community mentors may provide guidance, emotional support, and opportunities for early intervention before difficulties reach clinical thresholds.

Financial barriers, however, can substantially limit access to those opportunities. The Children's Society[95] reported that almost half of children and young people were unable to afford activities they wanted to participate in during the previous six months, while over one-third of parents struggled to afford extracurricular activities for their children. Those findings suggest that inequalities in access to community provision may directly contribute to inequalities in social connection and mental health.

Accessible community environments and shared social spaces may, therefore, play an important preventative role, particularly for families facing economic strain and social isolation.

> *"If they can't afford things, it also means they'll miss out on opportunities, and will feel left out."*
> **Young person, The Children's Society[95]**

> *"[The right community is] somewhere where you feel accepted for being yourself… I volunteered in this group, and because it's all neurodivergent individuals, I found it a really nice, accepting community to be in."*
> **Young person, YPAG focus group for this APPG report**

4.4 Summary: Community is part of the mental health system

Across contemporary research and UK policy evidence, community conditions have been shown to consistently shape children and young people's exposure to both risk and protection. Access to belonging, supportive relationships, trusted adults, and safe shared environments influence mental health trajectories alongside family, education, and healthcare systems.

In this chapter, we have seen that there is now strong evidence linking loneliness, social disconnection, and poor mental health outcomes across childhood and adolescence, alongside growing evidence that community-based approaches can contribute to prevention and early intervention. Viewing loneliness and social disconnection through a social justice lens highlights the importance of ensuring equitable access to safe spaces, supportive relationships, and opportunities for participation across all communities. Community infrastructure should, therefore, be understood as a core component of the mental health system rather than an optional addition to statutory services.

Improving child and adolescent mental health will require investment not only in clinical services, but also in the social and community environments that enable children and young people to feel connected, supported, safe, and valued.

5 What works in the community? Evidence on community-based mental health promotion and early intervention

Chapters 1–4 of this report demonstrated four interrelated findings. First, child and adolescent mental health difficulties are increasing while specialist services remain under substantial pressure. Second, many of the strongest drivers of poor mental health are social and structural, including poverty, housing insecurity, exclusion, weak social connection, and reduced access to supportive relationships. Third, prevention begins early, with parental wellbeing, early relationships, and emotional support during pregnancy, infancy, and early childhood shaping later mental health trajectories across the life course. Fourth, community environments and "third spaces" can function as protective systems by strengthening belonging, participation, and access to trusted adults.

This chapter, therefore, examines the evidence for community-based approaches to mental health promotion and early intervention, focusing on what is currently known about effectiveness, implementation, and equity. It argues that community approaches should not be viewed as peripheral to the mental health system, but as an important part of prevention infrastructure capable of strengthening wellbeing, reducing escalation, and supporting earlier access to help.

5.1 What counts as a community intervention?

Community interventions are supports delivered outside specialist clinical services, in the places where children, young people, and families already spend time. These include youth clubs, sports programmes, arts and cultural activities, family hubs, libraries, voluntary organisations, faith groups, peer support groups, and social prescribing services.

They matter because many of the drivers of poor mental health described earlier in this report are not only clinical. They are also social and relational: loneliness, weak belonging, exclusion, family stress, poverty, housing instability, and lack of access to trusted adults. Community interventions aim to address some of these risks by creating safe, accessible spaces where young people can build relationships, take part in meaningful activities, develop confidence, and access support before difficulties escalate.

Community interventions can work at different levels. Some are universal and aim to promote wellbeing for all young people, such as open-access youth provision, sports, arts, volunteering, or social activities. Others provide early support for young people or families when difficulties first emerge, such as mentoring, peer support, parenting programmes, youth hubs, or counselling in community settings. Others help young people navigate services, for example through social prescribing link workers who connect them to activities, practical help, or more specialist support. The key point is that community interventions are not a replacement for clinical mental health care. Instead, they form part of a wider prevention system. They can reduce isolation, strengthen protective relationships, improve wellbeing, and help young people access the right support earlier. This is particularly important in disadvantaged communities, where exposure to risk is often higher and access to protective spaces and activities is often lower.

5.2 Evidence overview

The evidence reviewed in Chapters 2-4 showed that many of the strongest protective factors for child and adolescent mental health are social and relational. Feelings of belonging, supportive peer relationships, access to trusted adults, participation in meaningful activities, and psychologically safe environments all help buffer against adversity and strengthen resilience. Community interventions are important because they aim to strengthen exactly these conditions.

Across the literature, community approaches appear most effective when they create regular opportunities for social connection, shared activity, trusted relationships, and early support before difficulties escalate.

What outcomes improve most consistently?

Recent systematic reviews suggest that community-based interventions most consistently improve outcomes linked to social connection, participation, and everyday functioning, including wellbeing, belonging, loneliness, resilience, and psychosocial functioning[92, 102, 104]. Evidence is generally strongest for interventions that provide sustained opportunities for shared activity, supportive relationships, and repeated social interaction rather than brief one-off programmes. The reviews examined organised activities, participatory arts programmes, and loneliness interventions and all suggest that community approaches can strengthen protective social and relational factors associated with better mental health outcomes among children and young people.

> *"It's quite important as well to just have an activity to do… It's nice to be able to go out and socialise with real people"*
>
> **Young person, YPAG focus group for this APPG report**

There is also increasing evidence that positive childhood experiences occurring in community settings, including mentoring, volunteering, sports participation, and supportive relationships with adults outside the family, contribute to resilience and better long-term wellbeing outcomes[87, 88].

Importantly, community interventions often appear particularly effective at improving everyday functioning and strengthening protective factors rather than directly reducing severe clinical symptoms. This suggests that their primary contribution may lie in prevention, early support, reducing escalation, and strengthening the social environments that support mental wellbeing.

What remains promising, but underdeveloped?

Several community approaches show promise, but currently have a more limited or developing evidence base. These include youth social prescribing, arts and cultural participation, nature-based interventions, hybrid digital–community approaches, and peer-led and co-produced interventions. Many of those approaches align closely with the protective mechanisms identified throughout this report, because they strengthen belonging, participation, social connection, identity development, and access to trusted relationships. However, the evidence base remains uneven and there are important gaps regarding implementation, sustainability, and long-term outcomes.

A recent meta-analysis of loneliness interventions for children and

adolescents found evidence that interventions involving shared activity, repeated social interaction, and opportunities for relationship-building may improve loneliness and wellbeing outcomes, but concluded that there is still limited understanding of which interventions work best for whom and under what conditions[102].

Similarly, evidence examining voluntary and community sector provision suggests that relational and place-based approaches may be particularly valuable for young people experiencing disadvantage because they can create psychologically safe spaces, strengthen trust, and increase access to supportive adults[105]. However, these same relational and community-specific features can make interventions difficult to standardise and evaluate using traditional models of evidence generation.

The evidence also highlights the importance of local context. Community interventions are often highly dependent on local relationships, community trust, transport access, available infrastructure, workforce capacity, and sustained funding. Approaches that work well in one setting may not transfer directly into another without adaptation.

Importantly, many promising community interventions are delivered through under-resourced voluntary and community sector organisations operating with insecure or short-term funding. This can limit programme continuity, workforce stability, evaluation capacity, and equitable access across regions. Areas experiencing the highest levels of disadvantage are often those with the weakest community infrastructure and fewest resources available for preventative provision.

Taken together, the evidence suggests that the challenge is not simply identifying whether community interventions "work", but understanding the conditions under which relational, community-based approaches can be implemented sustainably and equitably at scale.

5.3 Case studies: Community-based early interventions

The evidence reviewed earlier in this chapter suggests that community approaches are most effective when they strengthen the social and relational conditions associated with good mental health. Across diverse intervention models, the strongest evidence is not necessarily for reductions in severe clinical symptoms (that does require clinical support), but for improvements in belonging, participation, social connection, resilience, psychosocial functioning, and access to trusted support.

The following case studies illustrate how those principles are being implemented across different settings in the North of England. Together, they demonstrate how community-based approaches can create psychologically safe and accessible environments where children, young people, and families are able to build supportive relationships, participate in meaningful activities, and access help before difficulties escalate.

Although the interventions differ substantially in scale, target population, and delivery model, several common features recur throughout: trusted and sustained relationships; accessible and non-stigmatising environments; opportunities for belonging and shared activity; flexible and voluntary engagement; community embeddedness and local credibility; integration with wider systems of support; and responsiveness to local inequalities and unmet need.

Importantly, the case studies also demonstrate that community approaches operate across a continuum of prevention and early intervention. The examples include universal and open-access provision, targeted support for young people experiencing emerging difficulties, parenting interventions in early childhood, social prescribing models linked to mental health services, and whole-system approaches designed to rebalance investment toward prevention and community infrastructure.

Taken together, the case studies illustrate a central argument of this report: that community infrastructure is not simply an optional addition to specialist mental health care, but an important part of a broader preventative mental health system.

Case Study 1: Unity Gym Project

What this illustrates: How trusted non-clinical spaces rooted in local communities can strengthen belonging, routine, peer support, and informal early intervention for young people experiencing disadvantage.

Unity Gym Project (UGP) is a community weightlifting gym established by and for residents of an ethnically diverse and economically disadvantaged neighbourhood in Sheffield. It was founded in 2010 by Saeed Brasab, a local youth worker and community leader, in response to concerns about violence involving young people and declining youth provision. Since then, UGP has evolved into a broader community hub offering subsidised gym access, multisport youth sessions, one-to-one mentoring, volunteering opportunities, and leadership pathways including paid employment. Though principally attended by young Somali men aged 15–30, the gym functions as an inclusive community resource spanning multiple ethnicities, genders, and generations.

A distinctive feature of UGP is the integration of youth work principles within a gym environment. Practice is based on voluntary participation, relationship-building, informal support, and empowerment. Young people can engage flexibly without formal referral pathways or binding commitments.

Collaborative research with UGP members suggests that the combination of accessibility, community embeddedness, and trusted staff representative of the local community contributes to UGP being experienced as a psychologically safe environment supporting both physical and mental wellbeing. Shared activities such as weight training appear to facilitate supportive conversations and peer relationships that might not otherwise emerge.

Emerging evidence suggests that non-clinical community resources such as UGP may function as sites of "health creation" where people develop purpose, routine, belonging, confidence, and supportive relationships[105, 106]. Participants described the gym as a "first port of call" during periods of distress, often before formal services were considered.

The relational and place-based nature of resources such as UGP makes replication complex. However, the underlying principles — accessibility, trusted relationships, community ownership, and shared activity — may be transferable across settings. Current work involving the University of Sheffield, community researchers from UGP, and North Yorkshire's Children and Young People's Mental Health Transformation programme is piloting implementation of UGP principles across multiple community and commercial gym settings.

Case Study 2: Help with Our Mental 'Ealth (HOME)

What this illustrates: How integrated, youth-friendly community hubs can reduce barriers between wellbeing support, practical help, and mental health care.

Children and Young People's Empowerment Project (Chilypep) developed the Help with Our Mental 'Ealth (HOME) model following extensive consultation with young people across South Yorkshire. HOME provides a non-clinical "wrap-around" early intervention model for young people aged 11–25 in Barnsley. The hub combines youth work, counselling, peer support, employment support, and wellbeing activities within a single integrated setting. Young people can move flexibly between services without repeated referrals or assessments.

The model includes one-to-one counselling; peer support groups; employment and education support; creative and therapeutic wellbeing groups; and informal drop-in provision. Most referrals occur through self-referral routes, although schools, CAMHS, and social

prescribing teams also refer young people into the service. The HOME model reflects growing evidence that accessible, relational, community-based environments can improve engagement among young people who are less likely to access traditional clinical pathways. By integrating practical support, social connection, and emotional support within a single trusted setting, the model reduces fragmentation and lowers barriers to help-seeking.

Data collected through a Department of Health and Social Care contract using validated measures, including GAD-7, PHQ-9, and SWEMWBS, indicate improvements in wellbeing, social functioning, and loneliness reduction among participants. The service also reports high levels of user satisfaction.

Case Study 3: Incredible Years Toddler in Better Start Bradford

What this illustrates: How early-years parenting interventions delivered through trusted community settings can strengthen protective family relationships and reduce later risk.

The Incredible Years Toddler programme was a group-based parenting intervention delivered by Barnado's through Better Start Bradford to families with children ages 1-3 years.

The programme combines proactive outreach, home contact, and group-based delivery covering child-directed play, emotional development, routines, and behaviour management. Groups are delivered within community settings including children's centres, schools, family hubs, health centres, and mosques. Informed by social learning theory, it is designed to strengthen children's social and emotional development.

Implementation and process evaluations demonstrated that the programme successfully engaged ethnically diverse families living in disadvantaged communities and could be delivered with high fidelity (107, 108). Parents described benefits including improved confidence, stronger parent-child relationships, reduced isolation, and supportive peer relationships with other parents.

International evidence suggests that Incredible Years programmes improve parenting practices and child behavioural outcomes across different cultural and socioeconomic contexts[109-111]. Previous evaluations of the toddler version also suggest positive impacts on parenting and child behaviour[112, 113].

The Bradford implementation additionally highlights the importance of trusted community delivery and proactive face-to-face engagement. Uptake was stronger when recruitment occurred through local community settings rather than remotely. Practitioners also described how group delivery fostered social connection, mutual support, and community cohesion among parents from different backgrounds.

Case Study 4: Wellbeing While Waiting: social prescribing on CYPMHS waiting lists

What this illustrates: How social prescribing can support functioning, resilience, and connection while young people await specialist services.

Social prescribing has recently been tested as a "Wellbeing While Waiting" approach for young people awaiting support from Children and Young People's Mental Health Services (CYPMHS). The intervention involves approximately five to six sessions with a link worker focused on collaborative goal-setting and connection to appropriate community-based activities including sports, volunteering, arts, peer groups, and practical support services. Flexible delivery options and small participation budgets help reduce barriers related to transport and cost.

Qualitative evidence suggests that the person-centred and relational nature of social prescribing supports trust-building, autonomy, and emotional expression among young people[114]. Young people described feeling heard, respected, and supported, while participation in community activities strengthened routine, confidence, and social connection.

Evidence from a trial conducted across 11 CYPMHS sites in England involving 558 young people found improvements in resilience and psychosocial functioning after six months among those receiving social prescribing. Improvements included reductions in peer problems, conduct difficulties, and hyperactivity alongside increases in prosocial behaviour. However, no significant differences were observed for anxiety or depressive symptoms.

These findings reinforce wider evidence suggesting that community interventions may be particularly effective at strengthening protective factors and everyday functioning rather than reducing severe clinical symptoms directly. The evaluation also highlighted implementation challenges. The effectiveness of social prescribing depends heavily on the strength and accessibility of local community infrastructure. Under-resourced voluntary and community sector provision, transport barriers, and geographic inequalities may substantially limit equitable implementation, particularly within disadvantaged communities.

Case Study 5: Growing Up Well model

What this illustrates: How whole-system approaches can embed prevention and community infrastructure within regional mental health strategy.

The Humberside and North Yorkshire Integrated Care Board (ICB) serves approximately 1.7 million people across six local authorities and includes areas with some of the highest rates of child poverty in England. In partnership with the Centre for Young Lives, the region developed the Growing Up Well model[115] as part of a national mental health "trailblazer" initiative.

The model is informed by principles from Child of the North, including placing children first, reducing inequalities, adopting place-based approaches, integrating public services, embedding research and innovation, and strengthening data sharing and accountability.

The model positions the ICB as an "anchor institution" coordinating support across healthcare, education, local government, voluntary organisations, neighbourhood services, and community provision. Rather than focusing narrowly on specialist care, the model seeks to rebalance investment toward prevention, early intervention, and neighbourhood-based support.

Young people involved in the programme consistently emphasised the importance of accessible, stigma-free support delivered within trusted environments such as schools, youth organisations, and community spaces. They also highlighted the importance of opportunities for volunteering, sport, creativity, and social participation in supporting wellbeing and belonging.

Practical actions within the region have included expansion of neighbourhood wellbeing hubs, development of Young Futures Hubs, investment in school-based support, strengthening community partnerships, and improving data integration to identify inequalities and unmet need.

An independent evaluation conducted by the Centre for Applied Education Research concluded that the model generated meaningful shifts in organisational priorities, behaviours, and cross-sector collaboration, while creating a scalable and policy-aligned framework for system transformation.

5.4 What do effective community approaches have in common?

Despite substantial differences in target population, setting, and delivery model, the interventions reviewed in this chapter demonstrate a striking degree of convergence around a small number of core principles.

Relational practice. The most effective approaches prioritise trusted relationships, continuity, and psychologically safe environments. Young people repeatedly describe the importance of feeling listened to, respected, and accepted without judgement. Trusted adults, including youth workers, mentors, coaches, link workers, and community practitioners, appear particularly important for supporting engagement and early help-seeking.

Accessible and non-stigmatising environments. Support delivered through familiar community settings, including gyms, youth hubs, schools, libraries, family hubs, and voluntary organisations, can reduce barriers associated with formal mental health services and encourage earlier engagement. Young people are often more willing to access support in spaces they already know and trust.

Participation and agency. Successful interventions frequently provide genuine choice, voluntary participation, and opportunities for young people to shape support around their own interests and goals. This appears particularly important for strengthening confidence, motivation, and sustained engagement.

Shared activity and belonging. Interventions centred on shared activity, including sport, arts, volunteering, and peer groups, create opportunities for repeated social interaction, friendship formation, and identity development. These mechanisms are likely to be particularly important for reducing loneliness and strengthening belonging.

Community embeddedness. Interventions appear most effective when embedded within local communities and delivered by trusted individuals who understand local cultures, identities, and inequalities. Community ownership and local credibility appear especially important in disadvantaged areas where trust in formal systems may be weaker.

Integration with wider systems. Community approaches work best when connected to schools, primary care, family support, and specialist mental health services rather than operating in isolation. Flexible referral pathways and collaboration across sectors help reduce fragmentation and improve continuity of support.

Equity and infrastructure matter. The effectiveness of community interventions depends heavily on the strength of local community infrastructure. Areas with fewer youth services, voluntary organisations, transport links, and safe public spaces may struggle to implement or sustain preventative approaches without additional investment.

This is particularly important in disadvantaged communities where exposure to risk factors is often highest while access to protective spaces and activities is frequently weakest. Community interventions may, therefore, play an important role not only in prevention, but also in reducing inequalities in access to support, belonging, and opportunity. Together, the evidence suggests that community approaches are unlikely to replace specialist mental health services, but they can play an important role in prevention, early intervention, strengthening protective factors, and reducing escalation to crisis.

5.5. Summary: Community infrastructure as mental health infrastructure

The evidence reviewed in this chapter suggests that community approaches are most effective when understood as part of a broader prevention infrastructure rather than as isolated projects or short-term initiatives. Across diverse settings, interventions appear most successful when they strengthen belonging, participation, trusted relationships, and access to supportive environments.

Taken together, the findings from Chapters 1–4 suggest that child and adolescent mental health is shaped not only by access to treatment, but by the social and relational environments in which children and young people grow up. Poverty, housing insecurity, exclusion, loneliness, and weak social connection increase risk, while supportive relationships, safe spaces, participation, and trusted adults can strengthen resilience and protect wellbeing.

Community approaches matter because they act directly on many of these protective mechanisms. They can reduce isolation, increase opportunities for connection and participation, support earlier help-seeking, and strengthen the social conditions that enable children and young people to thrive.

Community infrastructure should, therefore, be understood not as an optional addition to mental health services, but as a core component of a preventative mental health system. Effective prevention requires sustained investment in safe spaces, trusted adults, voluntary and community sector provision, youth services, and opportunities for participation and belonging, particularly within disadvantaged communities where risks are greatest and access to protective resources is often weakest.

Importantly, the evidence reviewed throughout this chapter also suggests that prevention cannot be delivered through health services alone. Improving child and adolescent mental health requires coordinated investment across schools, families, neighbourhoods, community organisations, and wider social policy. The challenge is not simply expanding access to treatment after difficulties emerge, but creating the conditions in which fewer children and young people reach crisis point in the first place.

6 Building a preventative mental health system

6.1 The central message of this report

The evidence reviewed throughout this report points to a clear and consistent conclusion: child and adolescent mental health difficulties are increasing across the UK, inequalities are widening, and current systems remain too heavily oriented toward responding to crisis after difficulties have already escalated.

Across Chapters 1-5, the report has shown that many of the strongest drivers of poor mental health are social, economic, and relational rather than solely clinical. Poverty, housing insecurity, exclusion, loneliness, weak social connection, family adversity, and limited access to supportive environments all increase risk for children and young people. These pressures are not experienced equally. Children and young people growing up in disadvantaged communities, particularly across parts of the North and Midlands, are more likely to experience multiple and cumulative risks while simultaneously facing greater barriers to support. At the same time, the report highlights strong evidence for the importance of protective relationships and environments. Supportive families, emotionally safe schools, trusted adults, strong peer relationships, opportunities for participation, and accessible community spaces all help strengthen resilience and protect wellbeing. Community organisations, youth provision, sports, arts participation, volunteering, and neighbourhood support systems can create the social conditions that help children and young people feel connected, valued, and able to seek support early.

Taken together, the findings suggest that child and adolescent mental health is shaped not only by access to treatment, but by the environments in which children and young people grow up, learn, participate, and belong.

This has important implications for policy. If many of the drivers of poor mental health are social and structural, prevention cannot be delivered through healthcare services alone. Improving outcomes for children and young people requires a broader preventative mental health system that strengthens the conditions that enable children and young people to thrive before difficulties reach crisis point.

6.2 Why prevention matters now

The evidence presented in this report demonstrates growing pressure across children and young people's mental health services. Demand for support has risen substantially over the last decade, while many children and young people continue to experience long waits, rejected referrals, or unmet need. Specialist services remain essential, particularly for children and young people experiencing severe or complex difficulties. However, the current system is increasingly characterised by high thresholds for access and reactive responses once difficulties have become acute.

The report also demonstrates that many current pressures are unlikely to be resolved through treatment expansion alone. Rising rates of distress among children and young people reflect broader societal changes, including increasing poverty and inequality, reduced access to youth and community provision, school pressures, housing insecurity, social fragmentation, and growing loneliness among young people. Prevention is, therefore, not simply about intervening earlier within clinical pathways. It is about strengthening the social and relational conditions that protect mental health across childhood and adolescence.

Importantly, prevention should not be understood as a single programme or intervention. Effective prevention operates across multiple levels as follows:

- reducing exposure to adversity and structural inequality
- strengthening protective relationships and environments
- supporting families and schools
- increasing access to trusted adults and safe spaces
- creating opportunities for belonging, participation, and connection
- providing timely support before difficulties escalate

The evidence reviewed throughout this report suggests that community infrastructure plays an especially important role within this wider prevention system. Community organisations, youth provision, sports clubs, libraries, arts programmes, faith groups, family hubs, and voluntary sector organisations often provide accessible, relational, and non-stigmatising forms of support that sit between everyday life and specialist care.

However, many of those services have experienced long-term underinvestment and instability. In some of the communities experiencing the highest levels of disadvantage, opportunities for safe participation, social connection, and early support have become increasingly limited. This creates a paradox in which the areas with the greatest need may have the weakest preventative infrastructure.

6.3 What good prevention looks like

Across the evidence reviewed in this report, a consistent picture emerges of what effective prevention and early intervention look like for children and young people's mental health. Although interventions vary considerably in setting, scale, and target population, the most promising approaches share several common features.

The report provides multiple examples of excellent practice of

community-based mental health prevention and intervention through its case studies, demonstrating that investment in existing models and interventions is a promising and cost-effective way of improving children's wellbeing. Foundations, What Works Centre for Children and Families, provides local authorities with guidance on effective evidence-based interventions.

Importantly, effective prevention is not limited to delivering support earlier within clinical pathways. Rather, it involves strengthening the social, relational, and environmental conditions that enable children and young people to remain well, cope with adversity, and access support before difficulties escalate.

Prevention is relational
The strongest and most consistent theme across the evidence is the importance of trusted relationships. Children and young people repeatedly describe the value of feeling listened to, respected, emotionally safe, and accepted without judgement. Relationships with parents, carers, teachers, youth workers, mentors, coaches, peers, and community practitioners all have the potential to strengthen wellbeing and support early help-seeking.

Effective prevention, therefore, depends not only on services, but on the availability of trusted adults and supportive social environments within everyday life.

Prevention strengthens belonging and connection
Feelings of loneliness, exclusion, and weak social connection are increasingly recognised as important pathways into poor mental health. Conversely, opportunities for participation, friendship, shared activity, and community belonging can strengthen resilience and emotional wellbeing. Many of the most promising community approaches reviewed in this report work by creating regular opportunities for connection through sport, arts participation, volunteering, peer support, youth provision, mentoring, and shared activity. Those environments help children and young people develop social confidence, identity, routine, and supportive peer relationships.

Prevention starts early and continues across development
Many mental health difficulties emerge during childhood and adolescence, often alongside major developmental transitions. Effective prevention, therefore, begins early and continues throughout childhood, adolescence, and early adulthood.

Support for parents and caregivers, early-years interventions, emotionally supportive schools, opportunities for positive peer relationships, and accessible community activities all contribute to healthier developmental trajectories. Prevention is therefore not a single intervention delivered at one moment in time, but an ongoing process of strengthening protective environments across development.

Prevention is accessible and non-stigmatising
Children and young people are often more willing to seek support within familiar and trusted environments than through formal clinical services alone. Community spaces, schools, youth hubs, libraries, sports settings, family hubs, and voluntary organisations can therefore provide important opportunities for early support before difficulties escalate to crisis point. Flexible and voluntary engagement also appears important for reducing stigma and improving participation, particularly among groups less likely to access formal mental health support.

Prevention requires participation and agency
The evidence reviewed throughout this report suggests that children and young people engage most effectively with support when they experience genuine choice, voice, and agency. Co-produced and youth-informed approaches can improve trust, accessibility, and relevance. Providing opportunities for children and young people to shape activities, define goals, and participate meaningfully within their communities may itself strengthen confidence, self-worth, and belonging.

Prevention depends on strong community infrastructure
Effective prevention requires places where children and young

people can safely spend time, develop relationships, and participate in meaningful activities. Youth services, voluntary organisations, sports clubs, libraries, arts programmes, parks, and community spaces all form part of this wider prevention infrastructure. However, access to those resources is uneven. Many disadvantaged communities experience both higher exposure to risk factors and reduced access to safe spaces, trusted adults, and community provision. Therefore, prevention depends not only on programme design, but also on sustained investment in the community infrastructure that supports children and young people's everyday wellbeing.

Prevention must address inequality

Throughout this report, inequalities emerge as one of the strongest and most consistent predictors of poor mental health outcomes. Poverty, discrimination, insecure housing, educational exclusion, and limited access to support all increase risk across childhood and adolescence. Effective prevention, therefore, requires proportionate universalism: universal support available to all children and young people, delivered with greater intensity and investment where need is greatest. Without attention to inequality, preventative approaches risk benefiting those already best positioned to access support.

Taken together, the evidence suggests that good prevention is relational, accessible, community-based, and developmentally informed. It strengthens belonging, connection, participation, and trusted support while reducing barriers to early help. Most importantly, it recognises that children and young people's mental health is shaped not only by individual experiences, but by the wider social environments in which they grow up.

6.4 Priorities for policy and system change

The evidence reviewed throughout this report suggests that improving child and adolescent mental health requires coordinated action across multiple systems rather than reliance on healthcare services alone. Several priorities emerge consistently from the evidence:

1. **Reduce exposure to structural risk.** Persistent poverty, insecure housing, food insecurity, discrimination, and educational exclusion all increase the likelihood of poor mental health outcomes. Policies designed to reduce child poverty and socioeconomic inequality should be seen and integrated as core components of the preventative mental health strategy.

2. **Strengthen family support.** Families remain one of the most important protective environments for children and young people. Parenting support, family hubs, financial support for families, and early help services can all reduce stress and strengthen children's emotional wellbeing.

3. **Invest in schools as protective environments.** Schools play an important role not only in education, but also in belonging, emotional safety, peer relationships, and access to support. Prevention requires schools and local authorities to prioritise school connectedness, inclusion, attendance, emotional wellbeing, and relationships alongside academic attainment.

4. **Rebuild youth and community infrastructure.** The evidence reviewed in this report consistently highlights the importance of community provision in supporting wellbeing, belonging, participation, and early intervention. Long-term investment in youth services, voluntary and community organisations, sports, arts, libraries, and safe community spaces that reflect the needs of local communities should therefore be understood as investment in mental health prevention infrastructure.

5. **Strengthen early intervention pathways.** Accessible and non-stigmatising support delivered before difficulties escalate can reduce distress and improve functioning. Family hubs, school-based support, social prescribing, mentoring, peer support, and community wellbeing services all have the potential to strengthen prevention and reduce escalation into crisis.

6. **Improve system integration.** Fragmented and siloed systems create barriers for children, young people, and families. Prevention requires stronger collaboration across health services, schools, local government, youth services, voluntary organisations, and communities. Place-based approaches and shared accountability for wellbeing may help strengthen coordination and continuity of support.

7. **Prioritise equity.** Children and young people facing the greatest levels of disadvantage are often least likely to access timely support. Prevention strategies therefore need to prioritise equity and proportionate universalism, ensuring that support is available universally, but delivered with greater intensity where need is greatest.

6.5 Conclusion

This report has argued that improving child and adolescent mental health requires a shift from a predominantly reactive system toward one that places greater emphasis on prevention, belonging, relationships, and community infrastructure.

Mental health difficulties among children and young people are increasing at a time when many of the social conditions that protect wellbeing have weakened. Rising poverty, insecurity, exclusion, loneliness, and pressure on families and communities are contributing to growing distress among children and young people, particularly within disadvantaged communities.

At the same time, the evidence reviewed throughout this report demonstrates that supportive relationships, safe environments, opportunities for participation, trusted adults, and strong community infrastructure can all strengthen resilience and protect mental health. The challenge is, therefore, not simply expanding access to treatment after difficulties emerge, but creating the conditions in which fewer children and young people reach crisis point in the first place.

Building a preventative mental health system will require sustained long-term investment across multiple sectors, including healthcare, education, housing, youth provision, local government, and voluntary and community organisations. It will also require a shift in how mental health is understood: not solely as an issue for clinical services, but as a collective social responsibility shaped by the environments in which children and young people grow up. Children and young people need more than access to treatment. They need safe and supportive families, inclusive schools, trusted relationships, opportunities for participation, and communities in which they feel connected, valued, and able to thrive.

Afterword

By Aisha Adeyoola, Salma Abdulrami & Arisha Hussain
Youth Community Healthcare Champions, Sheffield

We are a group of college students who have worked as Community Youth Healthcare Champions for the past 8 months to raise awareness of mental health in our community. As a group, we are only too aware of the stigma surrounding mental health that constantly plagues our experiences. We all come from ethnic backgrounds where mental health is normally not discussed enough, as well as being from disadvantaged socioeconomic backgrounds in the North of England. We were delighted to see this Child of the North report discuss the subjects of disadvantage and community. In our group, our shared experiences and similar backgrounds helped us build up this sense of community. We bonded with each other over our discussions about mental health and our aim to help other adolescents grow up in a community that prioritises their mental health along with their education.

As Community Youth Healthcare Champions, we came to a consensus that mental health seems to be an underdiscussed topic, especially within ethnic minority backgrounds. As part of our work, we devised a survey for our college entitled: how stable do you feel in your relationship with your given family and chosen family (friends). We have had a lot of responses to the survey, which shows how keen other young people are to engage in conversations around mental health, and how timely this report is.

In our group, we discussed how being from ethnic minority backgrounds, we find it quite difficult to talk to our family members and family friends about the topic of mental health, as they are either reluctant to being open-minded to such a topic or they have limited education about mental health due to how they grew up with it being stigmatised. As a result, we have parents who are living with the lasting effects of mental health deteriorating yet believing that they don't need to get help and thinking that feeling this way is normal. This continues the cycle of generational trauma, having all these outbursts when they are stressed, being emotionally unaware or emotionally stunted by seeing vulnerability as weakness. The report highlights how parents' mental health could leak over into other relationships, especially with their children. We believe a key strength of this report is that it discusses these generational cycles of mental health as one of the most important factors to consider in children's mental health, and that it includes recommendations around how to support parents' mental health. As Community Youth Healthcare Champions, we strive to change intergenerational cycles of stigma and trauma and improve mental health in our community. We want to make sure that everyone matters. We want people to know how important mental health is and how we should value mental health. We are very happy to see similar themes in this report.

Being from the North deeply impacts how mental health support is accessed. Some of us have seen or have experienced first-hand how a lack of funding can lead to performing worse in school. A lack of opportunities affects students' ability to perform well academically as they face more adversity, resulting in less kids being in education. Disadvantage could lead to some kids feeling like they don't have the potential to strive to be somewhere greater than they are, leading them to be in places that don't reflect what they are capable of, making their mental health feel even worse. When students face anxiety due to academic pressure, they are less likely to achieve top grades in GCSEs, which limits their options in sixth form or college. In this way, the place you live influences your experiences in life and your mental health, which is one of the central messages of the report.

We believe mental health is important because it shapes how a person responds to adversity and struggles. For example, someone facing depression could fail to recognise the sudden isolation or loss of their sense of self which increased during difficult periods like the COVID-19 pandemic. This is why the report highlights gym communities as well as youth hubs and other community spaces to gain that support that they truly need. By having strong relationships and safe spaces around them, a person has somewhere to turn to when they find themselves struggling. However, the report indicates that the North is underfunded when it comes to community spaces, which makes things worse for them to face these types of problems with no community and limited access to immediate mental health facilities.

These communities, especially in the North, could help young people facing mental health problems but won't immediately get rid of it. That is why we strongly support the report's message of prevention. The report highlights the fact that there are more people that need mental health help than the NHS can handle which puts them underneath significant pressure and makes it harder for the problem to be resolved or decrease anytime soon. So, this is why building community comes as a preventative measure to make sure that it's not only when mental health is severe that people have access to services to strengthen their wellbeing.

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Data availability:

The #BeeWell dataset is available only via protected access arrangements at the University of Manchester.
Understanding Society data are available to download from the UK Data Service:
https://datacatalogue.ukdataservice.ac.uk/studies/study/6614#doi
UK Millennium Cohort Study data are available to download from the UK Data Service: https://doi.org/10.5255/UKDA-Series-2000031
NHS Mental Health Services Monthly Statistics are freely accessible from NHS England: https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/mental-health-data-hub/dashboards/mental-health-services-monthly-statistics
NHS Cheshire and Merseyside data are available only for projects with approved access to the Cheshire and Merseyside Secure Data Environment.

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