Access to mental health support
for children and young people involved in or at-risk of serious youth violence across England and Wales: findings from a multi-strand project

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Executive summary

This report presents findings from a multi-strand research project exploring what access to mental health support children and young people (CYP) involved in or at risk of serious youth violence across England and Wales have, and how this access can be improved. The study brings together:

- A rapid scoping review of effectiveness studies

- A narrative literature review on barriers and facilitators

- Secondary analysis of publicly available administrative data

- A service mapping exercise of voluntary and community sector provision

- In-depth qualitative research with over 100 professionals, caregivers, and young people with lived experience

Taken together, these strands reveal that children and young people in this cohort with the greatest mental health needs, often shaped by multiple, intersecting forms of adversity, face some of the most significant barriers to accessing timely, appropriate, and trusted support.

The findings highlight a mental health care system that is frequently siloed, fragmented, and difficult to navigate. Services span education, health, youth justice, social care, and the voluntary and community sector, among others, yet are often disconnected from one another and from the lived realities of young people's lives. Key barriers identified include:

- Restrictive eligibility criteria that can exclude those with complex, overlapping needs

- Long waiting times, high thresholds, and repeated rejection or redirection of referrals

- Lack of flexibility in how and where support is offered, especially for those not in mainstream education or experiencing instability

- Language and communication barriers, including a mismatch between clinical models and how children and young people express distress

- Stigma, distrust, and fear of criminalisation, which can inhibit help-seeking

- Procedural and bureaucratic obstacles that can make access feel adversarial or inaccessible

While many children and young people are affected, those facing additional marginalisation, including racially minoritised children, those in care, neurodivergent young people, and those living in poverty, were often disproportionately impacted. However, our findings noted that current commissioning models and service configurations often fail to account for this compounded disadvantage.

Schools can be a key point of potential access, offering daily contact with young people and early opportunities to identify need. Yet this potential is often constrained by resource pressures, knowledge gaps around the presentation of trauma, mental health and neurodiversity, and a growing trend of exclusions and absenteeism, particularly post-pandemic. For many children and young people, particularly those whose distress manifests behaviourally, rigid disciplinary approaches were thought to further isolate them and drive disengagement.

Despite these challenges, examples from the qualitative research highlight features of provision that participants see as more accessible and supportive. These include services that are multidisciplinary, community-based, relational, culturally attuned, and embedded in young people's everyday spaces. However, such services were described as often precariously funded, disconnected from statutory pathways, or geographically uneven.

The project also identifies important gaps in national data and reporting. Administrative data are limited in their ability to reflect the specific experiences of children and young people involved in or at risk of violence and offending, particularly in terms of tracking individual access journeys, outcomes, and demographic patterns. This constrains the ability to design responsive, needs-led services and to ensure accountability.

A central theme throughout the research is that children and young people, families, trusted adults such as youth workers and mentors, and frontline practitioners who often hold the deepest understanding of what support looks like in practice, are rarely meaningfully involved in shaping provision or policy. Meanwhile, frontline services that are best placed to respond flexibly are often under-resourced and excluded from commissioning processes.

Improving access to mental health support for children and young people affected by serious youth violence will likely depend on broader systemic changes, rather than adjustments at the individual service level alone. This could include:

- Investing in low-threshold, early support, including in schools and communities, before needs escalate.
- Addressing structural inequities, such as poverty, racism, and ableism, that shape both need and access.
- Ensuring inclusive service design and communication through co-production, cultural competence, and accessibility.
- Reforming commissioning and evaluation systems to support innovative, preventive and community-led approaches.
- Shifting power towards young people, caregivers and frontline practitioners through meaningful involvement in service planning and decision-making.

The report concludes with a series of practical recommendations for policymakers, commissioners, and service leads. These are grounded in evidence from across the research strands and are designed to support more equitable, inclusive, and responsive mental health systems, ones that better reflect and meet the needs of at-risk children and young people.

Acknowledgements

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List of Abbreviations

ACE	Advice Childhood Experience		**LA**	Local Authority
ADHD	Attention Deficit Hyperactivity Disorder		**LAC**	Looked-After Child
BACP	British Associationfor Counselling and Psychotherapy		**MDT**	Multi-Disciplinary Team
BAME	Black, Asian and Minority Ethnic		**MHST**	Mental Health Support Team
CAMHS	Child and Adolescent Mental Health Service		**MST**	Multi-Systemic Therapy
CBT	Cognitive Behavioural Therapy		**NCB**	National Children's Bureau
CYCJ	Children and Young People's Centre for Justice		**NHS**	National Health Service
CYP	children and young people		**NICE**	National Institute of Clinical Excellence
DBT	Dialectical Behaviour Therapy		**NGO**	Non-Governmental Organisation
DBS	Disclosure and Barring Service		**NSPCC**	National Society for the Prevention of Cruelty to Children
DfE	Department of Education		**ONS**	Office for National Statistics
DRV	Dating and Relationship Violence		**OT**	Occupational Therapist
EHCP	Education, Health and Care Plan		**PTSD**	Post-Traumatic Stress Disorder
EMDR	Eye Movement Desensitization and Reprocessing		**PRU**	Pupil Referral Unit
FfIC	Framework for Integrated Care		**RCT**	Randomised Controlled Trial
GBV	Gender-Based Violence		**ROM**	Routine Outcome Measure
GP	General Practitioner		**SALT**	Speech And Language Therapist
HMRC	His Majesty's Revenue and Customs		**SEN**	Special Educational Needs
IAPT	Improving Access to Psychological Therapies		**TVLP**	Thames Valley Link Programme
ICB	Integrated Care Board		**VRU**	Violence Reduction Unit
ITL	International Territorial Level		**WHO**	World Health Organisation
KPI	Key Performance Indicator		**YEF**	Youth Endowment Fund
			YJS	Youth Justice System
			YOT	Youth Offending Team

Glossary of Terms

Alternative Provision	An educational arrangement for pupils are unable to access mainstream schooling (e.g. exclusion, illness).
Austerity	A set of economic policies, aimed at reducing governmental debt, which often involve spending cuts and tax increases.
Criminalisation	The process of making something (e.g. an activity such as fox-hunting) illegal and subject to criminal penalties. Alternatively, the process by which someone (e.g. a young person) is drawn into criminal activity.
Cultural competence	The ability to reduce ethnic and racial health disparities by fostering a greater awareness and understanding of diverse cultures and communities. It encompasses a set of behaviours, attitudes and policies that enable professionals and services to operate effectively and deliver appropriate services for people from different backgrounds[1].
Demographic	In this context, a particular sector of a population.
Digital poverty	An individual suffers digital poverty when they are unable to participate fully in online activities due to lack of access to digital resources, skills, etc.
Education, Health and Care Plan (EHCP):	A legal document that outlines the special educational, health, and social care needs of a child or young person aged up to 25 who requires more support than is typically available in mainstream settings.
Grassroots	A grassroots organisation is one that emerges out of the collective effort of a community or a group of locals (bottom up) rather than elites or leaders (top down).
Holistic	A holistic approach is one that acknowledges how different elements of a problem or issue are interconnected. In mental healthcare, a holistic approach looks at the individual's experience, their social position, their family, etc.
"Hot potato effect"	A situation in which responsibility is passed but never held.
Hypervigilance	A state of excessive alertness and the feeling of constantly being on guard, even when the risk of danger is low. Often resulting from trauma or anxiety.
Intersectionality	A framework for understanding how the combination of different forms of oppression (e.g. racism, sexism and ableism) can change the quality, and not just the weight of the oppression.
Minoritised	In this document, we use 'minoritised' to indicate that 'ethnic minorities' are not intrinsically minorities, but only in certain contexts and as a result of certain social forces.
"Missing middle"	A cohort of children and young people structurally excluded from the healthcare system due to threshold limits.

Neurodiversity	Refers to the idea that human brains work in different ways, and that neurological differences like those found in autism and ADHD are natural variations rather than disorders.
Norm / normalisation	A norm is a behaviour or pattern that is considered typical, and implicitly endorsed, within a group. Normalisation is the process by which activities become normal or norms.
"Postcode Lottery"	The unequal regional distribution of provisions such as healthcare and education.
Person-centred	'Person-centred' care foregrounds the individual, ensuring e.g. that they are fully informed about their situation and included in decision-making.
Racialisation	In this document, we take the view that 'race' is a social but not biological category. Racialisation refers to the social process by which individuals are raced, i.e. seen to be a member of a race.
Realist evaluation	A research methodology that explores why interventions work or don't in specific contexts.
Risk factor paradigm	A sociological model that attributes causal powers to socio-economic factors.
Safeguarding	The protection of individuals, in this context children and young people, from harm, abuse and neglect.
School exclusion	There are different forms of school exclusion. 'Permanent exclusion' means a child is no longer allowed to attend a specific school.
Tier 2 CAMHS	provides targeted support for children and young people experiencing mild to moderate mental health difficulties, often referred from Tier 1 services or directly. These services are typically delivered in community settings like schools, GP clinics, and youth services, by professionals such as counsellors, psychologists, and therapists. Aims to address issues like anxiety, depression, and behavioral challenges before they escalate to more complex needs.
Tier 3 CAMHS	provides specialist, multi-disciplinary support for children and young people with severe or complex mental health difficulties. These difficulties might include psychosis, depression, eating disorders, or severe anxiety, among others. Typically delivered within local community settings, such as clinics or mental health centers, these multi-disciplinary teams often include professionals like psychiatrists, psychologists, nurses, and social workers. They provide specialist assessments, treatment plans, and interventions for children and young people with more complex or persistent mental health difficulties.

1. Introduction

This report outlines the findings from a research project aiming to investigate access to mental health support for children and young people involved in, or at-risk of, serious youth violence across England and Wales. While we recognise the importance of early intervention and support for younger children in addressing serious youth violence, our focus here is specifically on interventions targeted at the 10–18 year-old age bracket given that 10 is the age of criminal responsibility in England and Wales, and that the majority of funding at the Youth Endowment Fund is directed to those aged 10-18 years[2].

The project consisted of multiple research strands, including:

- Rapid evidence reviews (including a rapid scoping review of effectiveness studies and a rapid narrative review of barriers to access).
- Secondary analysis of publicly available administrative data.
- Qualitative research with service providers, parents / caregivers and young people with lived experience of the relevant systems.
- Service mapping exercise of voluntary and community sector organisations.
- An assessment of good practice.

The findings from each project strand have been synthesised and collated within this final situational analysis.

The findings of this report are relevant to practitioners, service-leads, policy-makers, and commissioners across a range of sectors including, but not limited to, Youth Justice Services, Child and Adolescent Mental Health Services, Education, Youth Work, Social Care and the Voluntary and Community Sector. The aim is that this report serves as a reference point to highlight the current barriers to access, and as a practical guide to help inform future funding, policy and service decisions.
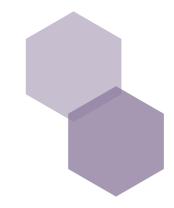
1.1 Research Questions

This project was guided by the following overarching research question:

What access do children and young people, at risk of or already involved in violence and offending, have to mental health support—and how might this access be improved?

To answer this question, the research was designed as a multi-strand study combining qualitative research, evidence reviews, secondary data analysis, and a service mapping exercise. Each strand explored distinct but interlinked sub-research questions, contributing to a fuller understanding of access and provision. These sub-questions are outlined below:

RESEARCH SUB-QUESTION	RESEARCH STRAND
What psychological and psychosocial interventions are delivered to children and young people involved in or at risk of serious youth violence, and how effective are they?	Rapid scoping review of effectiveness studies
What are the barriers and facilitators to access, engagement, and retention in services for this group?	Rapid narrative review Qualitative research
What factors hinder or enhance the effectiveness of these interventions (i.e. what makes them the 'right' intervention for a given child or young person)?	Rapid narrative review Qualitative research
How do regions within England and Wales compare in terms of the prevalence of serious youth violence, exposure to associated risk factors, and access to CAMHS?	Secondary data analysis
What are the geographic disparities between children and young people likely to be in need of therapeutic support and those receiving services?	Secondary data analysis
What mental health services are available to children and young people through voluntary and community sector organisations in different regions across England and Wales?	Service mapping exercise
What forms of practice and provision are viewed as promising by young people, families, and practitioners?	Qualitative research
What does accessible, culturally competent, and engaging support look like in practice?	Qualitative research Good practice assessment

The main findings of this report focus on the barriers and facilitators to accessing support, while findings from the other research sub-questions offer important contextual insight.
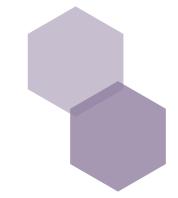
1.2 Overview of the problem

While levels of serious youth violence (SYV) have shown recent signs of decline it remains a critical concern across England and Wales. Encouraging trends include:

- A reduction in first-time entrants to the youth justice system, as well as falling reoffending and arrest rates for violent offences (YEF, 2024).
- Declining rates of homicides among 16-24 year olds and hospitalisations for knife assaults in those aged 0-17 since their peak around 2017-2019 (YEF, 2024).

However, the problem persists:

- In 2022/2023, 99 young people aged 16–24 were victims of homicide, and 467 children were hospitalised due to knife or sharp object injuries (YEF, 2024).
- A 2024 survey of 10,000 13–17-year-olds found that 20% had been victims of violence, and 16% had committed violence in the past year (YEF, 2024a).

Despite improvements, overall levels of serious youth violence remain higher than a decade ago, and growing pressure on policing, education, and mental health services has left many children and young people without the support they need (YEF, 2024).

Serious youth violence is not inevitable or an inherent feature of youth. Evidence shows that violence is preventable [3], and risk is shaped by multiple intersecting environmental factors. While these factors do not deterministically lead to violence, they highlight key areas where young people may require support. Mental health support has been shown to be one strategy that can help protect young people from becoming involved in violence (Ibid).
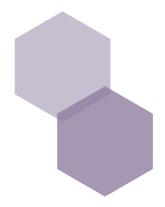
For the purpose of this project, serious youth violence is defined using the definition outlined by the Department of Education, relating to the following broad categories of offence groups and offence types: "violence against the person offences, indictable only; robbery offences, indictable only; possession of weapons offences, triable either way or indictable only" (DfE & MoJ, 2023). Sexual violence was excluded from our working definition. While overlapping in some policy areas, it typically involves distinct safeguarding, justice, and therapeutic responses, especially when considered within frameworks of child sexual abuse or exploitation. This decision was made to maintain analytical clarity while recognising the need for further research into the intersections between different forms of harm.

1.3 Why is this project necessary?

Experiences of serious youth violence have profound and lasting consequences for children and young people, and the wider community. Half of 7,574 teenagers surveyed in 2023 reported that violence negatively affected their daily lives, causing sleep disruption, difficulty concentrating, or school avoidance[4]. Beyond immediate harms, exposure to violence is associated with long-term risks such as poor mental health, substance misuse, and chronic health conditions (Royal College of Paediatrics and Child Health, 2020; Taylor, 2024). Serious youth violence also has a wider impact on communities and families, including on people's sense of safety (Ofsted et al., 2024). In addition, the case is economic. In 2018/19, serious youth violence across England and Wales cost £1.3 billion in economic and social harms. If current trends continue, the projected cost over the next decade is £10 billion. By contrast, running all 18 regional Violence Reduction Units (VRUs) for 10 years would cost £350 million. To be cost effective, the VRUs would only need to reduce serious violence between young people by 3% (Irwin-Rogers et al., 2020).

Children and young people involved in, or at risk of, serious youth violence often face overlapping challenges, including trauma, adverse childhood experiences, neurodevelopmental conditions, and socioeconomic exclusion (YEF 2024, YEF 2024a). These factors contribute to high levels of unmet mental health need (Ibid). Distress - often unrecognised or unsupported - can contribute not only to increased vulnerability but also to behaviours that bring young people into contact with the criminal justice system (King et al., 2014; Muir et al., 2024). Justice-involved children and young people often describe mental health support as inaccessible, stigmatising, or untrustworthy (King et al., 2014; Rice et al., 2024).

There's an increased need for mental health support for children and young people generally, and a need for improved access (Newlove-Delgado et al., 2023; YEF 2024). In 2022/23, nearly one million children and young people were referred to CAMHS, but 28% were still waiting at the end of the year and almost 40% had their referral closed without treatment (Children's Commissioner, 2023). These system-wide issues are likely amplified for children and young people involved in serious youth violence, whose mental health needs are greater than that of the general population and whose complex needs are often not addressed (HM Inspectorate of Probation 2023; Soneson et al., 2024; Schilling et al., 2007).
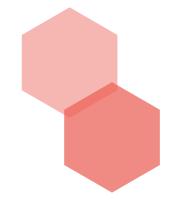
The first step in improving access to mental health support is in understanding the barriers and enablers that shape it. This project takes that step by identifying key obstacles and facilitators, clarifying what constitutes the 'right' support i.e. what effective and culturally competent support looks like for this group, and by exploring how systems can better respond to the realities of young people's lives. By providing a deeper understanding of these factors, we hope this report can be a first step to improving access to mental health support for at-risk children and young people.

1.4 What gaps does the project fill?

We believe our contribution fills a critical gap by combining multiple sources of evidence - including lived experience and practitioner insight - to generate practical, context-sensitive insights and recommendations for improving access to mental health support for children and young people involved in, or at risk of, serious youth violence.

While much is known about youth violence and mental health, clear, evidence-based recommendations on improving access remain limited. This project addresses that gap, offering a grounded, comprehensive view of the current access landscape and how it can be improved.

2. Methods

The following sections outline the methodology of the main project strands.

The project was conducted between August 2024 and May 2025 by a research team commissioned by The Youth Endowment Fund, in partnership with the Department for Education. The project was guided by an advisory board consisting of experts from a range of professional backgrounds including academia, health care, government and the voluntary and community sector. A range of strategies were employed to address the research question and sub-questions. Each project strand was conducted separately and a report was produced for each, detailing the findings. Data from this wide range of sources was integrated and synthesised to produce this report on current access to mental health support for at-risk young people.

This current situational analysis details the findings of the synthesised project strands. The sections below give an overview of the methods of each of the project strands. Summarised project reports for each individual strand are attached as annexes where the full methods and key findings for each can be found.

2.1 Rapid evidence reviews

Rapid scoping review of effectiveness studies

To investigate the research sub-question: *'what psychological and psychosocial interventions are delivered to children and young people involved in or at risk of serious youth violence, and how effective they are',* we conducted a rapid scoping review of effectiveness studies, which was subsequently split into two parts: a review of global literature reviews (an umbrella review), and a review of primary studies from the UK and Ireland.

Understanding effectiveness was important to our overall aim of improving access to support. It is not enough to expand access to any intervention, we must ensure we are improving access to the *right* types of support. This strand of work therefore aimed to identify which interventions are most likely to be beneficial for this population, in order to provide important context and inform more meaningful and evidence-based approaches to service provision and commissioning.

We searched academic databases and carried out a targeted grey literature search. The methodology, including the search strategy and list of databases and sources, alongside key findings for both the umbrella review and review of primary studies have been included in Annex 1 and 2, respectively. Search terms targeted our population of interest (children and young people), involvement in or risk of serious youth violence (including perpetration and known risk factors), psychological or psychosocial interventions, and relevant outcomes. Boolean operators were used to combine terms, and results were limited to English-language publications from the last 10 years.

Studies were eligible if they focused on young people aged 10–18 involved in or at risk of serious youth violence, and if the interventions were psychological or psychosocial in nature. Eligible studies also needed to include measurable outcomes aligned with our focus, such as reductions in violence or offending, improvements in mental health, or reductions in risk behaviours (e.g. substance misuse, aggression, or externalising behaviours).

The initial search returned 8,488 results. Due to the volume, we restricted inclusion to global literature reviews (66 included reviews) and UK/Ireland-based primary studies (46 included studies), which were reported on separately. Data were extracted and synthesised to provide an overview of the types of interventions delivered and their effectiveness in reducing risk and/or improving mental health. Full findings are presented in two annexed reports.

Rapid narrative review on barriers to access

As part of the broader evidence review project strand, we conducted a rapid narrative review of predominantly qualitative literature to answer the research sub-questions: *'What are the barriers and facilitators to access, engagement, and retention in services for this group?'* and *'What factors hinder or enhance the effectiveness of these interventions (i.e. what makes them the 'right' intervention for a given child or young person)?'*

This review differed from the earlier effectiveness review by focusing on qualitative insights, both UK-based and international. While the effectiveness review examined measurable outcomes, the narrative review explored the contextual and relational factors that shape whether, how, and for whom interventions work — aspects often overlooked in outcome-focused studies. We undertook this review to complement and inform our primary qualitative research. By examining what the literature already says about barriers, facilitators, and service responsiveness, we were able to cross-reference and validate our own findings, and situate them within the wider body of evidence. This helped strengthen the overall credibility and relevance of our conclusions.

While screening papers for the scoping review of effectiveness studies described in the previous section, we simultaneously identified qualitative studies and those with insights relevant to the current research sun-questions. Due to the volume of literature, we focused on reviews to capture global themes and patterns, and included UK and Ireland-based primary studies for contextual relevance. Select North American studies were also included where pertinent. To supplement this, we conducted a targeted hand search of UK-based primary studies and key websites for relevant grey literature.

We analysed 72 studies using qualitative thematic analysis. Inclusion and exclusion criteria were based on population, intervention type, outcomes, study design, and location. A range of study types (qualitative and quantitative and mixed-methods with relevant insights) were included to ensure comprehensive coverage. The summarised report with the full methodology and key findings findings are outlined in Annex 3.
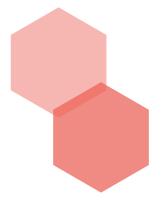
2.2 Secondary data analysis of publicly available administrative datasets

The secondary data analysis explored regional patterns in serious youth violence, associated risk factors, and access to mental health support for children and young people. It aimed to answer the following research sub-questions: *'How do regions within England and Wales compare in terms of the prevalence of serious youth violence, exposure to associated risk factors, and access to CAMHS?'* and *'What are the geographic disparities between children and young people likely to be in need of therapeutic support and those receiving services?'*

To do this, we developed three composite indices using publicly available administrative data:

- A Youth Violence Index, estimating the regional proportion of children and young people involved in serious violence;
- A Risk Factor Index, capturing the regional prevalence of indicators associated with elevated risk; and
- An Access to Mental Health Support Index, assessing regional variation in access to CAMHS.

Each index was built using a consistent method: we identified relevant public datasets, selected indicators representing the construct or suitable proxies, reformatted them to show regional proportions, and applied normalisation following the methods used in the development of the Human Development Index[5] to produce composite scores. This enabled regional comparisons across England (based on ONS International Territorial Level 1 (ITL1) regions) and, where comparable data allowed, the ITL1 region of Wales.

Youth Violence Index

To estimate involvement in serious violence, we used data from the Ministry of Justice and Youth Justice Board, including: children cautioned or convicted for weapon-related offences, those sentenced for serious violent crime, and average monthly youth custody figures. These were standardised by region and combined into a single index, based on the Department for Education's (2023) technical report definition of serious youth violence (excluding sexual offences;).

Risk Factor Index

We included 21 indicators across five domains: school-related, parent-related, victim-related, police contact, and deprivation. Indicators were selected based on the identification of relevant risk factors through the literature, consultation with our advisory board and an analysis of the available variables in public datasets. Data came from sources including the Department for Education, Ministry of Justice, HMRC, and the Labour Force Survey. Sub-indices were created for each domain and combined into an overall regional score. Wales was excluded due to insufficient data.

Access to Mental Health Support Index

Indicators included average waiting times, spending per child, number of children awaiting first contact, and proportion of closed referrals with at least two contacts. Data were drawn from the Children's Commissioner and NHS Mental Health Services Dataset. All indicators were standardised so higher scores represented poorer access, and then combined into a regional index. Comparable Welsh data were unavailable, necessitating that Wales was excluded.

A full methodological description, along with key findings and additional data tables is available in the summarised secondary analysis report (Annex 4).

2.3 Qualitative research
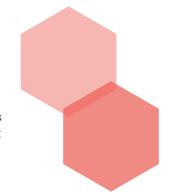
The qualitative strand explored the following research sub-questions: *'What are the barriers and facilitators to access, engagement, and retention in services for this group?', 'What factors hinder or enhance the effectiveness of these interventions (i.e. what makes them the 'right' intervention for a given child or young person)?' ,'What forms of practice and provision are viewed as promising by young people, families, and practitioners?'* and *'What does accessible, culturally competent, and engaging support look like in practice?'*

We engaged 100 participants, including service providers, professionals, parents/caregivers, and young people aged 15-18 with lived experience of services and situations relevant to our research project, including involvement with Youth Justice Services. Data were collected through 67 in-depth interviews and four focus groups, ensuring diversity in professional roles, experiences, and geographic coverage, where possible.

A favourable ethical opinion was granted by the Social Research Association[6] on the 18th November 2024.

Focus groups involved practitioners from Youth Justice CAMHS in London, a Youth Justice Team in the North West, and two groups of young people supported by NGOs in London. All youth engagement was conducted in person with support from trusted NGO staff. It took place on the NGO's premises as advised by NGO partners, to ensure safety and comfort. Most professional interviews were held online. All participants were offered vouchers in recognition of their time and contributions.

Professional participants represented a wide range of sectors and roles, including clinical and forensic psychologists, psychiatrists, youth workers, social workers, safeguarding leads, A&E navigators, trauma-informed practitioners, speech and language therapists, youth justice nurses, liaison and diversion teams, magistrates, educators, and NGO staff. Both frontline and strategic perspectives were included.

Participants were recruited via convenience and snowball sampling, with representation across England and Wales. The highest participation was from London and the West Midlands; the East of England was least represented. Urban, suburban, and rural experiences were captured:

GROUP	NUMBER OF PARTICIPANTS
Professionals	66 (66%)
Parents / Caregivers	10 (10%)
Young People	24 (24%)
Total	**100 (100%)**

REGION	NUMBER OF PARTICIPANTS
London	41 (41%)
South East	3 (3%)
South West	6 (6%)
East of England	2 (2%)
East Midlands	10 (10%)
West Midlands	13 (13%)
Yorkshire & The Humber	5 (5%)
North West	8 (8%)
North East	8 (8%)
Wales	4 (4%)
TOTAL	**100 (100%)**

All interviews and focus groups were recorded (with consent), transcribed, and analysed thematically. Thematic analysis is a flexible method for identifying, analysing, and interpreting patterns of meaning (themes) across qualitative data. It allows researchers to organise rich data – such as interview transcripts– either inductively or through a theoretical lens, with the researcher playing an active role in shaping the themes through clear analytic choices (Braun & Clarke 2006). This process enabled the identification of cross-cutting themes and context-specific insights, offering a nuanced understanding of the barriers children and young people face in accessing mental health support. Despite its flexibility and accessibility, thematic analysis has some limitations, including limited methodological guidance, risks of inconsistency without clear epistemological grounding, and the need for high transparency due to the researcher's active interpretive role (Nowell et al 2017). The full methodology and key findings have been outlined in Annex 5.

2.4 Identifying good practice and voluntary and community sector service mapping

This strand aimed to identify promising practices for delivering accessible, culturally competent, and engaging mental health support to children and young people involved in, or at risk of, serious youth violence.

We drew on three complementary sources of evidence:

1. **Evidence Reviews:** We revisited findings from the two earlier evidence reviews conducted as part of this project. These provided a foundation of existing research on what works and where gaps remain.

2. **Qualitative Data:** We synthesised insights from the qualitative strand of the project, including interviews and focus groups with young people, caregivers, and professionals. These data offered rich, lived accounts of what supports or hinders access, engagement, and retention in mental health services.

3. **Voluntary and Community Sector Service Mapping:** We conducted a targeted mapping of voluntary and community sector organisations across England and Wales to build a clearer picture of the types of psychological and psychosocial support available to children and young people outside statutory services. Drawing primarily on publicly available information, we captured key details about each organisation's focus, target population, delivery model, accessibility (e.g. cost, waitlists), and youth involvement. While not exhaustive, the resulting dataset provides a structured overview of service provision and highlights the diversity - and, in some areas, the fragmentation - of support on offer. Where available, we also recorded whether services had published evaluation or impact data.
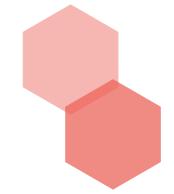
This mapping focused exclusively on voluntary and community sector services. Statutory services were not included, due to both practical constraints and the project's focus on building a resource that would be especially useful to children, young people and families who may not meet statutory thresholds for support. Voluntary and community sector services often operate with more flexible referral routes and may be less visible despite playing a key role in local mental health ecosystems.

Insights from all three sources were then thematically synthesised to identify shared features and approaches that appear to underpin good practice. The service mapping did not assess effectiveness specifically. Instead, it was used to provide contextual insight into the breadth and variation of provision, and to surface potentially relevant models for further consideration. This synthesis informed the development of a consolidated set of good practice principles for designing and delivering mental health support that is accessible and acceptable for children and young people affected by serious youth violence.

2.5 Limitations

While this project provides a rich and multifaceted analysis of access to mental health support for children and young people at risk of serious youth violence, several limitations should be acknowledged.

The evidence review was conducted as a rapid scoping review, prioritising breadth and timeliness over exhaustiveness. While rigorous screening and synthesis methods were used, some relevant studies - especially those outside selected databases or grey literature - may have been missed, reflecting the trade-offs inherent in rapid approaches. Many included studies were of low or moderate quality, with few UK-specific evaluations, particularly on

interventions targeting serious youth violence. Key populations, including girls and racially minoritised young people, were often underrepresented, as were community-based, relational, or preventative interventions. Most studies focused on individual-level outcomes, with limited attention to structural drivers of exclusion or access.

The secondary analysis of administrative data was limited by the availability, consistency, and granularity of public datasets. Most indicators were only available at the ITL1 level[7], limiting disaggregation, and Wales was excluded from some analyses due to data gaps or incomparable variables. Some relevant metrics, such as gang involvement or parental substance use, were approximated using proxies. Disaggregation by demographic characteristics was not possible. Crucially, it was not feasible to assess CAMHS access for the specific cohort of interest using public data, as this would require individual-level data linkage across systems - an important but out-of-scope analysis.

In addition, all correlations were based on the nine regions of England, as complete and comparable data at a more granular level could not be obtained. This inevitably limited statistical power. These analyses should therefore be regarded as exploratory and are useful in highlighting potential broad relationships at a regional level. They are not intended to provide definitive evidence of association, but rather to inform future research, ideally using more granular data where more robust statistical conclusions could be drawn.

While we reported p-values alongside correlations, these should be interpreted with caution. Our composite indices were built from a mix of population-level data, proxy indicators, and estimates. For population-level data, correlations reflect the 'true' relationship at the regional level, so p-values do not represent sampling uncertainty. For proxy and estimated indicators, some inherent uncertainty remains, and p-values can provide only a rough indication of how likely such results might arise under a null hypothesis of no association. Given this mixture, we decided to retain p-values but they should be viewed as descriptive and should not be over-interpreted as definitive evidence.

Taken together, these limitations mean the findings should be interpreted cautiously. They provide a useful but indicative overview of regional disparities in violence, risk factors, and service access, and should be seen as a foundation for more detailed, granular investigation in the future. Further detail is provided in section 5.1.3.

Recruitment for the qualitative strand, especially with parents and young people, was challenging and time-consuming. Planned arts-based workshops were not conducted due to difficulties engaging young people directly. Safeguards rightly put in place by organisations, along with the project's short timeframe, limited opportunities to build trust beforehand. Instead, interviews and focus groups were conducted with support from trusted NGO partners. This enabled more trauma-informed, relational data collection, but reduced control over delivery and, in some cases, data depth. Most young people were based in London; broader geographic representation would have strengthened the findings.

Perspectives from mainstream schools and teachers were absent from the qualitative sample, despite sustained efforts to engage them. This is a notable limitation given the central role of schools in young people's lives. While some participants reflected on the influence of school culture and staff attitudes on access to support, these insights were second-hand and should be interpreted accordingly.

Due to time constraints, the views of commissioners were not included, leaving a gap in a balanced understanding of how commissioning influences service models, access criteria, and partnerships, particularly as this was a theme discussed by many participants. We also could not engage staff from secure estates, as the required permissions process exceeded the project timeframe. As a result, the report may not fully capture system-level considerations or the specific challenges of supporting young people in custodial settings.

The voluntary and community sector mapping offered a useful overview of provision but was limited by the variability and patchiness of publicly available data. Many services lacked

clear reporting on access criteria, reach, or impact, and inconsistencies in how organisations presented their information made meaningful comparison difficult.

Finally, as with any qualitative and interpretive work, the potential for researcher bias must be acknowledged. While steps were taken to ensure rigour, reflexivity, and triangulation across project strands, the analytic process is shaped by researcher judgement and perspective.

3. Background and Context

This section provides important context to the research by examining the broader landscape of serious youth violence and mental health service provision drawing on national datasets, evidence reviews and some of the qualitative research. It is structured around two core areas: (1) the wider context of serious youth violence in England and Wales, (2) the landscape of mental health service provision for children and young people.

Understanding the scale, nature, and geographic distribution of violence and its risk factors, alongside the availability, configuration and effectiveness of services, helps illuminate where access challenges are most urgent. This sharpens the analysis of access barriers explored in Section 4 - which draws on qualitative insights from young people, caregivers, and professionals - to show why access matters, what is at stake, and how structural inequalities shape service realities.

3.1 The wider context of serious youth violence in England and Wales

- Serious youth violence is a complex, urgent, and evolving issue in England and Wales, shaped by overlapping structural and social risks.

- Despite growing evidence, mapping the prevalence and distribution of serious youth violence remains challenging due to data gaps and inconsistencies.

- Serious youth violence and its associated risk factors vary significantly across regions, highlighting stark geographic inequalities in vulnerability.

3.1.1 How does serious youth violence look across England and Wales?

Serious youth violence is a pressing issue in England and Wales (Ofsted et al., 2024a). The persistence of higher levels of serious youth violence compared to a decade ago requires high-priority and considered action. At the same time, it's difficult to build a precise picture of the occurrence of serious youth violence across England and Wales, particularly by region.

To address this, we sought to build a comprehensive overview of publicly available administrative data to map the occurrence of serious youth violence regionally across England and Wales. This seeks to answer the research sub-question: '*How do regions within England and Wales compare in terms of the prevalence of serious youth violence*' and provide insight into the question: '*What are the geographic disparities between children and young people likely to be in need of therapeutic support and those receiving services?*'.

In our secondary data analysis, we created a composite index to represent the occurrence of youth violent crime. This index was used to rank all ten regions of England and Wales, from the highest rate of serious youth violence, to the lowest. These rankings are:

1. **London (Highest)**
2. **the North West**
3. **the West Midlands**
4. **the East Midlands**
5. **Yorkshire and the Humber**
6. **the North East**
7. **the East**
8. **the South East**
9. **the South West**
10. **Wales (Lowest)**

London had the highest rate of estimated numbers of children cautioned and sentenced for serious violent crime (230 per 100,000 children) and highest average monthly youth custody population (12 per 100,000 children). Wales had the lowest rate of estimated numbers of children cautioned and sentenced for serious violent crime (92 per 100,000 children) and had the joint lowest rate for average monthly youth custody along with the South West (4 per 100,000 children). The full methods and key findings linked to the serious youth violence index can be found in the summary secondary analysis report attached as Annex 4.

It's evident that rates of children and young people's involvement in violent crime differs across regions (Figure 1). Understanding where serious youth violence is concentrated helps identify regions where access to psychological and psychosocial support may be most needed, and where barriers to support are likely to have the greatest impact.

Figure 1: Regional rates of serious youth violence across England and Wales

3.1.2 Correlates of serious youth violence

What previous studies say

Understanding who is most at risk of serious youth violence, and their access to support, is key to prevention (Public Health England et al., 2019). A UK mapping study based on practitioner interviews identified macro-level risk factors, including deprivation, trauma, abuse, limited youth provision, educational disruption, youth criminalisation (disproportionate punitive responses towards young people, often from marginalised backgrounds), and gang activity. At the community level, factors included educational and economic exclusion, exploitation, harmful masculinity norms, and the normalisation of violence (Watkins & Gearon, 2024).

Education-related vulnerabilities are prominent. Persistent absence, suspensions, and exclusions are associated with increased risk (YEF, 2024a). Children with special educational needs (SEN), particularly cognitive and learning difficulties, are overrepresented: 31% of over 10,000 13–17-year-olds surveyed had been perpetrators and had SEN, compared to just 10% without SEN (YEF, 2024a). Risk also increases with behaviours such as drug use, gang involvement, and weapon carrying - rising fivefold with drug use and over sevenfold with gang affiliation or weapon possession (Ibid).

These risks often co-occur. The Adverse Childhood Experiences (ACE) framework captures overlapping vulnerabilities, e.g. abuse, neglect, domestic violence, parental mental illness or substance use, family separation, incarceration, and care experience (Allen, 2015; Hughes, 2017). In a study of 14,000 adolescents, two or more ACEs were associated with higher risks of assault (19%), weapon involvement (57%), and gang affiliation (61%). For those with six or more ACEs, these rose to 45%, 150%, and 154%, respectively (Villadsen et al., 2025). Parental drug use, single parenthood, domestic violence, physical abuse, and parental illness or disability were the most harmful combinations.

Structural inequality also shapes risk. Racial disproportionality in the youth justice system is well documented (Bateman et al., 2022). While poverty has not been shown to directly cause violence, it has been associated with an increased risk of youth crime and violence (Clemmow et al., 2025). Neurodiverse children face additional risks, including misdiagnosis, exclusion, parenting challenges (difficulties faced by parents of children with neurodevelopmental disorders that can inadvertently lead to parenting practices which increase the child's risk of antisocial behavior and offending), and higher criminalisation rates (Hughes, 2017).

Mental health and neurodevelopmental conditions such as ADHD and autism are distinct but often intersect. Neurodiverse children face increased risks of mental health difficulties (e.g. anxiety, depression, self-harm) due to unmet needs and systemic barriers (Accardo et al., 2022; Bonti et al., 2024; Visser et al., 2024). Misinterpreting neurodiverse behaviours as solely emotional or behavioural problems can delay or prevent appropriate support. This report highlights both the overlapping vulnerabilities and the need for nuanced responses that distinguish between these domains while recognising their intersection.

Our administrative data analysis identified similar patterns. Deprivation-related indicators correlated strongly with other risk factors, suggesting socio-economic inequality intersects with multiple pathways into vulnerability. Children in the most deprived areas are 2.5 times more likely to experience violent crime than those in the least deprived (YEF, 2024). While disaggregation by ethnicity, gender, age, or neurodiversity was not possible in our analysis, their significance remains. Racial disproportionality in youth justice is worsening (YEF, 2025), and neurodiversity affects at least one in three justice-involved young people, with even higher rates among those in custody (Kirby, 2025). National data on neurodiverse children remains limited, but our qualitative findings suggest this is a key area for further attention.

Risk factors as themes emerging through qualitative research

Risk factors for involvement in serious youth violence also emerged through our qualitative research, many of which aligned with findings from the literature and administrative data. While not the primary focus of the qualitative strand, participants frequently spoke about the factors they saw as increasing vulnerability.

Professionals described a web of intersecting risks – exclusion, trauma, unmet needs, and social marginalisation – contributing to involvement in serious youth violence. These insights illuminated nuances not visible in quantitative data. Consistent themes included poverty and social exclusion as risk factors and the overrepresentation of Looked After Children (LACs) and those from minoritised communities in the youth justice system. Family trauma, undiagnosed or unsupported neuro-developmental conditions, and gender were also highlighted as upstream factors thought to correspond to risk of involvement.

Practitioners also observed shifting patterns in youth violence and service engagement, shaped by wider social, and technological changes. A key trend was the reduction in the overall number of children entering the youth justice system, alongside a marked increase in the complexity of needs among those who do:

> *"When we started work 10 years ago, annually, there were over 150 young people from the area sentenced to custody. We now are under 40 per annum… But in doing that, what we've done is we've now got the real complex young people who've had [some serious] life challenges."*
>
> Professional, Youth Justice Service, Yorkshire & The Humber

Another trend was the growing presence of younger children (under 13) involved in serious offences, often linked to grooming and exploitation by older cohorts. This "ladder of exploitation" – described as a one-way system through which younger children become increasingly involved in criminal activity, often influenced or manipulated by older peers or adults already

embedded in such networks – was seen as increasingly difficult to interrupt. Professionals also noted a rise in girls involved in youth justice or services such as PRUs, which they attributed to social media-fuelled conflict, exposure to online harms, and unmet mental health needs.

Digital technology was described as both a risk factor and a protective strategy: it increases the risk of exploitation, while also offering young people privacy and control. Professionals and young people alike noted the impact of the COVID-19 pandemic in exacerbating isolation, anxiety, school disengagement, and vulnerability, especially among neurodiverse children.
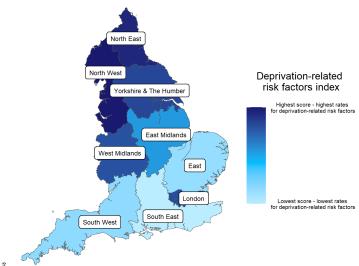
These findings suggest that emerging risks are not static, and that services must adapt to respond to evolving needs.

What the administrative data shows

There was broad consensus in our qualitative research about the risk factors for involvement in serious youth violence. However, to the best of our knowledge, there is currently no analysis which considers the regional distribution of children and young people who experience these risk factors. We sought to fill this gap, addressing the research sub-question: *'How do regions within England and Wales compare in terms of the prevalence of exposure to associated risk factors?'* and provide insight into the question: *'What are the geographic disparities between children and young people likely to be in need of therapeutic support and those receiving services?'* by identifying the rates of children and young people regionally likely to be in need of therapeutic support due to exposure to these risk factors. This analysis is an important step in ensuring that access to support is available to those who need it most. The identification of specific risk factors, combined with distribution mapping, allows targeted use of resources on two levels: resources can be funnelled towards areas with greater proportional risk, and the specific risk factors can be targeted for intervention.
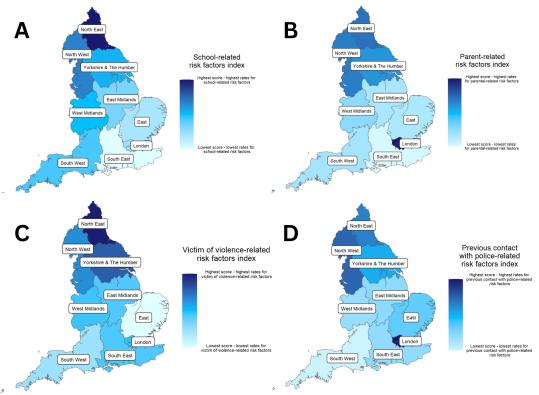
Our analysis of public administrative datasets allowed us to rank the regions of England by sub-categories of risk factors. Each index displays the proportion of 'at-risk' young people within that area. Sub-categories of risk-factors include those that are: school-related; parent-related; deprivation-related; victim-related; and those related to previous contact with the police. Risk factors were defined and isolated based on the literature and through consultation with expert stakeholders. Further methodological detail can be found in the summary secondary data analysis report (Annex 4). The maps below (Figures 2 and 3) show the indices for individual risk factor groups.

Figure 2: Regional distribution of the rates of deprivation-related risk factors

Figure 3: Regional distribution of the rates of school, parent, victim of violence and previous contact with police related risk factors

Regional patterns emerged across the different risk domains, with London and the North East consistently ranking among the highest for multiple risk factors, while the South East and South West tended to have the lowest levels of risk exposure. Using composite indices for each risk domain, we ranked regions in England from highest to lowest based on standardised rates (per 10,000 children). Key findings include:

- **Police contact-related risks:** Highest – London; Lowest – South West
- **School-related risks:** Highest – North East; Lowest – South East
- **Parent-related risks:** Highest – London; Lowest – South East
- **Victim of violence-related risks:** Highest – North East; Lowest – East
- **Deprivation-related risks:** Highest – London; Lowest – South West

These differences highlight geographic inequalities in the distribution of risk factors associated with serious youth violence, suggesting that access to support may need to be tailored to reflect local patterns of risk and need. This has important implications for ensuring that mental health services are equitably distributed and responsive to the specific challenges faced by children and young people in different areas.

3.1.3 Links between risk factors and serious youth violence

Having examined risk factors, the evidence points to strong associations between certain experiences and serious youth violence. As Bateman (2020) notes, "children who come to the attention of criminal justice agencies are disproportionately drawn from working class backgrounds with biographies replete with examples of vulnerability."

However, while such associations are well-established, relying on risk factors uncritically can be problematic. The attribution of causal (explanatory) powers to socio-economic factors, which the *State of Youth Justice 2020* report (National Association for Youth Justice) highlighted as emerging out of the Crime and Disorder Act 1998, has received criticism. This "risk factor

paradigm" can pathologise children as passive subjects, reducing complex lives to predictive indicators (Bateman, 2020). This may skew professional responses toward managing future harm, rather than meaningfully engaging with children's lived experiences.

Nonetheless, identifying risk can play a useful role in enabling early access to support, especially mental health services, when used to empower rather than categorise. Our secondary data analysis found significant positive correlations between regional exposure to multiple risk factors including deprivation, parental risk factors and police contact, and rates of serious youth crime (Figure 4). This reinforces how overlapping structural and experiential disadvantages tend to cluster in areas with higher prevalence of violence, underscoring the importance of place-based, holistic responses. These findings are correlational and should guide further investigation and holistic support, rather than serve as predictive tools or fixed pathways. They reveal opportunities for intervention, with risk factors rooted in wider structural and social inequalities that can be addressed through meaningful support.

Mental health support plays a vital role. Interventions range from universal strategies, such as improving early years provision, addressing socio-economic inequalities, and promoting wellbeing in schools, to more targeted responses that address trauma, exclusion, or family disruption (Big Lottery Fund, 2018).

The following section explores, from existing research, which interventions have been tried, what works, and whether young people can access this support.

Figure 4: Correlation matrix of composite indicies including data from the nine regions of England

	Serious youth violent crime	Overall risk factors	School risk factors	Parental risk factors	Victim of violence risk factors	Previous contact with police risk factors	Deprivation risk factors
Serious youth violent crime							
Overall risk factors	0.71*						
School risk factors	0.04	0.43					
Parental risk factors	0.72*	0.96*	0.48				
Victim of violence risk factors	0.25	0.65	0.73*	0.60			
Previous contact with police risk factors	0.74*	0.98*	0.28	0.92*	0.48		
Deprivation risk factors	0.68*	0.78*	0.73*	0.80*	0.76*	0.68*	

*Values in bold where $p < 0.05$

KEY

| 1 perfect positive correlation | | 0.5 | | | | −0.5 | | −1 perfect negative correlation |

3.2 The landscape of mental health provision for children and young people

- A wide range of statutory and non-statutory services offer mental health support to young people at risk of serious youth violence, but awareness of and access to this support remains uneven.

- Access to mental health services, particularly CAMHS, varies significantly by region.

- Many voluntary and community sector organisations deliver psychological and psychosocial support, but the service landscape is fragmented and rapidly changing, especially for smaller or local providers.

- A broad range of psychological and psychosocial interventions show promise for improving wellbeing and reducing risk, but evidence remains fragmented, uneven, and exclusionary.

3.2.1 Current service provision across England and Wales

This section generates insight into the research sub-question *'What mental health services are available to children and young people through voluntary and community sector organisations in different regions across England and Wales?'*. Understanding access to mental health support for children and young people involved in or at risk of serious youth violence requires first mapping what services are available. A wide range of statutory services play key roles across youth justice, mental health, education, social care, policing and the voluntary and community sector. These include Youth Offending Teams (YOTs), Child and Adolescent Mental Health Services (CAMHS), Pupil Referral Units (PRUs), Local Authority Children's Services and public health services, Violence Reduction Units (VRUs), and embedded police or youth-focused teams in schools and communities, as some examples.

YOTs, established under the Crime and Disorder Act 1998, work with children at risk of or convicted of offending, offering coordinated support across education, housing, family, substance use, and mental health (King, 2014). CAMHS provides psychological and psychiatric care from early intervention to specialist and forensic services. Specialist CAMHS supports those with significant emotional, behavioural, or mental health difficulties. Forensic CAMHS focuses on young people whose needs involve high-risk behaviours or serious safeguarding concerns. PRUs and Alternative Provision support those excluded from mainstream education or with complex health needs, often serving as key sites for identifying wellbeing or safeguarding concerns.

Despite the range of services, our qualitative research highlighted widespread gaps in knowledge about what support is available, among young people, their families, and even professionals. This was particularly pronounced regarding non-statutory services which participants attributed to a lack of centralised information points and a rapidly changing service landscape. To address this, we conducted a detailed mapping of voluntary and community sector organisations supporting the target cohort across England and Wales. We prioritised examples of good practice (defined in Section 7) to understand how provision could be strengthened.

Nearly 500 organisations were identified. About 60% offered psychological therapies (e.g. CBT, psychotherapy, counselling, art therapy) and 40% delivered psychosocial support (e.g. mentoring, sports, mediation). Many delivered integrated services and several demonstrated good practice and published evidence of impact. London had the highest concentration of services (103, or over 20%), though some operate nationally. The regional breakdown is shown below:

REGION	NO.	REGION	NO.
North East	22	London	103
North West	55	South East	40
East Midlands	84	South West	31
West Midlands	31	Wales	43
Yorkshire and Humber	52	National	38
East of England	50		

While this mapping exercise of voluntary and community sector organisations and services was extensive, it is not exhaustive. Some organisations, particularly smaller ones or those with limited online presence, may have been missed. It is also important to note that the mapping provides a snapshot in time, reflecting the landscape of service provision as it stood in early 2025. Given the dynamic nature of the voluntary and community sector, this landscape is constantly evolving, with services emerging, changing, or closing. Nonetheless, the exercise offers valuable insight into the range and distribution of relevant psychological and psychosocial support available to children and young people across England and Wales, and provides a useful resource for young people, their families, and service providers at this particular moment.

3.2.2 Access to Child and Adolescent Mental Health Services across England

It is important to understand what types of services exist. However, the availability of services does not guarantee their accessibility, especially for children and young people facing multiple forms of disadvantage. Drawing on publicly available administrative data, we conducted a secondary analysis to answer the research sub-question *'How do regions within England and Wales compare in terms of the rates of access to CAMHS?'* The analysis in this section helps us begin to interrogate not just what support exists, but how effectively it is accessed.

We developed a composite index to assess regional access to these CAMHS services. This went beyond attendance figures to include waiting times and regional mental health spending for children and young people. As noted in the methods, Wales was excluded from this index. Full details of the index construction and detailed data tables are available in the Summary Secondary Analysis Report (Annex 4).
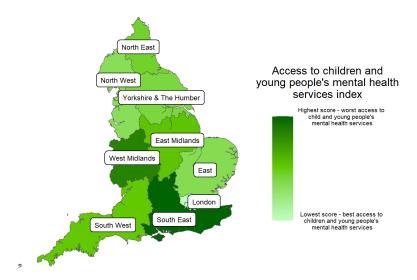
The regional ranking of access to CAMHS, from best to worst, is as follows (Figure 5):

1. **London**
2. **North West**
3. **East**
4. **Yorkshire and the Humber**
5. **North East**
6. **South West**
7. **East Midlands**
8. **West Midlands**
9. **South East**

Figure 5: Regional rates of access to children and young people's mental health services

Our assessment of regional access to CAMHS aligns closely with findings from a 2020 Education Policy Institute study (Crenna-Jennings & Hutchinson, 2020), which considered waiting lists and rejected referrals. While our composite index included waiting times and closed referrals, both analyses identified similar patterns:

- London had the lowest percentage of rejected referrals, followed by the North, with higher rejection rates in the South generally, Midlands, and East.

- London and the North have the best overall access to CAMHS.

- However, London also had the longest waiting times, followed by the South and then the North.

- The shortest waits were in the Midlands and East.

- Both studies noted challenges in accessing robust service-level data, due to inconsistent reporting across regions and time periods. A more standardised, transparent system for tracking access is urgently needed to inform improvements.

These findings should be considered alongside evidence that some children, particularly those in unstable housing or life situations, are deemed ineligible or have referrals rejected despite high need (Mannes et al., 2024). One practitioner we spoke to noted that services with higher access thresholds may report shorter waits and fewer rejected referrals, not due to greater capacity but because they use a 'single point of access' model, where referrals are triaged and redirected, sometimes before being formally recorded.

This raises important questions about how thresholds are applied and whether current models reflect the complex realities of the most vulnerable. Formal indicators may not fully capture real-world accessibility, potentially underestimating unmet need. These patterns highlight the need to assess not just service availability, but meaningful access. Greater transparency, inclusive data collection, and research using linked individual-level records are essential to understand who is being excluded and why.

Data on access to mental health services for children involved in or at risk of serious youth violence is limited. Justice-involved children have higher rates of mental health needs than the general population - mental health concerns were identified in 72% of children sentenced in the year ending March 2020 (HM Inspectorate of Probation, 2023). However, provision is inconsistent. A review of youth offending services (2018–2020) found mental health was a factor in 31% of cases, but support was sufficient in only 59%. While in-custody provision was often strong, just 40% of those needing support post-release received it (Ibid).

Our analysis found a significant negative correlation between CAMHS access and the overall risk factors index. This suggests regions with better mental health service access tended to report lower levels of these risks, particularly those related to parents and police contact (Figure 6). These patterns are correlational and drawn from aggregate-level administrative data using proxy indicators. They reflect regional associations, not causal relationships or individual trajectories. Still, they indicate geographic disparities in service provision and risk exposure, supporting the argument for strategic resource allocation, and informing regional planning.

No significant correlation was found between access to CAMHS and the overall serious youth violence index, however. This may partly reflect limitations in the data and methods, including the use of aggregate rather than individual-level data. It may also be that improved access to mental health services alone is not sufficient to reduce serious youth violence, or that any effects take time to emerge. Other possible explanations include misalignment between service provision and the needs of young people most at risk, variation in how thresholds are applied, or geographic and administrative mismatches in how data are reported. Further research using linked individual-level records is needed to explore these relationships in more detail.

The findings above highlight the need to broaden how 'access' is defined. It is not simply about offering a service or assuming openness equates to accessibility. As one CAMHS professional noted, barriers are often attributed to 'hard-to-reach' young people, but many arise from how services are designed, commissioned, and delivered - whether geographic, cultural, or financial. From this perspective, the issue is less about disengaged young people and more about 'hard-to-access' services, a theme explored further in our qualitative research.

While the secondary analysis provides useful insights into regional variation, it also highlights the limitations of administrative data. Metrics like wait times or availability do not fully capture the complexity of access and engagement. Understanding why some young people do not access or remain engaged with support requires listening to those directly affected. Section 4 draws on qualitative research with children, families, and professionals across England and Wales to explore these issues in depth.

Figure 6: Correlation matrix of composite indicies including data from the nine regions of England

	Serious youth violent crime index	Risk factors index	School factors index	Parental factors index	Victim of violence index	Previous contact with police index	Deprivation index	Access to CYPMHS**
Serious youth violent crime index								
Risk factors index	**0.71***							
School factors index	0.04	0.43						
Parental factors index	**0.72***	**0.96***	0.48					
Victim of violence index	0.25	0.65	**0.73***	0.60				
Previous contact with police index	**0.74***	**0.98***	0.28	**0.92***	0.48			
Deprivation index	**0.68***	**0.78***	**0.73***	**0.80***	**0.76***	**0.68***		
Access to CYPMHS**	−0.56*	**−0.69***	−0.20*	**−0.76***	−0.07*	**−0.74***	−0.44*	

*Values in bold where p<0.05 **Children and young people's mental health services (CYPMHS)

KEY

1 perfect positive correlation		0.5				−0.5		−1 perfect negative correlation

3.2.3 Evidence on effective psychological and psychosocial interventions

To explore access to effective mental health support for children and young people involved in or at risk of serious youth violence, we reviewed global and UK evidence on psychological and psychosocial interventions for this group. The review asked: 'What psychological and psychosocial interventions are delivered to children and young people involved in or at risk of serious youth violence, and how effective are they?' As well as assessing whether young people can access support, it is crucial to understand what the 'right' support looks like so that efforts to expand provision are evidence-informed and responsive to need. Key findings are outlined in Annex 1 & 2; this section summarises key patterns, effectiveness, and evidence gaps.

A wide range of psychological and psychosocial interventions have been delivered to children and young people involved in or at risk of serious youth violence. These typically fall into five overlapping categories: therapeutic (e.g. CBT, DBT, trauma-informed therapy), family-focused (e.g. parenting or multisystemic programmes), community-based (e.g. mentoring, violence reduction), school-based (e.g. mindfulness, targeted prevention), and creative, alternative, or sports-based approaches.

Therapeutic approaches, especially trauma-informed and CBT-based interventions tailored to young people with complex needs, consistently showed benefits for mental health, emotional regulation, and behaviour. CBT, widely delivered by the NHS, remains the most common and well-evidenced therapy, often considered the 'gold standard' (David et al., 2018). Family-based programmes also improved parenting, aggression, and family functioning, though findings on reoffending were mixed. Some school-based and substance misuse interventions targeting resilience and emotional skills reduced risk-related behaviours (e.g. exclusions, police contact). Generic or poorly structured programmes were generally less effective.

While many interventions focus on mental health and behaviour, direct evidence linking them to reduced offending or recidivism is limited, though some findings are promising. Tailored, community-based approaches, such as focused deterrence and violence reduction initiatives, have reduced weapon carrying, offence severity, or harm in high-risk groups. Parent-focused programmes like Non-Violent Resistance improved behaviour and reduced delinquency, though UK trials of Functional Family Therapy (FFT) and Multisystemic Therapy (MST) found no impact on reoffending. Internationally, MST and FFT were strongly linked to reduced recidivism, especially when delivered with high fidelity. However, many studies, particularly those focused on mental health or trauma, do not report offending outcomes. Stronger long-term evidence on reoffending is needed.

Creative, sports, and animal-assisted interventions show promise for improving wellbeing, confidence, and emotional regulation. Arts-based programmes supported self-expression, relationships, and behavioural change, with some reductions in aggression and modest declines in reoffending. Sports, especially outdoor or non-contact, improved mood and reduced hostility, while animal-assisted therapies helped reduce PTSD and internalising symptoms. "Creative and innovative therapeutic activities which might not be seen as 'traditional therapy'" (Williams, 2020, p.43) were especially valued for racially minoritised youth. Practitioners in our qualitative research highlighted that creative, play-based, and multimedia approaches support trust-building and act as standalone or bridging interventions. Creative expression fosters resilience in trauma-exposed youth (Fellin et al., 2019), and sustained activity engagement is linked to lower justice involvement (Youth Access, 2024). However, evidence of impact on violence or reoffending remains limited, with mixed findings for passive music therapy and writing, and challenges around inconsistent delivery and over-reliance on sports, which may exclude girls.
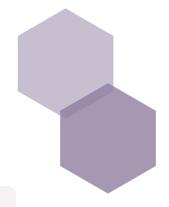
Creative, mindfulness, and community-based approaches remain underrepresented, as do interventions for victims of violence, looked after children, and young people with autism. Evidence is also limited for programmes addressing co-occurring mental health and substance misuse, or using digital or creative formats for complex conditions such as psychosis. Few studies evaluate long-term outcomes, implementation quality, cost-

effectiveness, or fidelity, highlighting key evidence gaps. Addressing these gaps is important for developing more inclusive and effective responses to serious youth violence.

Research on the role of Allied Health Professionals—particularly Speech and Language Therapists (SALTs) and Occupational Therapists (OTs)—in supporting trauma-exposed young people is limited. This is a notable gap given strong evidence linking speech, language and communication needs (SLCN) with trauma and mental health (Lum et al., 2018; Sylvestre et al., 2015; Wadman et al., 2011). SLCN are disproportionately common in youth justice populations, yet evidence on addressing them in the context of serious youth violence remains scarce (Redgate et al., 2022). OTs, well placed to deliver trauma-informed, sensory-based interventions that support regulation and daily functioning (Lehr et al., 2023; Rosa & Hartmann, 2022), remain underused in community settings (Mazzeo & Bendixen, 2023; Royal College of Occupational Therapists, 2023). Further research is needed to strengthen their integration into holistic care models.

The evidence base remains fragmented, with many studies using small samples, quasi-experimental designs, short follow-ups, and inconsistent outcome measures. Girls, racially minoritised youth and neurodiverse young people, who are often overrepresented in risk contexts, are underrepresented in research. These gaps limit generalisability and hinder understanding of what works, for whom, and in which contexts.

4. Key Findings

4.1 Barriers to mental health services and support for children and young people involved in or at risk of serious youth violence

The following sections draw on the qualitative study conducted with service providers and professionals, parents and caregivers, and young people with relevant lived experience. These sections explore barriers to mental health services and support experienced by those involved in or at risk of serious youth violence. The qualitative study consisted of in-depth interviews and focus groups with 100 participants:

- 66 service providers and professionals
- 24 young people
- 10 parents and carers.

Findings from the qualitative study are supplemented with the findings from our narrative literature review on barriers to accessing mental health services and support.

The research sought to build a detailed picture of the challenges young people face by engaging directly with those most closely affected. While existing quantitative data can provide a high-level overview of service uptake or referral patterns; qualitative research provides insight into the real-world obstacles—structural, relational, and emotional—that shape young people's experiences of accessing mental health support.

Capturing the perspectives of those delivering services, those navigating services with and for their children, and the perspectives of young people themselves is essential for identifying not only the gaps and pain points in current provision, but also the opportunities for more responsive and equitable approaches. These insights are critical for informing future policy decisions.

One result of our investigation was a more nuanced view of 'access'; access issues range from getting 'through the door', to accessing the 'right' service, to ensuring 'continued access'. This is ultimately how we structured the findings. The sections that follow present a detailed analysis of the barriers children and young people face in accessing mental health support, organised around key themes that emerged from interviews across England and Wales:

- **Missed opportunities:** We focus on missed opportunities for early identification and support across professional settings including health, social care, and education.

- **Obstacles to initial engagement:** We examine obstacles for children, young people, and families initiating engagement with support services such as stigma, societal influences and mistrust of services.

- **Obstacles to accessing services:** Access-related challenges beyond initial engagement are discussed, such as thresholds, waiting lists, and the inability of services to hold risk or deal with complexity.

- **Continued access (retention):** We address issues of retention in mental health support, highlighting the importance of trust, communication, family influence, and person-centred care.

- **Systemic and structural factors:** We look at systemic and structural factors associated with these barriers, including funding limitations, commissioning practices, fragmented service design, and the role of inequity.
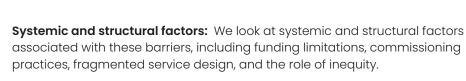
Figure 7 below gives a visual representation of how the data and the findings in this section have been structured.

Figure 7: Structure of qualitative findings

Barriers to mental health services and support for CYP involved in or at risk of serious youth violence

MISSED OPPORTUNITIES FOR EARLY INTERVENTION

Factors contributing to missed opportunities
- Professional knowledge gaps
- Racialisation & misdiagnosis
- System reactivity
- Punative & restrictive school policies
- Falling out of the school system

BARRIERS TO SUPPORT SERVICE

Barriers to engagement
- Stigma
- Toxic masculinity & hypervigilance
- Mistrust of services & cultural competence
- Challenges of an overwhelming system

Barriers to access
- Geographic & financial barriers
- Lack of information
- Language barriers
- Institutional language norms & expectations
- Waiting lists
- Rigid service structures & strict thresholds
- The 'hot potato' & inability to hold risk
- Inflexible services

Barriers to retention
- Trusting relationships
- Ongoing communication barriers
- Home environment

SYSTEMIC UNDERPINNINGS

Funding & commissioning
- Lack of funding & resources
- Funding deficits & fragmented care
- Funding decisions
- Funding cycles
- National vs devolved models

Structural challenges in design & delivery
- Lack of multiagency & multidiscplinary working
- Pressure on non-statutory services
- Voices heard in design & delivery
- Lack of trauma-informed care

Inequitable systems
- Structural racism & cultural exclusion
- Neurodiversity, gender, classism & poverty
- Systemic & intergenerational cycles of violence
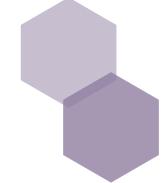
4.1.1 Factors contributing to missed opportunities

In this section, we consider mechanisms that increase the possibility of children and young people "falling through the gaps" and being missed for early intervention, thereby increasing the risk of their involvement in youth violence and the youth justice system.

- Gaps in professional understanding of neurodiversity - including autism & ADHD - often lead to mislabelling, exclusion, and missed opportunities for support.

- Racial bias contributes to the misdiagnosis, over-criminalisation, and under-support of Black and racially minoritised children, especially boys.

- A reactive system of thresholds and crisis response means children often access support only after significant harm has occurred.

- Punitive and exclusionary school policies - including isolation rooms, rigid uniform rules, and informal removals - can actively harm young people and delay mental health support.

- Children out of mainstream education may fall into a situation where statutory entitlements are not upheld and support becomes harder to access, increasing vulnerability and risk.

Professional knowledge gaps

Participants from a range of professions identified knowledge gaps as a central issue contributing to missed opportunities for early intervention, particularly in relation to neurodiversity. Some expressed deep concern that children with autism, ADHD, or other neurodevelopmental or neurodiversity needs are disproportionately excluded and misdiagnosed. This knowledge gap was referenced across various sectors including education, children's services, police, youth justice and CAMHS.

Young people with special educational needs, especially those awaiting assessment for ADHD or autism, were frequently described as being "misunderstood". In professional settings they risked being mislabelled as "disruptive" or "shy", "challenging" or "withdrawn", rather than supported appropriately. The result was thought to be an increased risk of school exclusion and isolation, and potential contact with the youth justice system. It is important to note, however, that not all neurodiverse young people exhibit behavioural-related symptoms; a wide range of presentations exist, and many needs can go unrecognised when they do not align with dominant stereotypes.

> *"they often get categorised into this naughty category or disruptive category at school, and actually, there's something else underlying that they haven't felt comfortable to speak to other professionals or carers about"*
>
> –Professional, Youth Justice Service, North West

> *"I feel like some external providers may label children as being naughty or having behavioral this, that, or the other, when actually it's not. There's been an underlying neuro-developmental condition that's not been picked up till now".*
>
> –Professional, Youth Justice CAMHS, North West
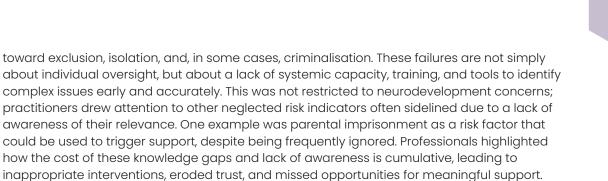
Children and young people, especially boys, were seen to be particularly vulnerable to this kind of mislabelling. The difficulty of distinguishing between trauma-related behaviours and undiagnosed neurodevelopmental needs – which can be co-occurring – was a recurring theme. Professionals described how lack of clarity has serious implications for referral decisions and the types of support young people receive:

> *"Neurodiversity and trauma often present in a very similar way... It's often assumed that it's the trauma presentation that we're seeing, rather than something else."*
>
> –Professional, NHS Vanguard, West Midlands

Without adequate understanding of neurodevelopmental conditions, children and young people may be referred to inappropriate services or have their needs overlooked altogether. One participant described a young person who had been involved with CAMHS from a young age, only for later assessments to reveal significant speech and language delays that had rendered years of therapy largely ineffective. This highlights how an absence of early and accurate identification of needs can result in years of inappropriate / ineffective support, compounding disadvantage.

There was widespread agreement among the professionals we spoke to: when behaviours linked to autism, ADHD, or communication difficulties are misread, particularly externalising behaviours, young people are not only denied the support they need, they are actively pushed

toward exclusion, isolation, and, in some cases, criminalisation. These failures are not simply about individual oversight, but about a lack of systemic capacity, training, and tools to identify complex issues early and accurately. This was not restricted to neurodevelopment concerns; practitioners drew attention to other neglected risk indicators often sidelined due to a lack of awareness of their relevance. One example was parental imprisonment as a risk factor that could be used to trigger support, despite being frequently ignored. Professionals highlighted how the cost of these knowledge gaps and lack of awareness is cumulative, leading to inappropriate interventions, eroded trust, and missed opportunities for meaningful support.

The knowledge gaps documented here are drawn from qualitative research. Where professionals specified particular sectors or roles, this has been noted; however, some referred to knowledge gaps more generally. This highlights the need for further work—such as survey-based research—to more precisely identify where and how these gaps occur.

Racialisation, misdiagnosis and missed support

Participants linked knowledge gaps and the conceptual limitations of the health and social care systems. These limitations included restrictive frameworks used in services, and the impact of oppressive social forces such as racism.

In the previous section, we noted how children and young people can be mislabelled, e.g. as "disruptive", rather than appropriately supported. Professionals also described how mental health diagnoses often relied on simplistic categorisation and presentation: it was necessary for the young people to express their distress in the "right" way, particularly those from racially minoritised backgrounds. These professionals also noted that labels such as "naughty" and "disengaged", often replace deeper assessments of factors such as trauma and neurodiversity. This was particularly the case in relation to the education sector but was also highlighted in reference to police and social care. A large proportion of these young people are therefore missed when it comes to support; they are labelled, marginalised, and managed, but not supported. By the time their needs are finally acknowledged, the opportunity for early intervention has often long passed.

It was clear in the interviews that professionals thought this mislabelling was particularly evident for those from Black and minoritised backgrounds. Cultural misunderstandings and bias, both overt and subtle, were frequently cited as factors contributing to misdiagnosis, neglect and late recognition. As one practitioner described:

> *"Black and Asian people have been misdiagnosed, over medicated and generally failed by mainstream mental health services"*
>
> -Professional, NGO, London

The adultification of young people, especially Black boys, was highlighted by practitioners as a cause of the overrepresentation of Black children in the Youth Justice System. This was seen to contribute to missed opportunities for interventions. Practitioners described Black, Asian and Minority Ethnic young people are disproportionately seen as threatening rather than vulnerable, and how this racialised lens contributes to punitive rather than supportive responses across a number of sectors including criminal justice, mental health and education.

> *"We see that with a lot of our young Black males, in particular... they're very much experiencing adultification in the criminal justice system. Often the identification of the need is overlooked, because we see them as adults and not vulnerable children."*
>
> -Professional, CYP Health and Justice, West Midlands

Another supported this by explaining:

> *"Officially, black young males are exponentially more likely to be sectioned than anybody else. So there's a deeper systemic issue there with the labeling, and the frequency of young people black people being labeled as 'dangerous' men"*
>
> –Professional, NGO, London

Institutional biases and structural inequalities were seen to shape how young people's needs are recognised, or overlooked, across systems. Professionals described how early signs of distress or vulnerability are often missed for those who do not fit dominant expectations. As a result, support is frequently delayed until statutory thresholds are met, by which point opportunities for early intervention may have been lost. These patterns, for many interviewees, reflected systemic misalignment with the lived realities of the children and young people they work with.

System reactivity and delays

Another central concern discussed was the reactivity and delay of services, rather than proactive prevention. Practitioners described how the professional knowledge gaps and racial biases described in the previous section not only damages trust, but can also delay critical interventions, sometimes by years, entrenching distress and disconnect from services. It was generally the view of the professionals and caregivers we spoke to that, by the time support is offered, the opportunity for prevention has often been lost.

> *"People missed the boat. The stigma has grown... trust of professionals has reduced. By the time they meet thresholds, the window to engage was two years prior."*
>
> –Professional, Youth Justice Service, East Midlands
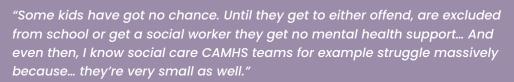
In some cases, the lack of early intervention has very real and serious consequences. Some professionals talked about cases where serious violent offences were committed due to young people not being picked up.

> *"With a lot of our children that commit those serious offences, when you look at each one of those children individually and break it down, for the majority of them there are gaps where they should have been picked up, whether that be from an education perspective or elsewhere."*
>
> –Professional, Youth Justice Service, North East

The emphasis on reactivity rather than proactivity was seen to be a systemic failing. In many of the cases discussed, support was only offered to young people once a situation had escalated or a statutory threshold was met. Participants highlighted that whilst multiple points of access to the system exist, delays in early intervention due to factors such as knowledge gaps and institutional bias mean that many only access support, or receive diagnoses, once difficulties escalate, or they come into contact with statutory services, such as youth justice or social care. Even then, they noted, service access is uneven and often dependent on advocacy and inter-agency relationships:

> *"Some kids have got no chance. Until they get to either offend, are excluded from school or get a social worker they get no mental health support… And even then, I know social care CAMHS teams for example struggle massively because… they're very small as well."*
>
> –Professional, Youth Justice CAMHS, London
>
> *"…why have these things not been identified and picked up much sooner?"*
>
> –Professional, CYP Health and Justice, West Midlands

Practitioners talked about how mental health support actually improves once a young person is criminalised. One professional described how Youth Justice Services can paradoxically unlock access to care previously out of reach:

> *"There'll be kids that might have been sitting on waiting lists for assessment for sometimes over a year or two years, and they commit an offense, come into contact with the youth justice service, and suddenly, a couple of weeks later, get an assessment."*
>
> –Professional, Youth Justice Board, London

Other professionals described how some children and young people may have had multiple referrals from multiple agencies, but contact with Youth Justice Services is often the first time they are able to engage due to the rigid structure of services that fail to take into account their complex situations.

In several areas, youth justice teams had embedded CAMHS practitioners or direct referral pathways that facilitated quicker assessment and support. The need for this service was perceived not as a strength, but as an indictment of the failings of system reactivity over proactive prevention.
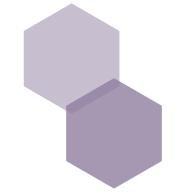
> *"It's a source of frustration for pretty much everyone involved in youth justice that it takes something bad happening for them to come into contact with the system to get that kind of accelerated service… If that had happened earlier, they may never have committed an offence."*
>
> –Professional, Youth Justice Board, London

The irony was not lost on the young people themselves, several of whom described the increase in support only after being labelled "troubled":

> *"It's easier if you're a troubled kid than, like, if you're not. I was a bit naughty and then I got all… the youth workers and support workers and that. But my sister [was well-] behaved, and wanted [support], but didn't get it. I did get it because I was naughty. I had loads of [help], I had youth workers, social workers, Youth Offender workers and that."*

Rather than acting as protective or preventative, these systems were described as responding only once harm has occurred, when needs have escalated, when behaviours are criminalised, and when children and young people have already disengaged from school and community.

Punitive and restrictive school policies

Many participants identified schools as critical settings for early intervention — spaces with the potential to offer stability, belonging, and accessible support. At the same time, participants also reflected on the ways in which school environments could unintentionally compound risk for vulnerable children and young people, particularly when behaviour was misunderstood or unmet needs went unrecognised. These dual roles reflect the complexity and competing demands placed on the education system.

A number of professionals raised concerns about disciplinary responses to externalising behaviours, particularly when these responses were not accompanied by efforts to understand potential underlying causes. In these accounts, young people were sometimes seen to be disadvantaged by school policies when their neurodiversity or mental health needs were unrecognised or unsupported. However, they also acknowledged that managing behaviour in classrooms is a complex task: schools must maintain order and safety for all students, and teachers may feel unsupported in balancing learning with rising levels of need.

Many participants linked certain disciplinary responses to knowledge gaps around trauma and neurodiversity, as previously described, speaking to the need for more trauma-informed practice in schools as a means of understanding behaviour in context and avoiding missed opportunities for support:

> *"They need to actually take the time to understand why some of these young people are presenting how they're presenting. It's not always a behavioral thing."*
>
> –Professional, NGO, London

Participants also pointed to how policy rigidity can create barriers in ways that fail to accommodate neurodiverse needs, provide wraparound support or improve pathways for securing Education, Health and Care Plans (EHCPs)[8]. Inflexible uniform policies were cited as one example of a barrier to supportive interactions for sensory-sensitive students:

> *"If we've got a child who we know is sensory dysregulated, that can be the difference between them sitting and coping in the classroom or not."*
>
> –Professional, CYP Health and Justice, West Midlands

Others expressed concern about the use of isolation practices. While recognising the challenges schools face in managing classrooms, some professionals questioned the impact of isolation rooms, especially when they involved limited educational input or prolonged periods away from peers. One youth worker noted how a young person had relayed to her: *"They put us in this unit at the back of the school... They say it's not punishment"*. She went on to explain that in her opinion, *"unless there's a good program in that unit that you're going to learn from, I don't see the point"* as this strategy isolated young people without addressing the core issues.

These concerns were echoed in interviews with parents, who described how school policies can both limit opportunities for support and undermine the wellbeing of vulnerable children. One parent recounted how her child, who had only recently received an ADHD diagnosis, had spent 70 days in isolation the previous academic year. Isolation, in this case, involved being confined to a booth, unable to speak or move freely, with minimal educational input and generic work that bore little relevance to their actual learning. The policy, she argued, not only failed to address her child's behavioural needs but also made reintegration into the classroom more difficult. The escalation of isolation days was experienced as disproportionately harsh and lacking recognition of neurodiversity.

"We do feel like it's discrimination. [Son] obviously struggles [to meet behavioural standards] more so than other children, and so because of that, he ends up spending a lot of time in isolation. And I feel that it's disproportionate...it's not a level playing field, [he] can end up spending over half his time in isolation, and it's just taking so much of his education away"

Participants acknowledged that behaviour can be both disruptive and a sign of unmet need and that schools may be both trying to support and struggling to manage. The goal, they suggested, is not to replace boundaries with leniency, but to embed support and understanding within structured, consistent environments.

In some cases, the missed opportunities to support certain students as a result of knowledge gaps or restrictive school policies appeared unintentional; a number of professionals said that some schools were receptive to input from, for example, occupational therapists and educational psychologists, but this was often down to the individuals in decision-making positions rather than the system. In other cases, however, school teams were described as difficult to work with. It was recognised that the main job of schools is to educate and that teachers are often overstretched, but many of the professionals we interviewed also noted that, in their experience of trying to engage, some schools actively resisted suggestions of reasonable adjustments or wraparound support, prioritising instead reputation management and academic achievement.

"Teachers not letting the young person have their hood up...teachers are human as well. If they're feeling frustrated and annoyed, and maybe that child's been a bit cheeky and rude already, and then they're triggered and they want to take control back...it's an easy win for control is to control what they see."

–Professional, NHS Vanguard, West Midlands
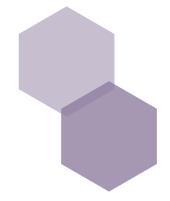
These challenges were also seen to be exacerbated by structural changes such as the shift to academy status, with some professionals reporting a perceived decline in responsiveness or collaboration following schools' movement out of local authority oversight.

Crucially, however, participants emphasised that these issues must be understood within the broader context of systemic pressure. Schools operate within accountability frameworks that prioritise academic attainment, often without the resources or specialist support required to meet increasing levels of need. Several interviewees noted that teachers, particularly safeguarding leads, are carrying enormous emotional burdens without adequate training or supervision. One professional described the cumulative toll:

"Teachers are holding, really, they're holding a lot of... really complex young people...If they were a social worker, they'd have supervision. But they're not a social worker, and they've got nowhere to offload. So they leave the profession..."Everything is back to the teacher, and you could take away the pressure... just by having multi-disciplinary teams available in schools."

–Professional, National Professional Body for Mental Health Specialists, London

While this section highlights consistent concerns about school policies and practices, it is important to note that we were unable to include the perspectives of mainstream school staff in this study. Despite outreach efforts, we did not receive responses from teachers or

school leaders willing to participate. As such, the findings presented here reflect the views of professionals working in adjacent roles who often interact with schools but may not have direct experience working within them. We recognise that these perspectives, while valuable, may not fully capture the pressures, constraints, or rationale behind certain school-based decisions, and we recommend further research that brings school staff voices into this conversation.

Falling out of the school system

Practitioners also raised concerns about what happens when young people become disengaged from or removed from mainstream schooling, whether through formal exclusion, reduced timetables, or more informal off-rolling practices. These moments were described as key points of risk, where children and young people may lose access to both structured learning and the wider network of support that schools can provide.

Formal exclusions were viewed by several participants as missed opportunities for early intervention. In some cases, children with emerging or undiagnosed needs, including neurodivergent young people, were seen to be excluded before appropriate support had been offered. One interviewee described how students with Education, Health and Care Plans (EHCPs), or those awaiting assessment, were sometimes left with no consistent provision:

> *"I'm dealing with loads of kids that are not going to school, not because they don't want to, it's because the school is saying that [they can't]... These are some young people with EHCP plans... They've got no structure. Then you talk about county lines, you talk about exploitation—it's because of all these things...I'm just so annoyed with the way [schools] treat young people, especially the ones with SEN or those who haven't been diagnosed with ADHD or autism... There's a whole cohort of young people that want to go to school. They've been told that because of whatever reason, they can't attend... They're still on roll, but nine months later, there's still nowhere else for them to be educated."*
>
> –Professional, NGO, London
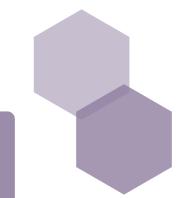
While formal exclusions were the most visible form of school removal, participants also highlighted more informal practices, such as encouraging parents to home educate or placing students on extended reduced timetables, as potential points of disengagement. In some cases, these moves may have been intended to avoid a formal exclusion or de-escalate tensions, but participants warned that without clear plans in place, such decisions could increase the risk of students becoming 'invisible' to support services.

> *"We've got so many home educated children... presenting with ASD who are not being picked up and going under the radar, really. It's so worrying, it really is....I just feel so passionately about it... seeing senior leadership persuade parents to educate their kids at home, to get them off the register. And these are the kids that end up in the criminal justice system... I just think it's absolutely criminal."*
>
> –Professional, National Professional Body for Mental Health Specialists, London

Professionals also voiced concern about what happens during school hours when children are not in education. They pointed out that families, particularly in low-income households, may not be able to supervise children at home during the day, leaving them vulnerable to exploitation or criminal involvement:

> *"Parents are working. Parents are not there when the kids are out of school. When the kids are out of school, what are they doing?"*
>
> –Professional, NGO, London

More broadly, participants emphasised that school is not only a place of learning, but also a potential site for trusted relationships and informal mental health support. When young people fall out of the school system, particularly without other services stepping in, they can lose access to the environments where early support might otherwise have been offered. This absence of safe, structured spaces was seen to further limit opportunities to access formal psychological help or engage with trusted adults.

Several participants described how young people entitled to additional support under EHCPs were effectively left in limbo, especially where provision broke down or was never fully implemented. Over time, patterns of disengagement, behavioural escalation, and exclusion were seen to become entrenched. Practitioners reflected that by the time these young people are picked up by youth justice or crisis services, years of unmet need may already have shaped their identity and relationship with support.

Others reflected on systemic shifts within education policy and school structure. Some spoke about the loss of dedicated youth workers or pastoral support roles within schools, previously seen as bridging the gap between behavioural issues and wellbeing. A few participants even reflected nostalgically on the former "middle school" model, suggesting that the leap from primary to secondary school, particularly for neurodivergent children, may be too abrupt. These young people were described as previously able to "mask" their needs in the more nurturing environment of primary school, but as struggling to adapt when transitioning into more structured and performance-driven secondary settings:

> *"A lot of this group of people that are in the neurodivergent group, they have been neurodivergent all their lives, and they've used tools and strategies [to help them cope] and when they get to high school, those strategies and tools start not to work anymore…that could be when their behavior starts to draw attention to the police and to they turn to criminality. Often, they develop their strategies to mask their neurodivergence, but they can only do that for so long"*
>
> –Professional, Youth Court, East Midlands

Participants also reflected on the links between educational exclusion and wider vulnerability, including exploitation, social isolation, and involvement in serious youth violence. They expressed concern that behaviour-focused policies and accountability pressures sometimes overshadow efforts to understand or respond to the broader social and psychological factors influencing student behaviour. One example cited was the Behaviour Hubs programme and guidance following Tom Bennett's 2016 review. While these initiatives aim to improve behaviour and create safe learning environments, several professionals felt that, in practice, they could risk reinforcing punitive approaches if not accompanied by deeper support for mental health, SEND, and underlying needs (Rainer et al., 2023).

At the same time, many of the concerns raised about education echo the wider system-level challenges described throughout this report, including staff shortages, high thresholds, limited specialist provision, and misaligned commissioning. Participants were clear that schools should not be expected to solve these problems alone. They called for a rebalancing of responsibility across services, recognising both the unique role schools can play, and the need for other systems to work alongside them to provide timely, coordinated support for the children and young people at greatest risk of exclusion.

4.1.2 Barriers to engagement

- Stigma, shame, and cultural taboos around mental health remain major barriers to engagement - particularly for boys and racially minoritised young people.

- Toxic masculinity and hypervigilance, especially in environments shaped by violence or instability, make emotional expression feel unsafe and help-seeking feel weak.

- Mistrust of services - often grounded in lived experiences of exclusion, racism, and misdiagnosis - makes it harder for young people and families to engage.

- Mental health systems are confusing, fragmented, and burdensome to navigate - often requiring advocacy and persistence that many families cannot sustain.

- Services often interpret disengagement as lack of need, rather than a protective strategy rooted in survival, fear, or systemic failures.

If children and young people are identified and picked up by the system as needing support, they may still be reluctant to engage with mental health services, even when the services are ostensibly "accessible". Previous research has highlighted that although young people may attend certain services, such as Youth Offending Teams, they often do not fully engage, creating a distinction between those who are physically present, and those who are 'psychologically engaged' (King et al., 2014). Low rates of engagement of children and young people with mental health support have been cited as a significant public health concern, particularly as low engagement has been associated with poor outcomes (Kagan et al., 2023).

Participants described barriers to initial engagement including: internalised stigma; cultural taboos; mistrust of services. These barriers were seen to emerge from the complex interplay of individual, relational and systemic issues. The phenomena described below therefore cannot be taken in isolation from each other.

Stigma

Throughout the interviews, stigma was seen as a significant barrier to service engagement, including internalised stigma from children and young people themselves.

> *"'[Children and young people would say] 'I'm not mental, why are you sending me there?'"*
>
> –Professional, Higher Educational College, North East
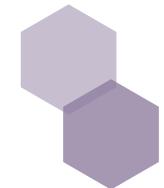
Practitioners spoke of the careful navigation required to avoid triggering defensive reactions from children and young people to language like "mental health" or "counselling," which can imply something is "wrong" with the young person. One interviewee shared how even the name of their organisation initially deterred engagement:

> *"For the first year and a half I operated as 'Counselling'... even the name is a barrier... because you say you need counselling, that suggests something's wrong with me. So we now operate under the working name 'Support'—just more soft."*
>
> –Professional, NGO, London

Previous research suggests that children and young people, including those already involved with the criminal justice system, may worry that seeking support might increase their vulnerability and social exclusion. Internalised stigma can perpetuate "avoidance and detachment from critical support systems" (King et al., 2014). Stigma and mistrust can be reinforced by family members who may share societal concerns about mental health support (Klymkiw et al., 2024; King et al., 2014).

The professionals we spoke to highlighted how, in many communities, mental health difficulties are still deeply taboo, associated with weakness, madness, or danger. They discussed how a reluctance to engage is often reinforced by cultural or generational beliefs, and help-seeking is often discouraged or even pathologised, leading to silence, suppression, or shame, particularly among boys and young men (we discuss this further in the next section).

> *"You are raised in households where you don't talk, so there's a lot of things that go on behind closed doors that just never get spoken about... you're supposed to appear tough, strong."*
>
> –Professional, NGO, London

Inevitably, these attitudes lead children and young people to "bottle up" their emotions. As one young person put it:

> *"...it gets to the point where you don't want to talk to anyone because it feels like no one's listening."*

Other professionals spoke about how cultural expectations around strength and stoicism contribute to internalised stigma and resultant shame and, ultimately, maladaptive coping strategies such as substance use:

> *"... A lot of people grow up in environments where 'what goes on in the house stays in the house'... So, a lot of times people bottle things up, you know, because you're supposed to appear to be tough, strong. And then, as a result of that, they find escapism through drugs and alcohol."*
>
> – Professional, NGO, London

Intergenerational trauma was also identified as an issue. Discussions centered around the fact that where mental health has historically been pathologised, young people may grow up without the language to express distress, or without role models who model help-seeking behaviour. In these contexts, emotional expression can be fraught or dangerous. Participants described families where vulnerability is equated with weakness, or where emotional needs were seen as secondary to survival.

> *"In some families, it's like – keep your head down, stay out of trouble, don't talk about your feelings. That's how they were raised."*
>
> –Professional, NGO, London

Professionals also described how some parents and carers were actively reluctant to seek a diagnosis for their children, including mental health diagnosis and diagnosis for neurodiverse conditions, for fear of labelling or stigma. This idea is supported by previous research which suggests that diagnostic labels can be experienced as stigmatising and can therefore contribute to "disenfranchisement and disengagement" (Kagan et al., 2023).

Importantly, children and young people may also resist engagement because of complex feelings about encounters that led them to service access. One young person described their resistance to therapy on the grounds that it would force them to confront experiences they thought were shameful.

> *"...You're going to be asking me questions about what I've done in the past... yeah that's just going to piss me off ...I'll end up smashing and breaking everything in the room... I've done certain [things] I should not have done..."*

Significantly, stigmatising attitudes – directed towards oneself or another person – don't just come from the young people and their families. As one of our interviewees noted:

> *"You'll still hear professionals saying things like 'he's got mental health'... using that as a really negative thing—crazy, mad, losing the plot."*
>
> –Professional, Higher Education College, London

Toxic masculinity and hypervigilance

Throughout our interviews, internalised stigma was thought to be noticeably acute for adolescent boys. Several practitioners described how cultural expectations of masculinity can make emotional openness or help-seeking feel like a weakness. This was linked to social stigma and to the developmental stage of adolescence, when identity, independence and peer perception are particularly pressing:

> *"...It's kind of like for the males, [they think] I don't really need that mental health support."*
>
> –Professional, Care prevention team, West Midlands

This is a long-standing issue. It has been highlighted in a previous study, which noted how a minority of young males in a Youth Offender Institution identified peer-support as valuable while the majority "felt unable to seek support from peers due to the masculine ethos of the environment" (King et al., 2014). The same view was captured in interviews with the children and young people in our study, with a number of them explicitly mentioning "toxic masculinity" as an impactful social force. Some professionals described how this intersected with racialisation.
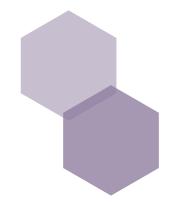
> *"There's a lot of toxic masculinity. You're told... 'men don't cry'. ...It's expectations from society, like they expect a man to be tall and strong and stuff like that. They can't cry..."*
>
> *"I do think that there is still a lot of stigma around young Black men engaging in mental health support... we have some parents who don't believe their child has mental health issues—'it's not such a thing.'"*
>
> –Professional, NGO, London

Crucially, a number of the young people we spoke to linked toxic masculinity and the need to appear "manly", to worsening mental health.

> *"Boys want to be seen as masculine, as tough, ...so most likely they wouldn't want to speak about mental health. ...They might think 'If I speak about mental health, I'm going to look weak and not masculine.' It's the same when people say 'boys can't cry'."*

This resonates with a recent report from Power the Fight and London's VRU (Williams et al., 2020), which found that "Black and male respondents were less likely to talk about [experiences of violence] and more likely to deal with these feelings through retaliation". These views were also represented by older cohorts within research conducted by the South London & Maudsley NHS Foundation Trust Mental Health Promotion Team and Lambeth Black Thrive (Myrie et al., 2020). Relatedly, professionals in our research discussed how support can be stigmatised because of its associations with vulnerability. It has already been noted that for some children and young people living in dangerous environments or under constant threat, maintaining a hardened exterior is a necessary defence mechanism. In this context, practitioners described, services that require you to talk about your "weaknesses" can be disturbing.

> *"...if you've been hypervigilant, letting your guard down can be threatening."*
>
> –Professional, NHS Speech & Language Therapy, London

Hypervigilance (a state of excessive alertness often due to trauma or anxiety) is common in young people growing up "in a community or family context with persistent threat, [where] there is often insufficient experience of safety for recovery, stabilization and deactivation of the stress response" (Kagan et al., 2023). Survivors of community violence often emphasise their need to stay "on point" (Smith and Patton 2016). Unfortunately, there are negative consequences to a constantly active stress response, including "higher mental health symptoms, compromised immune system, impaired executive functioning…" (Kagan et al., 2023). As Kagan et al. (2023) note, hypervigilance and defensive reactions may sometimes be misperceived as "symptoms of psychopathology leading to referral to psychiatric facilities, child welfare systems and criminal justice system". While referral to child welfare services can in some contexts be appropriate, the authors caution that such responses are sometimes driven by misinterpretation of trauma-related behaviours, rather than recognition of the underlying need for safety and support.

"Toxic masculinity" and the performance and assertion of "manliness" were seen by professionals to be damaging, both for those displaying these behaviours and those on the receiving end. At the same time it seemed that the boys and young men we spoke to found they benefited from "masculine" forms of socialising, such as boxing and often violent video-games (e.g. "Call of Duty"). This corresponds to findings described in previous research such as a study on violence and resilience in South East Asian men in California, which saw young men using "violence and gendered codes to navigate their social context to improve resilience" (Gwata et al., 2024). This suggests that encouraging masculine ways of expressing emotions, like saying "a real man talks about his feelings", can be helpful. However, these approaches are not without risks, as they can still be linked to harmful ideas about masculinity, like those found in the online "manosphere."

Mistrust of services and the importance of cultural competence

Participants described how many of those involved in serious youth violence have learned a mistrust of professionals because opening up to others, especially "strangers", can be perceived as risky. Some of the young people we spoke to expressed concerns that information can be weaponised by peers or professionals, or have legal repercussions (e.g. police involvement). This has long been a theme in the literature, highlighted in Naylor, Lincoln and Goddard's 2008 findings about 'widespread resistance to referral' (quoted in King et al., 2014). As King et al frame it "Not wanting to talk to a stranger about personal issues, feeling labelled, and anxiety caused by not understanding the process, were identified as barriers to engaging with mental health services." (King et al., 2014). Young people in our research described how a fear of sharing information can leave them feeling as if they have nobody to turn to:

> *"...Nowadays, you open up to someone, and that person, maybe not tomorrow, maybe not next week, but they'll use it against you somewhere along the lines."*

Defensive attitudes were described as survival strategies shaped by social expectations and dangerous environments. It was clear from our discussions that they are not easily resolved, and the work of dismantling them is much harder when attempted by strangers. Pushing children and young people before they are ready, or without addressing these barriers, can reinforce stigma, resistance and disconnection.

Mistrust may also be a legitimate response to genuine shortcomings of services. A number of participants noted that provisions are often detached from the communities they serve, both culturally and operationally, and that this increases the risk of misunderstanding and harm for users.

It was widely acknowledged that racially minoritised communities are underrepresented within mental health service providers, in terms of a lack of therapists and professionals from representative backgrounds, and that this negatively impacts engagement. This reflects previous research which suggests that "youths of color who do receive service are more likely to drop out prematurely, attend fewer treatment appointments, and receive services that poorly match their needs" (Kagan et al., 2023). While not all services lack cultural competence, many parents and young people expressed concerns about their needs and experiences being misunderstood or misinterpreted by practitioners. Both parents and practitioners highlighted that in addition to internalised and community stigma, young people can be stigmatised by professionals and services, through stereotyping, particularly of Minority Ethnic boys and young men.

For some parents, this amplified a corresponding fear that they might be seen as a "bad parent", or that engaging with statutory services might carry consequences for their child, such as being labelled, excluded, or monitored by social care.

> *"...they could even end up having their role as a parent being looked at by social care... because they think that these parents are unstable"*
>
> –Parent, West Midlands

A lack of culturally competent or representative services was also identified in the voluntary and community sector as an obstacle to engagement.
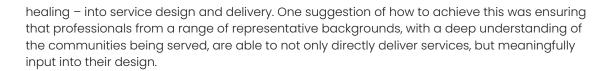
> *"There are no counselling charities [in this area] that provide culturally competent counselling services for our Black and Asian communities..."*

It was recognised that shared characteristics do not inevitably translate into a shared connection, but do increase the likelihood of mutual understanding.

> *"It doesn't mean just because you're Black you'll understand, but there's a cultural competence that lets you understand the nuances."*
>
> –Professional, NGO, London

Practitioners repeatedly emphasised the need for culturally competent and community rooted approaches to meaningfully engage young people and their families. Participants emphasised that cultural competence goes beyond superficial training. It requires sustained efforts to embed knowledge of local communities – demographics, histories, patterns of harm and

healing – into service design and delivery. One suggestion of how to achieve this was ensuring that professionals from a range of representative backgrounds, with a deep understanding of the communities being served, are able to not only directly deliver services, but meaningfully input into their design.

> *"As a Black-led organisation… we are very aware that a large percentage of our clientele… come from a Black, African, Caribbean demographic. And the truth is, they do not see a lot of representation. That can often easily be a barrier."*
>
> -Professional, NGO, London

Trust was seen as hard-won, especially in communities where past interactions with statutory services, policing, or social care had been negative (Williams et al. 2020). "Marginalised groups often deeply distrust organisations and institutions due to consistent experiences of structural harm through inequality in health care, education and criminal justice systems" (Ibid). Similarly, other research has described the negative experiences that children from minority ethnic groups in the UK report in relation to lack of police training (McCulloch, Eve and Parry, 2024). As one professional noted:

> *"Some communities are not willing to open up… maybe their experience with police, maybe with social work—it's always been on a negative tone."*
>
> -Professional, NGO, London
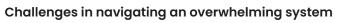
Several interviewees reflected on how the roots of exclusion run deep, not only within affected communities, but within the foundations of the mental health system. One practitioner explained:

> *"When you look at psychotherapy, it was a very small minority of people that pioneered the whole industry, and those individuals were middle-aged, white and male. …There were a lot of other people who contributed greatly to the field, but because they were the wrong skin colour, or the wrong gender, their work was dismissed…From the very beginning of psychotherapy, there's been a cultural bias"*
>
> -Professional, NGO, London

Practitioners were explicit on this: systems that are meant to offer support often stigmatise children and young people, by for example, punishing non-attendance, pathologising behaviour, and failing to demonstrate safety or understanding. These exclusionary attitudes lead some young people to disengage from the start, feeling that "there's no place for them" within formal mental health systems. According to one practitioner:

> *"The way they're treated, discredited, discriminated against… a lot of people would not go to mainstream services even if they needed support… 'Why would I go to somewhere where the person doesn't understand me, doesn't want to understand me, doesn't care whether I'm healthy or unhealthy?'"*
>
> -Professional, NGO, London

Challenges in navigating an overwhelming system

Professionals warned that systems too often interpret hesitancy to engage as a lack of need, rather than a protective strategy rooted in lived experience. This can lead to services that, intentionally or not, create additional practical and logistical barriers to engagement.

Practitioners noted that mental health systems often assume a level of proactivity, advocacy and persistence that many families do not have the capacity to demonstrate, particularly those experiencing poverty, marginalisation, or mistrust.

> *"We talk about young people disengaging, but sometimes it's the parents. They're overwhelmed. They've got three other children, they're working three jobs, and they don't know how to fill out the CAMHS form…If the parent doesn't push, the referral doesn't go anywhere. But not all parents can push."*
>
> –Professional, NHS Vanguard, West Midlands

These environments can prevent young people from engaging with services. Previous research has discussed how services can be "experienced as continuing neglect of basic needs or punitive" (Kagan et al., 2023). This can particularly be the case when services are confusing to navigate and not easily aligned. "The mismatch of diagnostic assessments, treatment plans and services offered may be a primary factor in why engagement can be so challenging for youths and parents/caregivers who have been, and may continue to be, experiencing complex interpersonal trauma" (Ibid). Research suggests that this is particularly acute for families experiencing high levels of stress and multiple problems (Attride-Stirling et al., 2004; Thompson et al., 2007)

Many of the people we spoke to, both parents and professionals, described how navigating the mental health system is an intimidating task, even for experienced service providers, let alone parents who may be under stress or lack the necessary knowledge. One participant said:

> *"It's a minefield… As a professional, I find it quite daunting, but as a parent… that's quite a big challenge."*
>
> –Professional, NHS Vanguard, West Midlands

A lack of parenting knowledge or confidence can be a significant barrier, despite the willingness on the part of parents to engage.
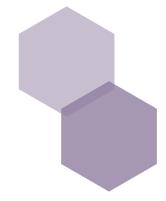
> *"Parents lack the skills to sit down on the computer and fill in a referral."*
>
> –Professional, NHS Vanguard, West Midlands

Family members are typically expected to initiate referrals, chase follow-ups and understand bureaucratic distinctions between "CAMHS", "social care", "school support teams", and "GP referrals", frequently without clear guidance or accessible language. Parents repeatedly described feeling exhausted, burdened and isolated as they tried to advocate for their children:

> *"I had to coordinate everything—his assessments, school meetings, chasing the GP—and I'm not even a professional."*
>
> –Parent, London

> *"I had to stop working to be there for him, because no one else was going to fight for him the way I would."*
>
> –Parent, East of England

> *"Honestly, the energy it took for me to do that was a lot, and so I really feel for other parents that are, you know, having to battle the system."*
>
> –Parent, South West

Parents and practitioners highlighted the bureaucratic hoops that complicated referrals. Others spoke to the emotional and administrative burden of repeatedly applying for support that might be short-lived or underfunded.

> *"Even the application process can sometimes be so tedious that it just feels like a lot of work and a lot of effort... even those things then start to become a barrier."*
>
> –Professional, NGO, London

For Looked After Children and those young people on the edge of care, these issues were thought to be more severe; a lack of supportive and trusting adult figures can prevent them from knowing how to access help. Participants highlighted how parents, carers and families can be essential support systems for children and young people involved in serious youth violence, and that often, they want to help, but lack the necessary resources to navigate the complex and overwhelming system.

4.1.3 Barriers to access
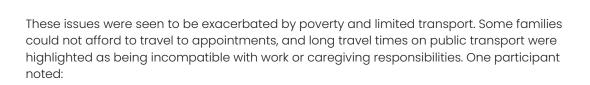
In the previous section, we documented some of the reasons given that explain why children and young people may not want to engage with support services. In this section, we lay out some of the obstacles to access described by professionals, parents and young people, even if children and young people do decide to engage .

Geographical and financial barriers

Professionals noted that young people often experience physical barriers, such as distance, to attending services delivered in particular locations. Time is needed to ensure young people are able to attend appointments, especially with children who need accompanying and when parents are constrained by work. Practitioners consistently raised transportation and location as key barriers to access. Services were frequently concentrated in urban centres, creating challenges for those living on the outskirts or in rural areas. In some cases, outreach services were less likely to visit or prioritise young people based in "harder-to-reach" locations.

> *"I might drive an hour just to go and visit... but it's an hour both ways, and that's sort of half your day gone visiting one child. There's definitely issues there in terms of... numbers. It's difficult to make the argument to resource this team well and resource the health offer well. But when you look at the geography, it's vital."*
>
> –Professional, Youth Justice Board, Wales

These issues were seen to be exacerbated by poverty and limited transport. Some families could not afford to travel to appointments, and long travel times on public transport were highlighted as being incompatible with work or caregiving responsibilities. One participant noted:

> *"I would certainly say that poverty also plays a part. People not having funds to get on the bus to get to an appointment, maybe running out of credit on the phone to talk to staff."*
>
> -Professional, Youth Justice Service, North West

Some parents described how they stopped bringing their children to services because it was too complicated alongside other obligations. This was particularly true for those in single-parent households or without access to a car.

> *"We had to drive almost an hour to the therapist...given that I'm busy, his mother is busy, the boy can't drive himself down there [we had to stop going]...it was far to travel and difficult to get to"*
>
> -Parent, London

Research suggests that engagement is more difficult for young people and families experiencing "poverty, insufficient housing, community violence and chronic caregiver adversity" (Kagan et al., 2023). Other participants discussed how limited finances made it difficult for some families to access services through alternative routes e.g. by paying for private diagnoses or therapeutic activities. This made some practitioners reluctant to introduce children and young people to certain community resources:

> *"We could have six weeks of horse-riding lessons... but at the end of six weeks, the parent can't afford it. So what? Have we made things better, or have we given with one hand and taken away with another?"*
>
> -Professional, NHS Vanguard, West Midlands
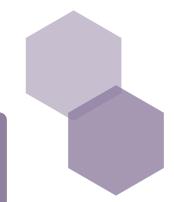
Physical access was also about safety. Several participants spoke about how territorial boundaries created by county lines or gang-related activity made it dangerous or impossible for some young people to travel to certain areas. Services in particular locations could be inaccessible because of perceived or real risk of violence.

> *"...there might be areas of the borough we can't go to because it's not safe for them. There'll be other groups or gangs that have a problem with them, and that might create some risk."*
>
> -Professional, Youth Justice Board, London

The shift to virtual services, accelerated during and after the pandemic, was thought to mitigate these issues. However, some professionals highlighted how online services can lead to digital exclusion. Unequal access to digital resources can create additional barriers, with a reliance on web-based interventions further risking exclusion:

> *"Our cohort are often in digital poverty… access to smart devices isn't always readily available,"*
>
> -Professional, CYP Health and Justice, West Midlands

This contrasts with the views expressed in Dunne et al's study of barriers to access, where online interventions were seen to have "near universal reach, 24-hour access, little or no cost of access, confidentiality or anonymity, ease of updating of materials, interactivity, and linkability", as well as being as effective as face to face interventions (Dunne et al., 2017). Still, there appears to be broad agreement that, where they are accessible, online interventions can be incredibly helpful, resulting in "positive effects for treatment and symptom reduction of anxiety and stress…post-traumatic stress, first episode psychosis, and eating disorders" (Ibid).

Logistical challenges and systemic shortcomings were described as combining to create persistent barriers that prevent young people and families from accessing the support they need. Issues like transport, cost, and time are not just inconveniences, but reflect deeper inequalities that complicate access and make engagement with services unsustainable or even impossible for many. They also reflect barriers that are rooted in the rigidity of where services are based.

Lack of information

Access was also impacted by a lack of available information about relevant services. Services were not always clearly mapped or advertised with the result being that potentially interested children and young people may be unable to find them. This was a theme that also emerged during our service mapping exercise of voluntary and community sector organisations. The key challenge was a rapidly changing and extensive service landscape, often due to short commissioning cycles, which we have discussed further in Section 4.2.1; this led to information quickly becoming out of date. A lack of up-to-date, centralised information made finding services difficult and time-consuming. Websites were not always user friendly, and often didn't contain the relevant information. This was consistently highlighted in the qualitative research, with participants highlighting that a lack of information about available services was a significant barrier to accessing support for families:

> *"I would say lack of awareness of services that they can tap into."*
>
> -Professional, NGO, London
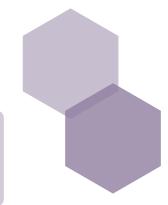
This was reflected by parents themselves, even in relation to accessing mental health services through primary care:

> *"I didn't know that GPs were in mental health services. I thought they were for other types of illnesses"*
>
> -Parent, London

This absence of easily-accessible information both prevents access and leads to isolation and a sense of helplessness. Many families ended up resorting to informal sources of support such as friends, family and community and religious groups.

Similar challenges also appeared in schools. Participants explained how parents didn't feel supported in finding their children the correct support, and often struggled to get information from schools, or to advocate for reasonable adjustments:

> *"Sometimes parents feel quite lost with their voices in schools… they're trying to say stuff, and they're not being listened to."*
>
> –Professional, NHS Vanguard, West Midlands

Significantly, a lack of information was also seen to impact practitioners, who described concern at their own confusion or lack of awareness about other available services, how to refer, or about diagnostic categories. One participant noted:

> *"Sometimes there might be challenges in knowing which kind of route to take… is it speech and language need, is it a kind of mental health need, is it something best dealt with through SEND…?"*
>
> –Professional, Youth Justice Board, London

This has also been commented on in the wider literature, with a lack of awareness among staff about the availability or implementation of new programmes also preventing referrals being made (Appleby et al, 2023). The situation is exacerbated by the material realities of the system, where burn-out is high. High staff turnover can prevent the continued delivery of programmes and services, often due to challenges with ensuring that new staff are fully trained in delivery or aware of available services that they can refer to (Ibid).

Language barriers

Language barriers were a central concern for children and families where English was not the first language. This was true both in relation to administrative access, such as understanding how to arrange a therapy session, and in relation to treatment itself. Talking therapies often rely heavily on verbal expression, and providers noted the lack of readily available, linguistically open services:
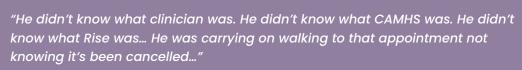
> *"Sometimes we get interpreters who… don't speak the same dialect. So you worry about what message is actually being translated."*
>
> –Professional, Youth Justice Service, Yorkshire & The Humber

> *"When we see children where English isn't their first language… if we look at talking therapies…access to support in their native language isn't readily available at all… "*
>
> –Professional, CYP Health and Justice, West Midlands

In such cases, young people and their families can be left without avenues to communicate their experiences or needs, further marginalising them within the system. Participants highlighted how services also frequently make assumptions about English literacy levels, including an awareness of relevant terminology like "clinician" and "referral pathway". Matters are further complicated when each sector (NHS, police, education, etc.) has its own processes, forms, referral routes and terminologies. Those unfamiliar with institutional language are particularly disadvantaged. One practitioner described supporting a father who received a voicemail cancelling his son's appointment but didn't understand what it meant:

> *"He didn't know what clinician was. He didn't know what CAMHS was. He didn't know what Rise was… He was carrying on walking to that appointment not knowing it's been cancelled…"*
>
> –Professional, Care prevention team, West Midlands

Young people with communication needs also face major obstacles. Professionals reflected on the failure of services to recognise or adapt to underlying language and comprehension difficulties, especially for those with neurodevelopmental conditions or histories of trauma.

> *"We have a case who has …significant learning and communication needs and has come through on two statutory orders and has been let down. He's almost 18, and has not had any health screenings or had his needs analysed, and that will be a pattern for the rest of his life. I think policing and legal especially need some significant education around neurodiversity, speech, language and exploitation…"*
>
> –Professional, Youth Justice Service, North West

Institutional language norms and expectations

Participants described the language of the mental health system, both literally and structurally, as a significant, often invisible barrier to access for children and young people. They highlighted how widespread reliance of services on technical language results in doors being opened by certain "key" words; access hinges on whether a young person, or the referring professional, can use the "right" language to describe distress in a way that aligns with the system's thresholds. These thresholds and language norms were seen to prioritise internalising symptoms, such as low mood, anxiety, and suicidal ideation. Externalising behaviours, more common among the young people in this cohort, were thought to be more frequently dismissed as disciplinary or social care concerns.
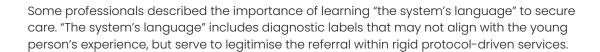
> *"There have been referrals from schools, there have been referrals from social workers [to CAMHS] and each time it's the same story - oh this is behavioural, this is for social care, this is not for us"*
>
> –Professional, Youth Justice CAMHS, London

> *"If you can't speak that language… you don't get through the door. When you express your distress and your trauma…through externalising behaviour in your actions, rather than traditional internalising symptoms…then effectively you're speaking the wrong language."*
>
> –Professional, Youth Justice CAMHS, London

Professionals highlighted how this terminological gatekeeping can lead to referrals being repeatedly rejected or misunderstood, despite multiple points of contact with services. In addition, they reflected that where young people have limited emotional literacy, or where distress is expressed through behaviour rather than words, therapy models that rely on verbal insight and emotional disclosure can be alienating and create further barriers to access.

Some professionals described the importance of learning "the system's language" to secure care. "The system's language" includes diagnostic labels that may not align with the young person's experience, but serve to legitimise the referral within rigid protocol-driven services.

> *"If you haven't put the right word in it, you might not get directed to the right place… You could be the greatest person in the world to do that job, but if you haven't put the right words in, you don't get through. The referral gets bounced back."*
>
> –Professional, NHS Vanguard, West Midlands

Other participants stated that the fact that statutory services require high-risk cases to be categorised through diagnosable mental health conditions creates scenarios where professionals and clinicians either can't help the young people they are working with to access mental health treatment, or they have to modify their risk assessments and language to fit in with the rigid structure and definitions of the service:

> *"…now I say he's carrying a knife because of PTSD, so it fits the risk model. Otherwise, he doesn't get seen."*
>
> –Professional, Youth Justice and PRU CAMHS, London

Waiting lists

Long waiting lists were repeatedly described as a significant obstacle to access, and were typically framed as unfortunate by-products of an overstretched system. In 2022/2023, almost 70% of the 949,200 children referred to CAMHS were either still waiting at the end of the year or had their referral closed before accessing the service (Children's Commissioner 2023). Nearly every participant raised serious concerns about the impact of delays in accessing services. It was also an issue that surfaced in conversations with children and young people:
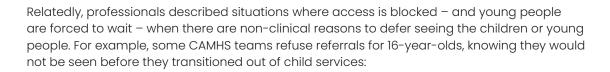
> *"It's not always easy to get a counsellor or a therapist. I was waiting for my therapist for a year…"*
>
> *"The wait was, like, ridiculous to get there to have the appointment, but it was kind of a dead end anyway. Wasn't really going to help."*

The impact of delays appeared to be particularly acute for CAMHS and for neurodevelopmental assessments, such as for ADHD or Autism Spectrum Condition. Young people in crisis were described as waiting months for support. During this time, participants highlighted that their needs can escalate or they can disengage from the process altogether. Some professionals noted that, by the time a young person is seen, the original issue may have worsened or changed entirely.

> *"CAMHS has a three year waiting list. So whilst they're waiting for that, sometimes things escalate…I think we're quite limited in terms of what support is available"*
>
> –Professional, Care prevention team, West Midlands

Relatedly, professionals described situations where access is blocked – and young people are forced to wait – when there are non-clinical reasons to defer seeing the children or young people. For example, some CAMHS teams refuse referrals for 16-year-olds, knowing they would not be seen before they transitioned out of child services:

> *"Authorities or CAMHS services tell me they won't take a 16-year-old onto their waiting list because they know they won't get to assess them before they're 18."*
>
> -Professional, Youth Justice Board, London

The waiting list issue was so prominent that in some instances it would prevent professionals from even making a referral, because they thought there was no point:

> *"Particularly for CAMHS, we hear a lot of social workers or schools will say there's no point referring because they won't be seen. The waiting list is so long it feels pointless."*
>
> -Professional, Forensic CAMHS, East Midlands

Some participants, especially those based within the CAMHS system, pushed back on this however as a wide misunderstanding and as a manifestation of externalising behaviours not being viewed as a potential mental health issue:
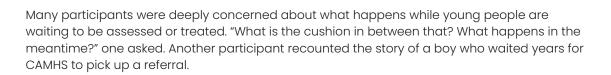
> *"Yes, there's a long waiting list for specialist intervention, but not for assessment...there are all those kind of biases...'what's the point? They act like that because of that, there's no point referring them to mental health'. We've done bits of work in the past on referral rates and quality of our referrals. The quality can be shocking of what people choose to refer and what they choose not to".*
>
> -Professional, CAMHS, West Midlands

Participants recounted that for neurodiverse children, being forced to wait for a diagnosis meant missing out on the educational and behavioural support that could keep them engaged in school and protected from other risks. Many children were described as "aging out" of child-focused services before ever receiving a diagnosis, leaving parents and schools unable to implement support plans like EHCPs. Participants described waiting lists for assessment ranging from a year in some areas to over seven in others. In response to this, many parents were often "[scrambling] money together to see if they can pay for it", which added to financial barriers and in some cases resulted in a waste of resources:

> *"...a lot of people are paying privately for their kids to have an ADHD assessment... but there was a Panorama documentary that was investigating private clinics and that's created a lot of backlash and really undermined private assessments...so now some schools won't accept private diagnosis and the NHS won't give medication because they say the assessments aren't reliable".*
>
> -Professional, NHS Vanguard, West Midlands

Many participants were deeply concerned about what happens while young people are waiting to be assessed or treated. "What is the cushion in between that? What happens in the meantime?" one asked. Another participant recounted the story of a boy who waited years for CAMHS to pick up a referral.

> *"This probably took about three or four years until the point that he stabbed somebody and ended up in custody... I'm not saying that would have prevented the offending, but I almost feel like we didn't even give him that opportunity."*
>
> –Professional, CYP Health and Justice, West Midlands

Waiting lists could be bypassed where teams had professional relationships and referral networks into CAMHS, and where Youth Justice Services had embedded mental health teams. In these cases, participants described assessments and treatment being fast-tracked. But, as also highlighted in Section 4.4.1, this raised ethical concerns around the need to have contact with Youth Justice Services in order to receive support:

> *"It should never have reached the point where the young person ended up in Youth Justice Services in the first place."*
>
> –Professional, Youth Justice Board, Wales

Professional frustration around wait times was exacerbated by the lack of clear information or answers to provide young people:

> *"They ask, why is it so long? Why does it take so long? How many weeks? And we haven't got the answers. All we can say is there's a referral process, there's a waiting list. And I think they're sick and tired of hearing about waiting lists."*
>
> –Professional, NGO, London
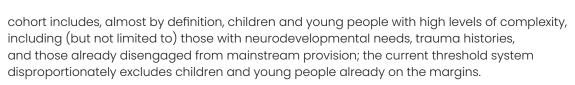
The lack of transparency about waiting lists exacerbates the problem. This is something we noticed during our service mapping exercise of voluntary and community sector organisations; it was challenging to understand from organisational websites whether waiting lists were being used.

Rigid service structures and strict eligibility thresholds

Restrictive eligibility thresholds also emerged as significant barriers to accessing services, which were described by some professionals as a necessary mechanism for resource management (and as such are discussed in detail in Section 4.2 on systemic underpinnings).

Across interviews, stakeholders consistently described how current mental health services, especially CAMHS, are structured around thresholds that exclude cohorts of young people whose needs are either not deemed "clinical enough" for the high thresholds of Tier 3 CAMHS[9] services, or are too complex for lower-tier, school-based and community services. This group was referred to as "the missing middle".

The "missing middle" is a cohort of young people who are structurally excluded from the system due to having a "moderate mental health need that cannot be met by CBT but who are not acute enough for a CAMHS intervention" (Barnados, 2023). According to a recent BACP report, this cohort may have amounted to 730,000 individuals in 2024 (BACP, 2025). Notably, this

cohort includes, almost by definition, children and young people with high levels of complexity, including (but not limited to) those with neurodevelopmental needs, trauma histories, and those already disengaged from mainstream provision; the current threshold system disproportionately excludes children and young people already on the margins.

Some stakeholders questioned whether the gap is as much about thresholds as barriers created by the rigidity of mental health services. They described how young people in alternative provisions or the youth justice system may meet the complexity associated with Tier 3 care but struggle to access services due to communication mismatches or medicalised models of care (this relates to the discussions in the previous section). Talking about a young person in their service, one interviewee summarised this:

> *"He's a tier three threshold. He met the threshold for that team, but even if he got there, he wouldn't have got the treatment... The children we see in youth justice CAMHS, in PRU CAMHS, have just as much complexity as our Tier 3 colleagues, if not more. And because of that, that's often the barrier."*
>
> –Professional, Youth Justice CAMHS, London

It is also clear from the wider literature that children and young people are blocked from accessing important services because of continued failure of these services to conceive of violence and vulnerability as health issues. As described in other research, CAMHS often "have insufficient resources to meet the needs of the young people affected by gangs and in order to protect themselves from this, their referral criteria is very stringent and effectively excludes this group of people" (Gwata et al., 2024).

As mentioned, participants emphasised that many mental health services are organised for young people with "straightforward" presentations – anxiety, low mood, self-harm – who are verbal, regulated and supported by engaged caregivers. Children presenting with externalising behaviours, neurodiversity, exploitation, or multi-agency involvement are often excluded on the basis of complexity:

> *"We get lots of children who are referred in and then they're kind of pushed away, because they see that it's a behavioral problem... rather than thinking, what's the root cause of what we're seeing?"*
>
> –Professional, CYP Health and Justice, West Midlands

This highlights how the rigid nature of services and their lack of ability to deal with complex presentations can create barriers to children and young people receiving support. This is reflected in other research, which describes how some systems impose rigid standards that exclude vulnerable populations, particularly those who may not meet specific diagnostic thresholds or who have co-occurring issues such as trauma or socio-economic disadvantages (Appleby et al., 2023; Gwata et al., 2024). This is particularly problematic for youth involved in the justice system, who often face additional barriers due to their legal status and the stigma associated with their circumstances (O'Hara et al., 2019). The lack of flexibility in eligibility criteria can prevent at-risk youth from receiving the support they need, thereby perpetuating cycles of violence and mental health crises (Appleby et al., 2023; Robertson 2022).

Participants emphasised that the current threshold system disproportionately excludes young people already on the margins. This dovetails with a broader critique not just of thresholds, but of how services are commissioned, structured, and delivered in ways that fail to account for the realities of young people's lives, especially those living with the intersecting challenges of exclusion, exploitation and systemic disadvantage. This is discussed further in Section 4.2.1.

The 'Hot Potato' effect and inability to hold risk

There was a broad consensus that core statutory mental health services, particularly CAMHS, are shaped by rigid clinical frameworks for assessing and managing risk which are poorly aligned with the complex realities of young people's lives. Risk, participants highlighted, is often conceptualised in terms of individual, internalising symptoms such as suicidality or self-harm, and managed through standardised protocols that do not take into account social context, trauma histories, or behavioural manifestations of distress. Young people whose lives involve high-risk situations, but whose experiences do not fit neatly within traditional diagnostic frameworks experience significant barriers to accessing CAMHS services. Participants reflected on the fact that the dominant models tend to equate risk with harm to self or clinically defined mental illness, which means that other forms of distress, such as exposure to violence, exploitation, or behavioural challenges, are often overlooked or deprioritised. As one participant explained:

> *"The outline of the services is basically based around the model where your risk is driven by harm to self or mental health risk. An example is that we do a lot of work with complex cases and do a lot of risk assessments but we would rarely [assess someone] as high risk because our risk protocols indicate that if it's high risk, I need to be saying that risk is due to a mental health disorder, and it's very difficult to define it that way."*
>
> –Professional, Youth Justice CAMHS, London

Some suggested that this narrow framing of risk may reflect systemic pressures, such as concerns about liability, safeguarding responsibilities, and limited capacity, which can make services more risk-averse and less willing to engage with complex, socially embedded forms of distress. Professionals discussed how even when children meet formal thresholds for access, their needs may still go unmet if they are considered "too complex" or "too risky". Services may assess but not treat; they may refer on to other agencies, creating a "hot potato" effect in which responsibility is passed but never held.
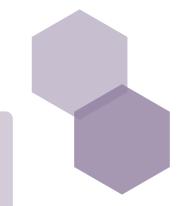
> *"I refer to it sometimes as a bit of a hot potato. You'll refer to a service who you feel will be appropriate, and they'll go, 'No, it's not for us that needs to go to this service'. And then they'll go, 'No, it's not for us. You need to go to this service'. And it's a bit of a hot potato, passing this person around.*
>
> –Professional, Liaison and Diversion, South West

> *"We do get a lot of cases where young people present in crisis...unfortunately, they then become perceived as a bit of a nuisance by the police and then other services, and they get bounced around...And then it becomes a bit like that hot potato that nobody then wants to work with"*
>
> –Professional, Forensic CAMHS, East Midlands

Participants described situations where each service viewed complex cases as someone else's to hold, which results in children and young people being left without support:

> *"Social care will say that's a police issue, police will say that's a social care issue, social care will say that's a CAMHS issue, CAMHS will say that's an education issue, and then education will say that's an SEN issue. Well, actually, it's the child's issue"*
>
> –PRU Safeguarding Team, North East

Participants noted how, in the context of CAMHS, even for young people who meet the relevant threshold, service access would be difficult due to the clinical structure of CAMHS delivery. They highlighted how referrals are frequently made but not followed through with meaningful engagement; instead, children and young people experience a revolving door of assessments and referrals. This is a barrier created by service design. It also demonstrates a particular limitation of the frameworks these services use:

> *"...half of these services aren't able to really understand the need, but also constantly revolve the door around them. Close, open. Close, open. So yeah, they get lost, lost."*
>
> –Professional, Youth Justice CAMHS, London

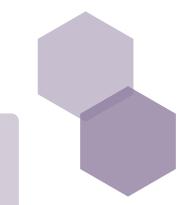There was broad consensus that core statutory mental health services, particularly CAMHS, operate with rigid models of clinical risk that are ill-equipped to respond to the realities of young people's lives. Risk is often conceptualised in terms of internalising symptoms such as suicidality or self-harm, and managed through standardised protocols that neglect social context, trauma histories, or behavioural manifestations of distress. Children and young people whose lives involve high-risk situations, but whose experiences do not fit neatly within traditional diagnostic frameworks, experience significant barriers to accessing CAMHS. The dominant models tend to equate risk with harm to self or clinically defined mental illness, which means other forms of distress, such as exposure to violence, exploitation, or behavioural challenges, can be overlooked or deprioritised.

Some professionals described an institutionalised anxiety within services around holding risk, particularly in cases involving offending or violent behaviour. This was seen as resulting in a default tendency to discharge, exclude or avoid cases rather than adapting support to meet young people where they are and acknowledging that a young person can be supported and their risk held by multiple agencies.

> *"The cases will come through, and if they're linked in some way to offending, we see what feels like a panic from services about young people and about their risk... not recognising that it's not on them to hold that risk... All they can really hear is this young person's offending."*
>
> –Professional, Forensic CAMHS, East Midlands

The lack of clarity in how services distinguish between different levels of support, e.g. Tier 2[10] and Tier 3, was thought to further confuse matters. Interviewees identified blurred lines between levels of service, particularly when risk is present, making it unclear who is responsible for what kind of support and where funding should be directed. Services that might otherwise work with children and young people presenting with anxiety, behavioural difficulties or trauma - both statutory and voluntary and community sector services - may refuse to engage once "risk" is introduced, irrespective of the sort of risk.

> *"CAMHS have such a strict referral criteria that if the young person is presenting with anxiety and low moods, they may not reach the threshold… so then there'll say there's a lower level… like a charity organisation that can offer support… but then they'll say, because of the risks, they're not prepared to work with the young person."*
>
> –Professional, Forensic CAMHS, East Midlands

Professionals saw this attitude resulting in young people being passed between services or discharged entirely when engagement was inconsistent or when their needs were seen as too complex. Children and young people involved in serious youth violence may be understood to be too great a risk. According to one participant, services such as CAMHS *"see situations such as carrying knives as a policing issue rather than a mental health issue."*

Voluntary and community sector, community-based and school-based services were also described as displaying reluctance to work with higher-risk young people. Participants spoke of services explicitly stating they would not work with young people who had experienced or perpetrated violence, who carried weapons, or who were involved in the youth justice system. Other services extended this to young people who displayed any level of risk, whether that was trauma, self-harm or challenging externalising behaviours. *"They don't work with risk,"* one practitioner stated bluntly, when discussing the existence of Mental Health Support Teams in schools. This was a theme that was reiterated by various participants.

Although practitioners repeatedly highlighted the need for earlier intervention within the system, the available support systems were often inaccessible due to their refusal to hold risk. Many of our interviewees saw this creating a gap for those most in need, particularly young people involved in serious youth violence. Violent behaviour was understood to lead children and young people to be excluded from both statutory and voluntary and community sector mental health support.

Schools were also implicated in this dynamic. Some participants spoke about schools excluding young people exhibiting risky or disruptive behaviour to avoid reputational harm, rather than seeking support or engaging with services that might address underlying causes

> *"The schools themselves sometimes want to keep things quiet so they don't get bad publicity… so sometimes they'll exclude a child rather than holding on to them."*
>
> –Professional, NHS Vanguard, South East

Inflexible services

Another theme that emerged from the qualitative data was the inflexibility of services, many of which are ill-equipped to adapt to the, often extremely complex, realities of young people's lives. Participants repeatedly highlighted how the rigid nature of statutory services are incompatible with the circumstances of this cohort. Several described how "three strikes and you're out" policies in CAMHS, for example, where young people are discharged after missed appointments, fail to recognise the chaos and unpredictability with which many young people live. In doing so, these services effectively penalise the young people services are supposed to support. As one professional explained:

> *"A clinic-based model for children, quite often, is a massive barrier, because the case gets shut down quite quickly if children don't engage. Where you've got very complex children, the likelihood of children engaging at the front end is very small. You have to work that engagement."*
>
> -Professional, Youth Justice Service, Wales

The dynamic was described as follows: high demand pushes CAMHS services to discharge young people when there is non-engagement, but this immediately creates a barrier for young people who cannot engage within the rigid structures of the service. One participant highlighted how even if a young person was able to get to the top of the waiting list, he would have struggled to engage with the service because of the way it is delivered:

> *"...his first appointment would have been his last. Because he would have sat there and gone, I don't want any therapy. Leave me alone. Goodbye. And that would have been it."*
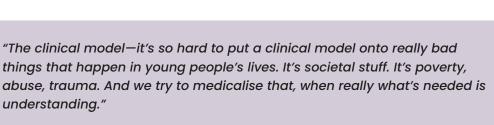>
> -Professional, Youth Justice CAMHS, London

Professionals repeatedly emphasised the intense need for flexibility in services offered to young people at risk of serious youth violence and how core and statutory services are unable to offer this. The need to attend a physical and clinical location was highlighted as problematic, since many young people in this cohort, particularly those who are neurodiverse or who have been exposed to trauma, can find it very difficult to engage in a space that they do not feel comfortable in. Professionals talked about how clinical spaces in hospitals, such as many CAMHS provisions, can be extremely anxiety-inducing for young people due to the sterile, formal and intimidating environment. They described situations such as having to navigate large, busy hospital buildings to reach the right office, engaging with a professional sat behind a desk or bright sterile lighting as contributing to children and young people's lack of desire to engage: they are not "safe spaces". This was frequently represented in the interviews with children and young people who put a premium on "cosy", "clean" spaces, and the need for safe environments.

> *"Personally, I hate big lights. Bright lights... I prefer to have this, you know, just subtle light, subtle lighting. Cosy." "[The place should be] clean. I don't want to sound rude, but if it's a clean house, I feel welcomed.*

This inflexibility is reinforced by clinical models that prioritise standardised processes over relational engagement. As one practitioner described it:

> *"The structure isn't built around the model that is centering the needs of these children".*

They described how services and treatment tend to be protocol-driven and limited in the variability of what can be addressed (this has been discussed further in Section 5 - Challenges and Tensions). The rigid structures of statutory services were seen to re-traumatise or shut down engagement entirely:

> *"The clinical model—it's so hard to put a clinical model onto really bad things that happen in young people's lives. It's societal stuff. It's poverty, abuse, trauma. And we try to medicalise that, when really what's needed is understanding."*
>
> - Professional, National Professional Body for Mental Health Specialists, London

As previously discussed, participants also described how young people can be missed because they fail to fit into a neat diagnostic box or are unable to use the correct "buzz terms". Services are often set up to treat specific conditions, with the result that they block access to children and young people with additional needs. For instance, one professional reflected critically on a neurodevelopmental service that refused to assess children until they had first completed trauma therapy.

> *"That is just a chicken and egg problem you've created… it completely discriminates against a huge group of children."*
>
> - Clinical Psychologist, Youth Justice Service, London

Another described mental health services that would not work with children and young people who were using substances, which is often an explicit exclusion criteria.
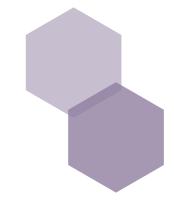
> *"One of our biggest barriers is substance misuse, because often complex trauma that leads to mental health issues gets hidden behind substance misuse issues and a lot of our services aren't set up for a dual diagnostic approach…if you come to CAMHS under the influence you get thrown out of CAMHS…"*
>
> -Professional, CAMHS, East Midlands

Young people with overlapping needs often require sustained, adaptable engagement, yet participants described how many services are not equipped or commissioned to provide this. Instead, they operate within narrow frameworks that can exclude those who do not fit into neat categories. These systemic limitations were thought to undermine the principles of trauma-informed and person-centred care, which emphasise safety, trust, collaboration, and responsiveness to individual experience. When services fail to embody these principles, they miss opportunities for intervention and risk reinforcing disconnection

4.1.4 Barriers to retention

- Relational trust is central to continued engagement and must precede formal therapy.
- Rigid, protocol-driven services often fail to meet young people where they are, which may impact retention.
- Poor communication, unmet expectations, and lack of follow-up can contribute to early dropout and disillusionment.
- When basic needs and home environments are unstable, mental health support is often inaccessible or ineffective.
- Families - particularly parents and caregivers - can be either bridges or barriers to continued engagement.

Even when young people make it through the door of a mental health service, there is no guarantee that they will continue to access it. National data reveal significant variation in non-consensual dropout from mental health services, with children nearly four times more likely to drop out depending on which service they attend and two-and-a-half times more likely depending on the practitioner they see (Edbrooke-Childs et al., 2023). These differences were not explained by levels of deprivation or young people's presenting problems, suggesting that service- and practitioner-level factors, such as therapeutic approach, flexibility, or relational dynamics, play a key role in shaping retention (Ibid). Our qualitative findings echoed this, highlighting how relational practice and adaptability to young people's lives are important factors in continued engagement.

Trusting relationships

Professionals spoke passionately about the importance of trust, safety, and human connection in enabling continued engagement. But they also described a system that undermines these foundations by prioritising protocols over people, and compliance over care. Professionals noted that young people, especially those with experience of trauma or violence, will find it hard to continue to access services unless they feel safe, respected, and understood.

> *"Someone who has a trusted adult relationship, that young person is more likely to be able to open up and to discuss what's going on for them than someone who's not got those strong attachments. I think that's consistent across the board for all of the young people we work with."*
>
> –Professional, Youth Justice Service, North West

In section 4.1.2, we described the need for accommodating defense mechanisms, including hypervigilance and guardedness. These were thought to be significant considerations for retention as well as initial engagement. In order to keep children and young people open to treatment, professionals described the need for slow, relational work, sometimes away from clinical settings. Work like this, which requires time, flexibility and presence, was described as increasingly hard to deliver within overstretched statutory services. Practitioners spoke of the importance of informal relationship building, and "soft" approaches such as playing pool, taking walks, or going for a milkshake. These activities create a sense of safety and trust and that must precede formal therapy:
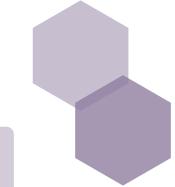
> *"All the work that has to be done before [accessing mental health support] … maybe just attending a session with just going out and having a coffee or a shake, or McDonald's… eventually leads up to those young people building confidence."*
>
> –Professional, NGO, London

This work was described as necessary "pre-therapy," but one that was often invisible and undervalued. This relational scaffolding was thought to provide young people with a view of adults as consistent, patient, and genuinely interested, not just in managing risk, but in who they are.

> *"All these different soft approaches eventually lead up to those young people building confidence, trusting that I've got your best interest at heart, and I'm not going to refer you somewhere if I think you're not ready."*
>
> –Professional, NGO, London

This need for a relational approach was echoed by parents:

> *"[What I think would make my son feel more comfortable] is a small, soft intervention, something like therapy, but that doesn't feel like therapy."*
>
> –Parent, London

Practitioners emphasised the importance of working flexibly, offering sessions in familiar or informal settings and accommodating missed appointments. One participant described the benefit of emotional wellbeing workers who "have the remit. There's no cut-off date as such". This contrasts with more time-limited services, particularly CAMHS and statutory settings, where there is limited time to establish rapport.

Many professionals described young people relying heavily on "instincts" or gut feelings to assess whether a practitioner was trustworthy or safe. Subtle dynamics like body language, tone, and perceived similarity, can be crucial. It was noted that power dynamics also played a significant role. Young people are often wary of hierarchies, where they may feel judged or controlled, participants highlighted. Several professionals described the importance of levelling the dynamic and offering young people ownership over the process:

> *"It'll be like pulling teeth with kids that aren't really aware why they're there... it's a different sort of experience. For some of them, it's a bit of work to get their head around it, that they're some sort of equal partner in this... the counsellor's role is trying to level that up with somebody that's not had that. It's a skill."*
>
> –Professional, National Professional Body for Mental Health Specialists, London

This theme of trust and relationship-building was not just about increasing retention; trusting, consistent relationships were seen as a core mechanism of the therapeutic process itself.

> *"Some of these kids have never had a chance to sit down with someone and just be asked, 'What's going on in your life? What do you hope for?'... It's the first time they can tell their story."*
>
> –Professional, National Professional Body for Mental Health Specialists, London

It was clear from the qualitative data that the critical role of trusted adults outside the family can take many forms: youth workers, teachers, mentors, community leaders, who can help bridge the gap between young people and services.

> *"Sometimes the person who makes the difference isn't a psychologist or a GP. It's a youth worker who says, 'I'll come with you to the first appointment.'"*
>
> – Professional, NGO, London

Participants also expressed concern that this kind of relational, local support work is often undervalued or underfunded. It can also be threatened by constant disruptions due to service transitions, as highlighted by Gondek et al. (2017). Where it exists, it can transform a young person's willingness to engage with mental health services; where it doesn't, services may see low retention, or lack of engagement, even when support is consistently offered.

Many participants highlighted the value of professionals who "show up", especially when young people push boundaries or test commitment. This persistence was seen as essential to overcoming what one described as "professional fatigue" in young people who have experienced repeated abandonment:

> *"You've almost got to get past that, where they're just testing how far they can push it... and that you're still going to be there to support."*
>
> –Professional, CYP Health and Justice, West Midlands

This underscores the value of relational continuity for continued access, where services work collaboratively with community figures that young people already know and trust. However, professionals also underscored the need for balance between this relational continuity and the maintenance of professional boundaries. Trust did not mean abandoning structure, but rather being honest, consistent, and clear about what could be offered. Some spoke about the pressure they felt to "be everything" for young people who had few trusted adults in their lives. One noted:

> *"They'll come and they'll want it from you, because they're comfortable and they trust that... but I'm not a counsellor. I have knowledge. I have a way of talking, but that's not what they always need."*
>
> –Professional, NGO, London

Many professionals described the need for models of support rooted in flexible, trauma-informed, and relational approaches. Several gave examples of early engagement strategies or rapport-building designed to proactively engage young people and "meet them where they're at". They stressed that the importance of trust and trusting relationships cannot be overstated: not a "nice to have", but a necessary foundation for continued engagement in mental health support. This is a theme constantly reiterated in the literature; interpersonal disconnection has been found to be a significant factor in premature dropout (Buckingham et al., 2016); and children and young people have repeatedly identified relational failures, and feelings of being misunderstood and disrespected by providers, as reasons for treatment discontinuation (Buckingham et al., 2016; Constantino et al., 2010; Garcia & Weisz, 2002).

Ongoing communication barriers

Even when a young person does meet the threshold for a service and is offered an appointment, participants discussed how there are often deeper issues of mistrust, trauma, or miscommunication that prevent continued access. One participant gave the example of a young person who had experienced a significant trauma:

> *"He turned up back at CAMHS's door after his cousin was murdered. Distress response, grief response. He declined support at the assessment, he said, 'I don't want to talk about this. I don't want to talk about my experience with you guys, what are you trying to do'... And also multiple neurodiversity diagnoses were talked about in that assessment as well, which were also quite challenging for him to hear."*
>
> –Professional, Youth Justice CAMHS, London

Although the clinical assessment may have followed correct procedures, the interaction failed to resonate with the young person's needs at that time. As the professional noted, "what I think it was, was a really poor translation of what was going on and his understanding of what was happening." This is backed up by the wider literature; in the context of Youth Offending Teams, for instance, young people typically saw the process as one to be tolerated, rather than as a source of potential support (King et al., 2014).

Communication emerged as a critical element in continued access, both in terms of how services explain their roles and processes, and in how they manage boundaries and expectations. Professionals described instances where a young person might technically meet the criteria for a service, but never receive the treatment they expected. In these cases, young people may interpret lack of follow-up as evidence of rejection. They may think that services are either not for them or simply not trustworthy. Several professionals reflected that young people often have little idea what therapy actually is, or what to expect. This could be due to a lack of time invested in helping to explain to young people what to expect, and may be exacerbated by often uninformative website signposting by organisations, which is something we noticed during our service mapping exercise. Often it was challenging to understand exactly what was on offer and what it entailed, with confusing and contradictory language a recurring theme as well as repetitive and fragmented programme descriptions and a lack of clarity around programme duration. Without clear, accessible explanations, young people may disengage quickly if the experience doesn't feel relevant, helpful, or emotionally safe.

> *"They don't know what's going to happen. No one tells them. Then they get into a room with a stranger and are expected to open up. Of course they're going to shut down."*
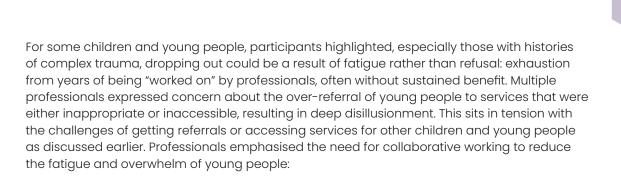>
> –Professional, CAMHS, East Midlands

Moreover, while some young people were increasingly familiar with the language of mental health, their expectations of what support involves were not always aligned with service realities. This was seen to lead to disappointment, confusion, and withdrawal when the support offered failed to match the young person's imagined experience of therapy. Professionals often attempted to bridge this gap by explaining the structure and purpose of different services, but acknowledged the difficulty of this work in the face of deep-rooted scepticism or previous negative experiences:

> *"Every professional is different, and I do try to explain that to young people. I explain to them that it's not always what you see or how you think... But it's a difficult one. It's a difficult one because some young people just fly into it, because they're so desperate they need something."*
>
> –Professional, NGO, London

Another barrier to retention, described by participants, was the expectation that young people repeatedly recount their experiences across different services and professionals. For some, professionals noted, this process can be retraumatising; for others, it's simply tiresome or meaningless when met with no visible change, and can contribute to professional overload.

> *"Some young people have never had the opportunity to tell their stories, and others repeat, repeat and repeat."*
>
> –Professional, National Professional Body for Mental Health Specialists, London

For some children and young people, participants highlighted, especially those with histories of complex trauma, dropping out could be a result of fatigue rather than refusal: exhaustion from years of being "worked on" by professionals, often without sustained benefit. Multiple professionals expressed concern about the over-referral of young people to services that were either inappropriate or inaccessible, resulting in deep disillusionment. This sits in tension with the challenges of getting referrals or accessing services for other children and young people as discussed earlier. Professionals emphasised the need for collaborative working to reduce the fatigue and overwhelm of young people:

> *"They've been referred to every man and his dog, and they feel that nobody's actually done anything to help them... So what's the point? ...Let's collaborate and share [information], rather than expecting them to keep repeating their story... it's about giving people the option of what they do, what they say, what they share, rather than forcing people through services."*
>
> –Professional, CYP Health and Justice, West Midlands

The absence of spaces where children and young people feel genuinely "heard" was also discussed as a barrier to initial and sustained engagement. While some young people may appear to resist help, others are asking, but are not being heard. One practitioner recalled a young person who had requested anger management support for over a year, only for this request to go unmet:

> *"He goes, I want help with my anger management... I've been saying it for over a year... Now, why's it taking so long? So I'm pushing. He's asking for anger management. That means he's ready."*
>
> –Professional, NGO, London

A strong theme across the data was that "disengagement" is often treated as a problem located within the young person, rather than as a reflection of service failure. Services discharge young people for missing appointments or "not engaging," without asking what could have been done differently to support them. Some professionals highlighted that there was a need to move away from this individualising line of thinking:

> *"I think we're really moving away from that hard-to-reach young person idea, but moving to this hard to access service idea"*
>
> –Professional, Youth Justice CAMHS, London

This issue was seen to be compounded by poor communication and weak feedback loops. Some participants described how young people are often not given a second chance, and professionals who made the initial referral may not be told why the service discharged them. This lack of reflection reinforces a revolving door dynamic where young people cycle through services without ever being truly "held".

Ultimately, the qualitative data suggests a significant misalignment between the services delivering mental health support and the lived experiences, expectations, and readiness of the young people engaging with them. Even when initial access barriers are overcome, the journey toward the 'right' (effective) support is far from guaranteed. Professionals called for a fundamental rethinking of how services understand and respond to disengagement, not as non-compliance, but as an opportunity to adapt, reconnect, and learn.

Home environment

Participants stated that many children and young people involved in or at risk of serious youth violence often face multiple, overlapping challenges, including unstable housing, family dysfunction, frequent placement moves, unmet basic needs, and histories of abuse or neglect. It was emphasised that, without stability, consistent adult relationships, and basic provisions such as food and safety, therapy may be inappropriate or ineffective:

> *"How do you provide that [therapeutic] need when the very, very basic needs are not being met? …When you're trying to provide it and they go back home to something that's very, very chaotic, they're not getting fed, they're not getting looked after. They may be suffering neglect and abuse."*
>
> –Professional, Youth Justice Board, Wales

Several participants commented on the difficulty of sustaining engagement due to frequent changes in address, phone numbers, or care placements, particularly for Looked After Children. This was highlighted despite many areas having dedicated pathways into CAMHS for children in care (Mannes et al., 2024) and a statutory duty to assess a child's mental health needs when they enter care, as part of their overall health assessment (Department for Education & Department of Health 2022). The transient nature of many children and young people made continuity of care difficult and sometimes meant that, by the time a young person was ready or able to engage, the service offer had already lapsed:

> *"Once they are offered a service, how chaotic their lives are – situations have moved on from the point where they were willing to accept a service… and so I think that's really where it breaks down."*
>
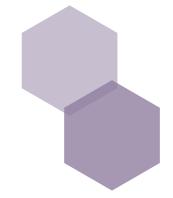> –Professional, CYP Health and Justice, West Midlands

Maslow's "hierarchy of needs" was frequently invoked to underscore the importance of addressing fundamental necessities in order to sustain engagement. Participants viewed this as an essential step before expecting young people to engage in deeper emotional processing. As one participant put it:

> *"They need to have food, warmth, shelter. They need to feel safe before they can move forward into what's going on for them and why they're at risk of anti-social behaviour, why they're at risk of involvement in the criminal justice system, why they're carrying knives"*
>
> –Professional, Youth Court / NGO, South West

The home environment was also described as having a direct influence on whether therapeutic interventions could be sustained. One practitioner noted that even well-designed interventions can be undone if the child returns to an unsupportive or harmful family situation:

> *"It doesn't matter how much work you're doing on these 16, 17, 18-year-olds, if they're going back home into those same environments, they're kind of undoing the work that's being done… consciously or unconsciously."*
>
> –Professional, NGO, London

Participants highlighted how in many cases parents and caregivers are worried about their children and want to help them, but are suspicious of mental health services. However, many of participants also made it plain that there are times when parents, carers or families actively work against the young person's best interests. Interfamilial relationships are complex and the home environment can itself be a factor in the young person's need for support.

> *"A lot of the kids we work with… there's normally abuse or neglect at home."*
>
> –Professional, NHS Vanguard, West Midlands

Parents' apparently positive approaches to mental health services were also seen to come with diverse motivations. A few professionals suspected that some parents might primarily use diagnoses (of e.g. autism, ADHD) to access financial or educational support, i.e. as a "meal ticket" rather than because the diagnosis is inherently valuable. While this perspective was raised by some professionals, it is important to situate it within a broader context: where families do seek diagnoses in order to access financial or educational support, this may reflect wider systemic issues, including the inadequacy of support available to families experiencing income insecurity. Other participants suggested parental service engagement might be a coping mechanism, as a way to explain a child's behaviour, and sometimes as a way to deflect from a parent's own behaviour;

> *"A lot of the young people that engage in our services, the referrals come from their parents, or usually the mum. One of the patterns that I've realised is every time a mum says, 'Oh, my child is this, my child is that, my child needs to speak to somebody. When we start engaging with the child, a lot of the problem is the mum".*
>
> –Professional, NGO, London

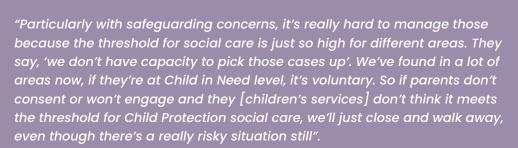> *"There's an awful lot of that…constantly looking for badges to justify their child's behaviour. And actually, in quite a lot of cases…it's the parents that need bloody counselling, not the kids"*
>
> –Professional, NGO, South East

Defense strategies such as hypervigilance can be understandable as responses to traumatic or abusive difficult home environments. The findings above correspond with the views of previous research that "treatment plans and programs stressing 'overcoming', 'healing', 'recovery,' eliminating hypervigilance and hyperreactivity', and talking about past traumas may appear out of touch, antithetical, or, even dangerous to youths and parents/caregivers focused on surviving persistent threats" (Kagan et al., 2023).

Children and young people, as well as parents and caregivers, may put little value on projects of "stabilization", when family members are "in danger or when youths are experiencing on-going abuse, violence, or neglect. Hypervigilance and hyperreactivity may be essential for surviving familial or community violence, and 'recovery' may seem like a fantasy when a community or society has been overtly or covertly persecuting, discriminating against, or oppressing a youth's family for generations." (Kagan et al., 2023).

Family dynamics, particularly parental engagement, figured as another key consideration in continued service engagement for children and young people. Some participants described local authorities closing cases because parents would not consent to voluntary interventions, even when professionals had serious safeguarding concerns (this relates to widespread parental mistrust of services, described above in section 4.1.2).

> *"Particularly with safeguarding concerns, it's really hard to manage those because the threshold for social care is just so high for different areas. They say, 'we don't have capacity to pick those cases up'. We've found in a lot of areas now, if they're at Child in Need level, it's voluntary. So if parents don't consent or won't engage and they [children's services] don't think it meets the threshold for Child Protection social care, we'll just close and walk away, even though there's a really risky situation still".*
>
> –Professional, Forensic CAMHS, East Midlands

While some services incorporated a small proportion of work with caregivers, others felt a more holistic and family-centred approach was essential, especially when parents themselves were struggling or resistant:

> *"There are families where it's not that the kids weren't engaged, it's that the family itself is too chaotic and maybe distrustful of services."*
>
> –Professional, NGO, South West

> *"If I'm doing work with a young person where they have parents that are impeding a lot of the work… I'll try to get the team to kind of support the parent whilst I do work with the young person."*
>
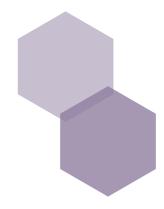> –Professional, NHS Vanguard, West Midlands

Crucially, this person-centred approach extended to the whole family system. Many professionals stressed that focusing solely on the young person without acknowledging the family and home environment risked undermining progress and retention. Some services incorporated family work as part of their core offer, while others partnered with family-focused teams or used peer-led approaches to support parents.

> *"We need to be working on families… there needs to be a holistic approach, to both the parents, the caregivers and the children."*
>
> –Professional, NHS Vanguard, West Midlands

> *"[We] incorporate parents in our work… A good kind of healthy ratio would probably be 80% with the child and 20% with the parent… but if I'm doing work and the parent's needs are impeding it, I'll try to get additional support in place."*
>
> –Professional, NHS Vanguard, West Midlands

Not only was there a call for wider education of parental rights and responsibilities, direct relationship-building with parents and families was also thought to be beneficial to facilitate trust and ongoing engagement.

> *"We had to get the right adult, not just for the child, but also for Dad...*
> *he lacked trust in professionals."*
>
> -Professional, Care prevention team, West Midlands

Several interviewees described how culturally competent, community based models could play a vital role in bridging the gap between statutory services and potentially mistrustful families. One participant highlighted a parent peer-support initiative designed to reach families dealing with serious youth violence:

> *"It's more about providing a parent peer-to-peer opportunity... Our parents*
> *who would have gone through a level of lived experience in terms of having*
> *their young people caught up in some level of criminality... then provide*
> *support to other parents... whatever the young person was going through*
> *would also affect the wider family. However, [the family] wouldn't have*
> *received as much support."*
>
> -Professional, NGO, London

These models were seen as crucial for creating trust and shared understanding, particularly where cultural stigma or unfamiliarity with mainstream services created barriers to continuing access. However, even when parents are motivated, professionals described how support is often unavailable, inaccessible, or inappropriate.

What is missing, professionals argued, is a more sustained, inclusive, and non-judgmental approach to family engagement, one that sees parents not just as part of the problem or solution, but as individuals with their own histories, traumas, and support needs. This aligns with research from Kagan et al (2023) who highlighted the importance of relational engagement with parents and caregivers given that "youth and family treatment outcomes are more likely to succeed when therapy can address couples' relational distress, caregiver social isolation and therapeutic attunement to the realistic parental stress levels for families coping with chronic adversity" (Kagan et al. 2023).

The involvement of parents and caregivers requires a subtle approach, which takes into account how their hopes and emotional reactions can conflict with those of the young people. This tension, between children and young people and their caregivers has been emphasised in other studies: "Despite the fact that carers were in general supportive and their involvement was sought after by children/young people, they also tended to be described as overly intrusive by service users, leaving them feeling excluded from playing a central role in their treatment (Gondek et al., 2017). Parents and caregivers tend to feel excluded if they do not receive information about their child's treatment, whereas young people may be less likely to share their full experiences in their presence. So it is important for professionals "to pay close attention to the delicate balance between service users' autonomy and parental involvement whilst reassuring service users about confidentiality of the information they share." (Ibid).

4.2 Systemic underpinnings

Throughout our interviews, professionals repeatedly emphasised that the barriers described above are, at least in part, the result of political decision-making, cultural norms and institutional design. In this section, we explore the systemic landscape as a whole, and how the system can create or compound access and engagement challenges. This is broken down into three sections:

- **Funding and commissioning:** Professionals expressed concern about the funding cuts that have resulted from austerity, and commissioning decisions that fail to engage with the material reality of the services and their users.

- **Structural challenges:** Those we spoke to connected these financial concerns to a fragmentation in the mental healthcare system, and to the lack of joined-up working. There were a number of discussions about the importance of multi-disciplinary and multi-agency working.

- **Inequitable systems:** Structural inequities around race, class, gender, neurodiversity, and trauma were seen to be baked into how services are commissioned, delivered, and evaluated.
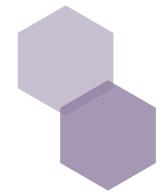
4.2.1 Funding and commissioning

- Chronic underfunding, exacerbated by austerity, is a central barrier to sustained, equitable, and effective mental health support.

- Fragmented and short-term funding models create instability, duplication, and inequity.

- Commissioning decisions are often disconnected from frontline realities and exclude those delivering services.

- The 'missing middle' is structurally produced through funding criteria and thresholds.

- Funding structures reinforce geographic inequity, creating a postcode lottery of care.

Lack of funding and resources

Lack of funding and resources was seen to be a major barrier to providing comprehensive and quality mental health support to children and young people at risk of serious youth violence. According to participants, the lack of funding meant services and professionals are often overstretched and unable to dedicate time to building relationships with young people and to reduce waiting lists. This was thought to be true across various sectors including CAMHS, education and voluntary and community sector organisations. Even for specialist services, focused on working with young people in the youth justice system, there was a lack of resources, which led to some cases necessarily being prioritised over others.

> *"We have to target all of our resources to statutory, because it's so busy. So we see most of these children who are on orders, it could be three months, nine months. We miss a lot of the children that are on out of court orders who actually might be looking to divert. You have to use a liaison team for that. I don't have enough resource to put a full-time clinician over there, because I'm focused on statutory… we're missing children even at the access point of youth justice, because there's not enough resource to make change."*
>
> –Professional, Youth Justice CAMHS, London

This was also reflected in research by the Children and Young People's Centre for Justice (CYCJ, 2020). This phenomenon was seen to intersect with the rigid thresholds and eligibility criteria, described previously. These eligibility criteria, often imposed by the commissioning body, can exclude young people whose needs are too complex for lower-tier services or insufficiently severe for specialist intervention. This results in the "missing middle" (described in section 4.1.3):

> *"...We've got criteria for our counselling, which was created by the commissioning body, and that supports mild to moderate needs for children and young people. CAMHS support severe [needs]. So between moderate and severe, there's a gap, and there's no provider who's providing support in that gap... Our counselling criteria says that we can support children and young people who are suicidal, who have suicidal ideation but no intent, and CAMHS will only support children and young people who have intent—real intent. So there's young people... that aren't supported by the service technically."*
>
> –Professional, NGO, South East

From this, it may seem that children and young people who are eligible for support are receiving the right support, but this isn't necessarily the case. Lack of funding was seen to prevent specialist services from being able to fully embed the flexible, multidisciplinary models that they were centered on:

> *"CAMHS provision in terms of youth justice, because we work with more complex children, is still extremely limited. We've got a CAMHS officer one day a week. That CAMHS officer is really squeezed. But CAMHS services are squeezed across the board, and I think it is about how we create enough resources to be able to advise those other practitioners where children are underneath that threshold: for that practitioner to assist those children that are not able perhaps to get to a clinic."*
>
> –Professional, Youth Justice Service, Wales

The lack of available and adequate funding was linked, by numerous professionals, to national austerity measures and government cuts in spending.

> *"I think the system of austerity, of government cuts for the last 15 years, has meant that those hardest hit areas of the country are not being reached for mental health services, or for any services. All the crisis intervention services are reacting to higher levels of need and higher thresholds, and actually those young people that are needing the early intervention, prevention and diversion, they are getting missed because there isn't any investment"*
>
> –Professional, NGO / Youth Court, South West

Funding cuts and austerity were referenced not only in relation to specialist mental health services, but in relation to all services supporting at-risk children and young people.

> *"We've been through a period of much reduced public funding, some would classify as austerity, where it's really squeezed, not only mental health service, but all manner of other services, which are the safety net and the fabric of a functioning society and safe society. Those additional services just haven't been there or been at the same scale to look after the children at the same level, and to keep those needs in check, prevent the needs from arising in the first place".*
>
> –Professional, Youth Justice Service, East Midlands

Some of the 'lower level' services highlighted as particularly important for early intervention were youth clubs and youth workers, but professionals noted how there are far fewer available youth clubs now compared to in previous years. The importance of youth work, youth hubs and similar spaces in providing this support has been emphasised in other research. In one study, a professional reported the views of the young boys of BAME background, who she worked with in prison. "All the boys I see tell me that things declined in their neighbourhoods when the youth clubs were shut down; they had nowhere to go and were increasingly exploited by older young men in the area to sell drugs" (Gwata et al., 2024). The austerity-induced closure of youth clubs is indicatively connected to affected children and young people being 14% being more likely to engage in criminal activity (Institute for Fiscal Studies, 2025). Similarly, Youth Justice Services were thought to be suffering from cuts, as were wellbeing services in schools and colleges.

Interestingly, some participants based in Wales felt that their services had been less affected by funding cuts. They referenced this, along with having less densely populated cities, as one of the reasons why youth violence tends to be less serious in nature in Wales compared to England:

> *"I think maybe Wales has been protected from some of those cuts, compared to England, because of the difference in the devolved government"*
>
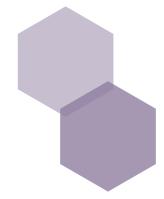> –Professional, Youth Justice Service, Wales

Funding deficits and fragmented care

Professionals from both statutory services and voluntary and community sector organisations talked about how funding deficits led to services and specific projects being put on hold, or stopped altogether. This was seen to contribute to disjointed and fragmented care. It also contributes to the confusion about referral routes, particularly in the voluntary and community sector, due to organisations constantly closing or changing their provision, as described by an NGO worker:

> *"Because of the funding situation, because we don't know if we can carry on beyond March, we're not taking new referrals at the moment for that main service, but as and when we secure any further funding, we will open that back up"*
>
> –Professional, NGO, Yorkshire & The Humber

Professionals talked about how, in some areas, services were brought in-house only to collapse due to funding instability. One practitioner described how a CAMHS service for justice-involved young people was lost when the youth justice service in that area went bankrupt, leaving children with no specialist pathway and year-long waits for universal provision.

A lack of funding was also referenced in relation to a retention crisis in the workforce. Professionals noted that salaries were low, especially in youth work and education, including specialist education such as PRUs, with one commenting that "you can make the same stacking shelves in Asda, without the stress." They also described how underfunding, and the resulting inability to offer quality support, contributed to a sense of disillusionment.

Overall, providers described a system where need outstrips capacity, where services are forced to compete for inadequate pots of money, and where innovation and community led approaches are frequently undervalued and underfunded.

> *"We're talking about people's mental health, we're talking about our future. We're talking about children. Cash shouldn't even play a story in this. But unfortunately, it does."*
>
> –Professional, Youth Justice Service, North East

Chronic underfunding, compounded by years of austerity, was described as a central barrier to delivering consistent, timely, and meaningful mental health support to children and young people at risk of serious youth violence. Funding constraints shape every aspect of service provision: from who gets seen to how long they wait, to the kind of support they receive. It was highlighted that current levels of funding are failing to keep pace with the growing prevalence of poor mental health among young people. Overstretched teams, short-term projects, and workforce burnout are not isolated issues, but consequences of a broader system that lacks the capacity to meet the scale and complexity of need. Critically, the pressure to prioritise statutory cases, the loss of preventive services, and the instability of grassroots provision all impact opportunities for early intervention, and for building lasting relationships with young people. This view was widely shared in the interviews, and appears regularly in the literature (e.g. Gondek et al., 2017).

Funding decisions

A clear message from practitioners was that commissioning decisions, often invisible in frontline practice, have enormous consequences for who gets support, where, when, and how. The people we spoke to described a complex and often fragmented landscape in which funding decisions were perceived as opaque, inconsistent, and disconnected from frontline realities. These dynamics created significant barriers to sustainable and equitable service delivery.

There was a recurring frustration around the disconnect between decision-makers and practitioners delivering services. Many felt that vital clinical and community expertise was excluded from the commissioning process. While this perspective was widely expressed by practitioners, we did not interview commissioners as part of this study, so were unable to explore this from their point of view. As one service lead put it:

> *"The decisions get made in rooms without us in… the people making the decisions often don't get to the root of the problem."*
>
> –Professional, Youth Justice and PRU CAMHS, London

This lack of inclusion not only eroded trust but also contributed to what was perceived as misaligned priorities.

Several participants also reflected on the fragmentation caused by multiple commissioning bodies, including ICBs, local authorities, and NHS trusts. In theory, responsibility for children and young people's mental health services is shared: Integrated Care Boards (ICBs) commission

most NHS-funded provision including CAMHS; local authorities oversee public health, social care, and education-related support; NHS England commissions specialist inpatient and secure services (Health Services Safety Investigations Body 2024). Schools also play a key delivery role, often hosting support commissioned through joint arrangements between health and education bodies such as Mental Health Support Teams in addition to pastoral care and Special Educational Needs Coordinators (SENCOs). The philanthropic and voluntary and community sector are also playing an increasingly large role (Large et al. 2024)

In practice, the landscape of child and adolescent mental health provision in England is fragmented and often inconsistently applied across local areas. Participants highlighted that these arrangements create ambiguity over responsibility, particularly for vulnerable groups with multiple needs, and make it difficult to hold services accountable. "Who has the levers to say to the trust, 'You've got a responsibility for these children'?" one participant asked.

Some participants, including those working in specialist services such as Youth Justice CAMHS, were also frustrated at the way services with 'red flags' such as higher waiting lists would often be the ones to receive funding, leading to a decommissioning of important specialist services.

> *"We can make as good a business case as we want, but the money ends up going to the services with a year-long waiting list and a bunch of red flags, rather than the ones that are saying [they can have an impact]. It's a sad state of affairs, frankly."*
>
> -Professional, Youth Justice and PRU CAMHS, London

Funding decisions were seen to be tied to labelling or definition of services, particularly within statutory services. For example, one participant expressed deep frustration with the tiered system of mental health care, which they described as outdated and poorly matched to the real needs of young people. They called it "an archaic way of looking at things," describing the funding implications of their service being labelled as tier two despite handling tier three-level complexity.

> *"We do extended assessments, team formulations, and consultations. We match tier three. But we're seen as tier two. The language doesn't translate, and that means we don't get the funding or recognition...I can't say enough how much I hate being called a tier two team..."*
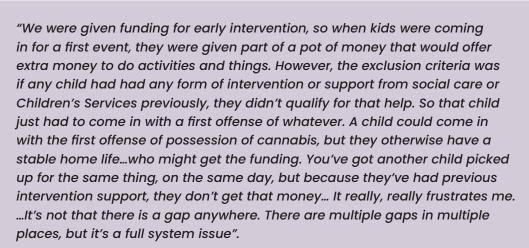>
> -Professional, Youth Justice CAMHS, London

The professional went on to state that although they recognised that the introduction of the Thive model was designed to address this issue by placing the child more firmly at the centre of care and decision-making, in reality, many services still operated within the Tier model.

> *"The problem is, every other model that's turned up after basically has to sort of adapt to meeting tiers. Even when I've seen i-Thrive implemented, it's basically just a proxy for Tiers"*
>
> -Professional, Youth Justice CAMHS, London

In this context, promising interventions can suffer from under-resourcing, limited scope, or short-term funding cycles, a view reflected by Hamilton and Richards (2024). Practitioners also expressed frustration about how ring-fenced funding pots and commissioning decisions based on certain criteria can create inequity in service provision for young people:

> *"We were given funding for early intervention, so when kids were coming in for a first event, they were given part of a pot of money that would offer extra money to do activities and things. However, the exclusion criteria was if any child had had any form of intervention or support from social care or Children's Services previously, they didn't qualify for that help. So that child just had to come in with a first offense of whatever. A child could come in with the first offense of possession of cannabis, but they otherwise have a stable home life…who might get the funding. You've got another child picked up for the same thing, on the same day, but because they've had previous intervention support, they don't get that money… It really, really frustrates me. …It's not that there is a gap anywhere. There are multiple gaps in multiple places, but it's a full system issue".*
>
> –Professional, Forensic CAMHS, East Midlands

This practitioner's concern about the exclusion of children with prior social care involvement is echoed by national evidence. A recent study found that children with current social work involvement are systematically more likely to be refused access to CAMHS compared to their peers, despite often facing greater need. Children on child protection plans are around twice as likely to be rejected, and those with general social work involvement are over three times as likely to be turned away (Mannes et al 2024). These findings point to potential structural inequities in how eligibility and commissioning criteria are applied, where previous involvement with support services may, in practice, become a barrier to access, reinforcing patterns of disadvantage.

The ring-fencing of funding for specific services and therapeutic provision was repeatedly referenced as a problem in the voluntary and community sector. Professionals highlighted how funding streams and opportunities were often misaligned with the needs of service users or the expertise of the sector, and that services would need to be adapted to meet funding criteria. In doing so, they felt their provision became less relevant to the young people in need of support:

> *"…We can say we're very successful at doing X, Y and Z. And funders go, that's great, come and apply for money because we're giving it for A, B and C. Well, that's not what we do…"*
>
> –Professional, NGO, North East

Participants in the voluntary and community sector also noted how they were often expected to pick up the work and fill the gaps from the lack of capacity in statutory services, without the relevant funding support. This highlighted how commissioning decisions are not matching the needs and expectations of services:

> *"Other services don't deliver so our sector will …help the local authority. We get so many referrals from the local authority, but we're not getting the funding at the minute."*
>
> –Professional, NGO, North East

The ring-fencing of funding was referenced as one of the reasons why there is a gap in service provision that leads to the "missing middle", given that in some circumstances it can dictate service thresholds. Some professionals described how they were restricted from providing

certain interventions, despite capacity, due to ring-fencing of funding. Organisations might find "work arounds", but they were not funded to do so. As such, children and young people were either unsupported or were held by other services – e.g. advice centres – without dedicated funding or appropriate clinical capacity:

> *"We're actively fundraising for that gap, because it's not funded. It's just not a funded service, and I think the commissioning needs to change to close the gap. They should have changed our counseling criteria, but they didn't. I think that's because they're trying to stem the flow of referrals coming into counseling because the service would be absolutely overwhelmed, but instead, there's just young people floating in an area of un-support."*
>
> –Professional, NGO, South East

These sorts of concerns were also raised by professionals in education. This was particularly the case for Alternative Provision, with one participant sharing how the reduced funding for PRUs in comparison with mainstream education for young people who needed extra support meant that they were frequently overburdened:
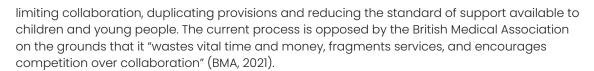
> *"We call ourselves the sixth emergency service, because we are the place where people come to if there's nothing else that's around or available…You have to be everything to everybody. And at some point we have to say, I'm sorry, but we're at our capacity now…we don't get any additional funding for students with EHCPS. We have a blanket funding stream. I've got a young person in my primary provision who, when he was in primary, was on a £45,000 EHCP. He was two to one, three to one support, at times. He comes to my PRU and I get £10,000 for his support. Now that doesn't mean he's any different within my environment, he still requires two to one, but our local authority won't give us the additional EHCP funding for anybody who comes into a PRU place".*
>
> –Professional, Pupil Referral Unit, North West

According to these professionals, funding structures and commissioning processes can create barriers that undermine equitable, sustained support for children and young people. When decisions about funding allocation are made without the involvement of those delivering services, they risk being detached from the realities of practice and misaligned with actual need. The dominance of short-term, ring-fenced, criteria-limited funding not only fragments service provision, but can actively exclude the young people most in need. Additionally, participants highlighted how these funding models often favour large, generalist providers over community-rooted organisations with local knowledge, making it harder for trusted, specialist services to survive or grow. In this context, service delivery is frequently driven more by what is fundable than what is effective, leaving professionals to absorb risk and responsibility without the necessary resources. These dynamics were seen to perpetuate gaps, particularly at the intersection of thresholds, and leave many young people unsupported.

Funding cycles

Funding cycles were seen to dictate the provision and availability of services. They were also seen to pit statutory services against each other, for pots of money, and to lead to a lack of sustainability in service provision, with programmes continually being commissioned and decommissioned. The tendering process in the NHS, in which services are required to bid for the same limited pot of funding was seen to result in services that have to act in competition,

limiting collaboration, duplicating provisions and reducing the standard of support available to children and young people. The current process is opposed by the British Medical Association on the grounds that it "wastes vital time and money, fragments services, and encourages competition over collaboration" (BMA, 2021).

Short-term commissioning cycles were seen to result in services being decommissioned just as they were gaining traction. These disruptions were thought to be particularly detrimental for specialist services with established community relationships or unique offers, such as services for neurodiverse young people or embedded youth justice teams.

Participants described how these commissioning and decommissioning cycles contribute to fragmentation, both for services commissioned by statutory bodies and for those in the voluntary and community sector. Specialist services are often temporary, meaning support is effectively withdrawn from children and young people, who are then required to turn elsewhere.

> *"The business cases I've tried to do in the past two years have gone nowhere. We did a two year pilot of a service, and had some very good data, frankly, but we're still not getting funding for a further two years, so the service gets decommissioned at the end of July. And that's because there's no new money.*
>
> –Professional, Youth Justice and PRU CAMHS, London

> *"...the challenge is for that individual, their issue hasn't come to an end, so it always comes down to having to look for the next thing".*
>
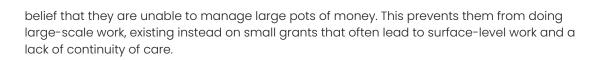> –Professional, NGO, London

The challenges around commissioning cycles were also raised by voluntary and community sector services. Smaller, community-embedded organisations, often closest to young people affected by violence, frequently struggled to secure meaningful funding. Participants from smaller grassroots organisations expressed frustration that, in their experience, commissioning structures favoured large, well-known organisations with little local contextual knowledge or understanding of the communities that they are serving.

> *"You've got some of the big boys that come in and get all the funding – I'm talking millions...And then the grassroots organisations struggle to get ten grand... That's the problem – it's how funds are allocated."*
>
> –Professional, NGO, London

This left many impactful organisations operating on short-term grants or pilot funding, unable to plan for the long term or build capacity. Several interviewees stressed that grassroots services were often the ones with trusted relationships and an intimate understanding of the community context, yet were systematically excluded from commissioning processes. This was thought to be due, in part, to funders and commissioners being unaware of these smaller organisations, and the challenges with identifying smaller organisations, particularly those without an online presence. This was validated by our mapping of voluntary and community sector organisations, given that it was often challenging to find information about smaller organisations and those with no online presence at all are likely to have been missed.

Moreover, participants highlighted how in their experience, funders are often unwilling to give substantial funding to grassroots organisations, including led by/for organisations, due to a

belief that they are unable to manage large pots of money. This prevents them from doing large-scale work, existing instead on small grants that often lead to surface-level work and a lack of continuity of care.

> *"They're too small to attract big funding and are stuck in the cycle of getting five grand here, five grand there…there's people doing great work out there, but they run very small operations, so the impact can't be scaled, it's not being scaled because they can't afford to scale it."*
>
> –Professional, NGO, London

Funding cycles were seen to act as a hidden but powerful force shaping young people's access to support. Short-term cycles, competitive commissioning processes, and a preference for larger organisations were cited as causing fragmentation across the system, undermining the continuity and sustainability of services. For children and young people, this means disrupted relationships, disappearing services, and a constant need to re-navigate a changing support landscape. For grassroots and community based providers, it means operating without security, recognition, or the resources needed to scale or sustain impact. If services are to meet the needs of young people facing multiple and compounding risks, commissioning models must shift to prioritise stability, local knowledge, and long-term investment in trusted, community-rooted care.
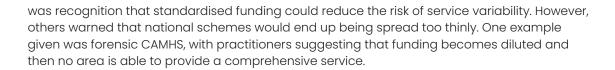
National vs devolved models

Many of the interviewees noted a tension between centralised models and locally devolved provisions. On the one hand, they highlighted how localised commissioning enabled tailored responses, building relationships, responding flexibly and shaping services to the unique needs of the area. This was referenced in relation to the need between different London boroughs, for example:

> *"…local leaders know the area, know the needs, and can provide a nuanced response."*
>
> –Professional, Youth Justice Service, London

On the other hand, however, participants noted that localisation also introduced geographical inequities, especially since funding in different areas often relied on the politics of local authorities, as well as the uneven capacity of local NHS services. In areas where services are under acute pressure, this was seen to contribute to the deprioritisation of children's mental health, reinforcing geographic disparities. This tallies with the geographic analysis of services emerging from our service mapping exercise. Several professionals described a "postcode lottery," where the type and quality of provisions varied between areas, with some councils offering more comprehensive provision. One example of this was the availability of mental health practitioners embedded within Youth Justice Services. One practitioner explained:

> *"We've got a holistic, one-stop shop, with mental health practitioners embedded in our team. In the next borough, they've got a nurse in YJS three days a week. There's a massive disparity."*
>
> –Professional, Youth Justice CAMHS, London

Participants compared localised approaches with centralised ones. Some saw potential, particularly in replicating successful local and regional models at a national level and there

was recognition that standardised funding could reduce the risk of service variability. However, others warned that national schemes would end up being spread too thinly. One example given was forensic CAMHS, with practitioners suggesting that funding becomes diluted and then no area is able to provide a comprehensive service.

> *"It [Forensic CAMHS] is spread so thinly it's barely present. It's such a small amount that actually I think it replicates more of the problem, which is you end up with a small resource and having to decant it into mainstream, and then you get the gaps problem, which is that there isn't anyone to work with these children"*
>
> –Professional, Youth Justice CAMHS, London

Some professionals suggested that funding should be made available to replicate successful models when they are identified. There was also widespread agreement that some form of national baseline was needed, but that this must be complemented by local flexibility and adequate funding:

> *"Maybe it's about having enough funding so that each area can have that embedded model. You have to start local... and then you can add the centralised element."*
>
> –Professional, Youth Justice and PRU CAMHS, London

It's important to note here that the unique position of Wales within a devolved UK system was also highlighted. One participant described the challenges of implementing centrally designed policies, particularly those developed in England, within a Welsh context where key services like education, health, and social care are devolved, but justice is not:

> *"We've got a kind of dual function in Wales... justice isn't devolved, but education, health, social services, and local authorities are. So we have to make sure things match and fit—otherwise central policies don't work here."*
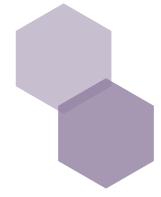>
> –Professional, Youth Justice CAMHS, Wales

They gave the example of the Turnaround funding programme from the Ministry of Justice, designed to address serious youth violence through early intervention. In Wales, where prevention funding and diversion pathways were already established through the Welsh Government, the programme's criteria were poorly aligned and difficult to implement:

> *"The criteria didn't fit... we already had prevention funding. So trying to get the criteria to fit was very, very difficult."*

This highlighted the importance of considering devolved contexts in national policy recommendations and funding decisions, particularly when these involve non-devolved areas like youth justice but rely on devolved services for delivery.

Ultimately, professionals emphasised the need for a balanced model, one that ensures a consistent baseline of provision across all regions, backed by equitable funding, while retaining the flexibility for local areas to design services that are responsive to their specific context. Without this balance, both over-centralisation and under-coordination risk reinforcing fragmentation and unequal access for children and young people.

4.2.2 Structural challenges in service design and delivery

- Effective multi-agency and multidisciplinary working is essential for continuity of care, but remains the exception, not the norm.

- Non-statutory services are increasingly relied upon to fill systemic gaps without adequate funding, support, or integration.

- Collaborative working is too often driven by personal relationships and professional goodwill, rather than system design.

- Current system structures, including short-term funding, high caseloads, and siloed commissioning, make truly trauma-informed care challenging.

- Professionals and young people with lived experience are often excluded from decision-making, despite being closest to the realities of need.

Lack of multi-agency and multidisciplinary working

One of the major criticisms of the system, highlighted by almost all of the professionals we spoke to, was a lack of multidisciplinary and multi-agency working. Several professionals spoke about how this hampered continuity of care, especially when young people transitioned between services. The lack of multidisciplinary and multi-agency working was considered a problem at both system and organisation level.
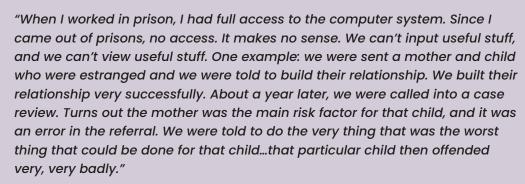
The transition period, where service users move from CAMHS to adult mental health services, can be especially fraught. Dunn notes that young people often feel estranged from services during this transition, which can lead to a significant decline in their engagement (Dunn, 2017). This estrangement is compounded by the pressure on individuals to take responsibility for their health care at a time when they are still navigating the complexities of adolescence. Such experiences can foster feelings of isolation and inadequacy, further traumatising young individuals who are already vulnerable (Dunn, 2017).

Practitioners described a system made up of parallel systems: health, education, justice, and social care. Each system, they highlighted, has its own referral criteria, access pathways, and digital infrastructure. Rather than shared data and decision-making, professionals are often required to "gain inputs" from multiple systems, navigating separate protocols and technologies, which results in disjointed and fragmented care for young people requiring holistic and cohesive support for intersecting needs.

> *"The NHS have a system. Education have a different system. Police have a different system… trying to get all the information together at the right time, for the right person is impossible."*
>
> -Professional, NHS Vanguard, West Midlands

Participants noted that mental health, education, youth justice, and social care often operate in silos, with poor information-sharing, conflicting thresholds, and misaligned priorities. This fragmentation, they said, creates confusion for young people and families and leads to duplication, missed opportunities, and neglect. As discussed in previous sections, the lack of ownership was seen to generate a "hot potato" effect, where young people are passed between services with no one agency taking full responsibility. The lack of joined-up working across agencies can lead to significant real-world consequences:

> *"When I worked in prison, I had full access to the computer system. Since I came out of prisons, no access. It makes no sense. We can't input useful stuff, and we can't view useful stuff. One example: we were sent a mother and child who were estranged and we were told to build their relationship. We built their relationship very successfully. About a year later, we were called into a case review. Turns out the mother was the main risk factor for that child, and it was an error in the referral. We were told to do the very thing that was the worst thing that could be done for that child…that particular child then offended very, very badly."*
>
> –Professional, NGO, South West

Professionals were not unaware of the difficulties of joint working. Among those discussed were: differing referral criteria, a lack of shared language or model, confidentiality concerns, competition between services for limited funding and a system culture that prioritises individual accountability over collective care. Discussions highlighted how these challenges are structural, not individual. They require leadership, resourcing, and time to overcome.

Within an organisation, multidisciplinary teams with embedded models of care were seen to be a significant asset. Services that had access to a range of professionals – youth workers, clinical and educational psychologists, speech and language therapists and occupational therapists, as just some examples – were able to meet the needs of young people coming into their service in a more streamlined manner. They were also able to reduce the feelings of professional fatigue in young people by limiting the number of interactions. In areas where youth justice CAMHS models had been locally embedded, practitioners described more holistic and flexible care. These models were often led by small, well-integrated specialist teams, providing a broader range of mental health support while also offering supervision and training to other services.
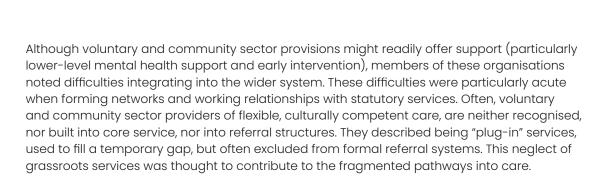
> *"What some services do is quite nice… they have a panel—clinical psychs, forensic psychs, ed psychs. A practitioner can bring a case and ask, 'What do you think?' It's not just about direct work, but reflective practice too."*
>
> –Professional, Youth Justice Board, London

Unfortunately, these teams appeared to be the exception rather than the norm, and their availability varied dramatically by area. In contrast, services without embedded multidisciplinary teams found it more difficult to get support for users, often having to refer through traditional routes and being subject to the same waiting-list and threshold challenges. For some services, this disparity was particularly stark where they had been funded for a multidisciplinary team and no longer had that funding, or vice versa.

> *"Not many Youth Justice Services have an in-house CAMHS practitioner on their team. So I think we're really fortunate… I've experienced it working in the youth justice and other authorities, where a barrier would be, you've identified these concerns, but then we've got to go to mainstream CAMHS, put them on the waiting list, and then they might get closed due to difficulties with engagement, whereas we've got that offer in-house where we're able to keep them open for longer and build relationships"*
>
> –Professional, Youth Justice Service, North West

Although voluntary and community sector provisions might readily offer support (particularly lower-level mental health support and early intervention), members of these organisations noted difficulties integrating into the wider system. These difficulties were particularly acute when forming networks and working relationships with statutory services. Often, voluntary and community sector providers of flexible, culturally competent care, are neither recognised, nor built into core service, nor into referral structures. They described being "plug-in" services, used to fill a temporary gap, but often excluded from formal referral systems. This neglect of grassroots services was thought to contribute to the fragmented pathways into care.

> "We're here. We're ready. But we don't get referrals from statutory services."
>
> –Professional, NGO, South West

Conversely, many statutory services, particularly Youth Justice Services, felt they had good relationships with voluntary and community sector organisations, the main challenge being that there weren't enough of them, or they suffered from the same demand and wait list issues as services like CAMHS.

Despite this lack of coordinated care, many practitioners found ways to form links with other professionals and services where necessary. However, this often relied on the personal networks of individuals within services, rather than being a mechanism of the system. In contrast to systemic rigidity, individual relationships and informal networks were described as helping practitioners "hold things together". Collaboration was seen to be driven by personal relationships, shared values, and workarounds rather than systemic integration. This relational mode of working was seen as essential for securing support for those whose needs fall between service boundaries.
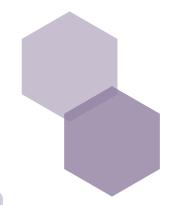
> "We have, thankfully, very good relationships with our colleagues in tier three and our CAMHS colleagues…We have a very supportive team, a very supportive consultant. I'm supervising a psychologist in tier three to work with a child I was going to see in youth justice. Tier three didn't want to see him… but because we were connected, we made it work…Being able to work with CAMHS as well as YJS means now we can bridge gaps."
>
> –Professional, Youth Justice CAMHS, London

While these efforts were praised, it was acknowledged that collaboration depended on individual initiative and goodwill rather than embedded processes and system support. Practitioners highlighted how their ability to "push" within the system, to challenge decisions, escalate cases, or advocate across service lines, was often what enabled young people to receive care. Some professionals described how their own specialist knowledge or lived experience helped them identify overlooked needs and advocate more effectively, especially for young people from marginalised backgrounds. This demonstrates the potential for collaborative, multidisciplinary working when it is underpinned by trust, shared space, and ongoing communication. Yet practitioners were also clear that these were exceptions rather than the rule. Models that were often reliant on specific local relationships and leadership, were highlighted as further contributing to a postcode lottery. It also suggests that these informal professional networks may be at risk of breaking down when staff leave certain positions.

> "There's a disparity even within our other colleagues. Some are embedded. Some are isolated. And it really changes what the young person gets."
>
> –Professional, Youth Justice CAMHS, London

Where multi-agency working does function well, professionals described better outcomes, more responsive care, and less burnout. Integrated teams, joint assessments, shared supervision, and co-location of services were cited as enabling relationship-based, flexible support.

> *"Having the psychologist in the youth offending team changed everything. Suddenly we weren't referring out – we were talking every day."*
>
> -Professional, Youth Justice Service, North West

Collaborative working was viewed as essential for managing complexity. As many participants noted, no single practitioner or agency can hold the risk, the history, and the nuance; multidisciplinary teams allow for shared thinking, collective care planning, and reduced pressure on single services. Consequently, many interviewees called for a systemic shift toward integrated and embedded models of care. They emphasised that integration must not come at the cost of flexibility or community connection; the hope was not to create a monolithic service, but to build networks that communicate and coordinate around the needs of young people to ensure services are truly person-centered and to reduce the numbers of professionals involved in young people's lives.

Multiagency working was thought to allow for shared thinking and to provide greater insight to professionals in those settings. For instance, police who work in multiagency settings are often seen to have "a much wider understanding of the health and social issues which are underpinning youth violence and exploitation in BAME communities." (Gwata et al., 2024). Ultimately, the most effective examples of multi-agency collaboration were seen to be relational, not structural, driven by practitioners who knew how to navigate the landscape, challenge gatekeeping, and piece together support where formal pathways had failed. While this demonstrates the ingenuity and commitment of many professionals, it also highlights the fragility of a system in which care depends more on who you know than what is in place.

Pressure on non-statutory services

There was seen to be mounting pressure on non-statutory services to fill gaps left by overstretched statutory provisions. Participants described a system where long waiting lists for specialist support, particularly CAMHS, left children and young people without adequate care during critical windows of need. In the absence of timely support, these young people often turned to trusted figures in their lives – youth workers, community practitioners and grassroots organisations, or teachers for help.

> *"More young people than ever are accessing our services since COVID, and they're having to wait weeks and months for mental health support… It's too long… what they were doing [in the meantime] was hanging on to their youth workers, or whoever was around them."*
>
> -Professional, NGO, London

Non-statutory organisations, particularly voluntary and community-based organisations, step in to fill these gaps, as previously discussed. However, several participants raised concerns about doing so without sufficient resources or funding. One provider spoke of the invisible burden of supporting young people with high levels of distress who don't meet the threshold for CAMHS, yet fall outside the scope of early intervention services. Their team does its best to support this cohort informally through advice centres and outreach, but this is unsustainable and puts emotional and professional strain on staff:

> *"We can provide support in that gap [between moderate and severe needs]... but we're not funded to... we're almost waiting... supporting them as well as we can, with no specific funding or real time to support them, until their mental health either gets worse enough to meet the CAMHS criteria, or we can work with them to bring them back down so they can achieve our counselling support criteria... which is odd."*
>
> –Professional, NGO, South East

The sense of professional isolation and risk was palpable in some interviews. One voluntary and community sector service provider spoke of the fear and helplessness that comes with holding safeguarding concerns for a young person, but not being able to secure support from statutory agencies:

> *"We've had lots of interaction with our so-called peers in statutory services where we're really worried about a young person and not got the backup... and actually been left thinking, 'Oh my God, this person is literally at risk for their life,' and I, as a professional, cannot access useful support."*
>
> –Professional, NGO, South West

In many areas, the lines of communication simply were not established; small organisations doing impactful work with marginalised communities were described as either invisible to statutory services or excluded from formal referral pathways.

> *"We've got the resources to help, we're in the community, but we're not on the map. So, people don't get to us."*
>
> –Professional, NGO, London
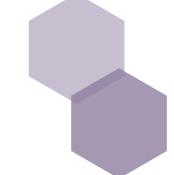
Non-statutory organisations also described challenges navigating fragmented systems, with providers stuck in complex and sometimes combative roles mediating between schools, parents, and children. This appeared to be particularly acute in academy settings where inconsistent engagement from schools was seen as compounding young people's struggles and placing additional strain on external services:

> *"Parents are up to here, not getting any response back... So our work is a lot harder in mediating between parents, school, young people, school, teachers. Who do we speak to? Who's the best person? Do they get a mentor? Oh, it's exhausting."*
>
> –Professional, NGO, London

Our findings highlighted that in the absence of integrated, adequately funded statutory provision, non-statutory services have become the safety net for many young people. These services are being asked to absorb risk, hold complex cases, and provide continuity of care without sufficient training, support, or financial backing. The result is not only strain on individual practitioners, but systemic instability and potential harm to the very young people they seek to support.

Whose voices are heard in service design, commissioning and delivery?

In earlier sections, we noted that decision-making power is seen to be concentrated at senior levels, often disconnected from those with direct, everyday experience of the needs on the ground. Professionals at the frontline are often thought to be best placed to know what is needed within provisions, yet they feel their insights are rarely sought in the planning and delivery of services. This sense of disconnection between leadership and frontline work was echoed by several professionals. Frontline staff, often those with the deepest understanding of young people's realities, felt their insights were sidelined. Another participant noted:

> *"If you're a service lead or a clinical lead you're probably going to get people to listen to you. I don't like to say it, but that's true."*
>
> -Professional, Youth Justice CAMHS, London

Practitioners also pointed to a gap in representation from those with lived experience, both in leadership roles and in the design and delivery of services. This resonates strongly with findings from the report by Williams et al. 2020. While some services had actively recruited lived-experience workers, this was not consistent across the system. Where it was present, it was seen as valuable:

> *"We have quite a number of lived-experience workers across our services, so people with a lived experience of the criminal justice system, which I think really helps."*
>
> -Professional, CYP Health and Justice, West Midlands

Beyond professionals, participants highlighted the absence of children and young people and their families in shaping care. Statutory services were described as heavily professionalised and process-driven, leaving little space for the voices of those at the centre of the system to be heard:

> *"Sometimes the family and children's voices aren't put across enough, because it's all professional views."*
>
> -Professional, Care prevention team, West Midlands

Practitioners stated the need for a system that listens: one where frontline insight is valued, where lived experience is embedded, where families and children are not just recipients but participants in shaping care, and where being heard – having a service be responsive to your needs – is the norm, not the exception. Service users will sometimes express concerns over "their capacity to be involved in decision-making during a crisis", but professionals can also "underestimate participants' capacity or willingness to participate in decision-making about their care" (Gondek et al., 2017).

Lack of trauma-informed care

While almost all practitioners highlighted that their work was "trauma-informed", a lack of trauma-informed care still emerged as a significant area in need of improvement. It was clear that, in practice, "trauma-informed care" can be hard to define and understand, and often requires different approaches depending on the context and the service.

> *"We've heard that word trauma-informed, trauma-identified practice, quite often over the past years, and agencies say 'yes, we're trauma-informed, we're this, we're that'. Sometimes defining what that actually means is an interesting conversation... they'll say, 'we've been on a course, we understand adverse childhood experiences... and we're empathetic to that and therefore we're trauma-informed'. But the next stage is all about well, how responsive are you? What do you do specifically around trauma? How far do you go down that line?"*
>
> –Professional, Pupil Referral Unit, Wales

When asked, many practitioners stated that a deeper understanding of trauma was an essential training need across all sectors working with at-risk children and young people, specifically among teachers and in educational institutions. An inability to understand trauma was seen to be one of the factors underpinning a view of young people as "naughty" rather than as in need of support, leading to the missed opportunities for early intervention discussed in Section 4.1.1.

> *"...there's a huge gap in understanding about that kind of awareness of trauma, in thinking about how we might identify these young people in the first place, how we might identify them as somebody who might need mental health support, rather than labelling them as a challenging young person"*
>
> –Professional, NHS Vanguard, West Midlands

Trauma-informed practice, as defined by the UK Government, is an approach to health and care that recognises the widespread impact of trauma on individuals and communities, aiming to create safe, culturally sensitive services that avoid re-traumatisation, foster trust, and support collaborative, empowering relationships between practitioners and service users. It recognises how "trauma exposure can impact an individual's neurological, biological, psychological and social development" (Office for Health Improvement and Disparities, 2022). It calls for services that are emotionally and physically safe, culturally competent, and built around relationships of trust and consistency (Griffiths et al., 2022; Sweeney et al., 2016). In practice, this means minimising the number of times a young person is required to retell traumatic experiences and reducing the number of professionals involved in their care. It also requires flexibility in delivery, recognising that traditional clinic-based models may feel inaccessible or alienating for young people, and a willingness to offer community-based or alternative therapeutic approaches where appropriate (Isobel et al., 2020).

Relationships and relationship-building are key parts of trauma-informed care. Nevertheless, participants described systems that actively inhibit this kind of work. They described how high caseloads, short-term funding, service fragmentation, and rigid commissioning models make it difficult, if not impossible, to offer consistent, relationship-based support. Staff turnover and service transitions were also referenced as disrupting relationships at key moments, with young people being passed from one worker to another, each time being asked to retell painful stories, rebuild trust, and re-explain their needs. These disruptions are not just frustrating, but re-traumatising, professionals highlighted. They can reinforce young people's sense that adults are unreliable, that systems can't be trusted, and that there's no point in opening up, because no one stays.

Even in services where trauma-informed training has been delivered, practitioners noted that this often resulted in surface-level awareness, rather than meaningful change. Training was sometimes reduced to one-off courses with limited follow-up or ongoing support. They

highlighted that there is a risk that trauma-informed care might become a label, rather than a practice. This is especially problematic given that meaningful trauma-informed care requires not just knowledge, but an ongoing commitment to relational working, cultural competence, and structural change.

Trauma-informed care must also attend to the intersection of trauma and culture. Participants and literature alike highlighted that many young people in this cohort are from Minority Ethnic or otherwise marginalised groups, and may have experienced or continue to experience racism, homophobia, religious discrimination, or socio-economic deprivation (Ranjbar, 2020). A culturally competent trauma-informed approach ensures services are accessible and meaningful across different social contexts, breaking down barriers linked to language, mistrust, or past institutional harm. Services that engage with the values, beliefs, and lived realities of young people and their families are better positioned to build trust and respond effectively (Williams et al., 2020).

Finally, trauma-informed care must also be gender-responsive. Gender differences in mental health needs often emerge in childhood and adolescence, and service responses should reflect this (Herrmann et al., 2024). Gender-responsive practice acknowledges how victimisation and offending patterns differ by gender and adapts interventions accordingly (Gila, 2023).

The range of barriers discussed in this report point to a system that is structurally intolerant to trauma-informed care. Long waiting lists, strict eligibility criteria, high thresholds, a lack of time and resources for relational working, clinical models of care, a lack of flexibility in service delivery and a lack of multidisciplinary and multi-agency working all fail to account for the fact that many young people exist in complex, chaotic and traumatic environments. They require services that understand, and are willing to acknowledge, and adapt to that.

4.2.3 Inequitable Systems

- Structural racism in mental healthcare reflects broader societal inequalities and contributes to mistrust, misdiagnosis, and exclusion.
- Services built around neurotypical, 'Western' norms fail to meet the needs of the most marginalised.
- Mental healthcare inequities cannot be solved through healthcare policy alone.
- Many barriers are intergenerational, rooted in histories of marginalisation, service failure, and institutional harm.
- Misplaced focus on individual pathology obscures the structural roots of harm.

Participants described a system that is unresponsive to the interests of the most marginalised. Structural inequities around race, class, gender, neurodiversity, and trauma were not seen to be incidental, but rather baked into how services are commissioned, delivered, and evaluated.

The theme of inequity and discrimination ran throughout the interviews, underpinning many of the barriers discussed throughout this report. Although not all participants spoke to this explicitly, those who did often had personal or professional experience working closely with minoritised communities and were often based in urban areas like London. They raised concerns about racism, classism, cultural exclusion, and the inflexibility of a mental health system rooted in Western, medicalised norms.

Structural racism and cultural exclusion

The patterns of misdiagnosis, delayed intervention, and behavioural mislabelling discussed earlier in the report in relation to racially minoritised children and young people do not occur in a vacuum. Rather, they reflect deeper structural and institutional racism embedded within the health, education, and justice systems. Participants highlighted how these systems are often built around dominant frameworks that fail to reflect or accommodate the cultural

realities of many racially minoritised communities. This systemic misalignment, including narrow definitions of mental health, lack of representation, and minimal space for culturally diverse understandings of distress, contributes to widespread exclusion and mistrust. Structural racism, in this sense, is not only evident in individual experiences of bias, but in the design and operation of services. It is also important to recognise that experiences of racism—within and beyond care systems—can themselves contribute to poor mental health outcomes (Williams and Etkins 2021)

Some interviewees highlighted the roots of this problem lie in the foundations of the therapeutic discipline. One participant explained that mental health care in the UK is based on a narrow conceptualisation of mental health developed by the white, male, middle class:

> *"That legacy is still present. So when you operate from a very Western framework, you don't take into account cultural nuance. A lot of people feel there's no place for them, so why would they access it?"*
>
> –Professional, NGO, London

This feeling of exclusion was linked, as we have previously highlighted, to a lack of representation for minoritised groups within the mental health care system. Relatedly, feelings of exclusion were also tied to systems' insensitivity to different cultural understandings and presentations of poor mental health. Participants noted that when systems adopt a narrow view of health, they marginalise and exclude those who don't fit dominant Western constructs.

> *"We talk about it in the Western eyes, the medical model of psychosis, but actually I've worked with people before that in their culture, they see it as a way of making contact with dead relatives, or they see it as a spiritual experience, whereas we're defining it as a mental health episode – and it may or may not be. It is according to Western society, but actually if we're saying, you're being visited by your dead ancestors and that's a problem, you need to come see a medical specialist that is going to put you on some medication, that is not going to go down well."*
>
> –Professional, CAMHS, East Midlands
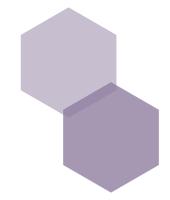
Some interviewees, particularly those working in less diverse areas, did not perceive the system as discriminatory. Others challenged the notion that cultural competency training is sufficient to address the systemic marginalisation that exists.

> *"We don't do enough to understand the impact of culture... around their understanding of mental health care or accessing support. Even things like the role that violence plays within families... I don't think we understand properly the nuances those cultural differences bring."*
>
> –Professional, CYP Health and Justice, West Midlands

We have previously discussed how this sense of exclusion contributed to mistrust and alienation from mental health services. Systemic racial inequities and a lack of cultural understanding were described as shaping young people's access to mental health support, particularly those from minoritised backgrounds. When services are developed within exclusively Western frameworks of mental health, and fail to recognise or accommodate diverse cultural understandings and expressions of distress, they risk not only misdiagnosing

or overlooking need but also reinforcing exclusion. The result, as many of the participants expressed, are systems that can feel alien or unsafe to specific groups. Without addressing these limitations, services will continue to reproduce inequities.

Structural exclusion beyond race: neurodiversity, class and gender

In addition to structural racism, participants described how systems of mental health support are also shaped by exclusionary structures linked to neurodiversity, class, and, though less frequently discussed, gender. These dimensions often intersect, compounding disadvantage for young people whose needs fall outside dominant norms.

While awareness of neurodiversity has grown in public discourse, participants consistently highlighted the failure of services and institutions to adapt in practice. Across education, mental health, and youth justice systems, neurodiverse children and young people were described as structurally marginalised - excluded not by individual oversight alone, but by policies and frameworks ill-suited to recognise or respond to neurodevelopmental needs. In schools, inflexible behaviour policies and a lack of inclusive support were seen to result in punitive responses, such as exclusion or off-rolling, rather than tailored care. These practices were understood as forms of institutional neglect, with participants emphasising that systems were designed around neurotypical norms and expectations.

Class-based inequities similarly shaped access to mental health care. Socioeconomic factors, such as the ability to travel, take time off work, or pay for private assessment, often determined whether families could access timely support. Participants described a system that implicitly favoured the most resourced: those who could articulate their needs in clinical terms, persistently advocate for support, and navigate opaque referral pathways. For families without these forms of capital, the system became a gatekeeping mechanism, embedding structural disadvantage rather than mitigating it.

> *"You need to speak our language to get these referrals, to get support. Unless your child is sitting in front of us saying, I have A, B and C—depression, low mood, and help me please—then it doesn't really work... it's an institutionally discriminatory system that is classist as a result."*
>
> -Professional, Youth Justice CAMHS, London

This was especially apparent in relation to diagnostic pathways. Long NHS waiting lists for autism and ADHD assessments, for example, meant that private diagnosis, an option inaccessible to many, often became the only route to recognition. Professionals reflected that this infrastructure gap not only delayed support but reinforced inequality, making access contingent on financial means.

The structural challenges described also had implications for gender. While gender did not emerge as a central theme across all interviews, some participants highlighted the lack of gender-specific mental health provision, particularly for girls and young women. This gap was raised alongside concerns about rising numbers of girls entering the youth justice system, and the limited availability of support tailored to their specific needs and experiences. Meanwhile, as explored earlier in the report, gendered assumptions about boys, particularly Black boys, contributed to their adultification and the erosion of care-based responses. Although our data on gendered barriers was limited, these dynamics point to the need for greater attention to how gender interacts with other systems of marginalisation, as has been discussed in previous research (Williams et al, 2020)..

Ultimately, these accounts reflect how structural exclusion is embedded across the systems designed to provide care. Unless these systemic dynamics are addressed directly, through redesign rather than accommodation, services will continue to reproduce inequalities.

Systemic and intergenerational cycles of violence

A number of participants throughout the research highlighted that many of the young people at risk of or involved in violence grow up in homes and communities where systemic inequality, trauma, and institutional neglect shape their lives from an early age and contribute to ongoing cycles of violence. These experiences do not occur in a vacuum, it was noted. Families are embedded in social systems that often fail to provide adequate support, and in some cases, actively contribute to cycles of harm.

Parents and caregivers described growing up in environments where their own needs went unmet, and their distress was misunderstood or pathologised:

> *"When I was a child, [there were] things that I wouldn't have recognised back then as being mental health issues caused by my environment... I can see that, I was suffering with those issues, and they did lead to some more severe issues in later life. And the help wasn't there because it wasn't recognised. I was just 'a naughty child'... My mom did try and get me support, but all that they could offer me was anger management. It wasn't that I was angry, I was afraid, I was terrified... That did lead to some quite dark times in my life."*
>
> –Parent, West Midlands

Families navigating poverty, trauma and bereavement described how they often found that the systems meant to support them instead compounded their struggles. Structural inequality, including inadequate resourcing of services and long delays in assessment, meant early support was often inaccessible. These stories illustrate how trauma becomes normalised, repeated, and entrenched within families and communities over generations. Exposure to domestic violence, loss, abuse, and community instability are not only personal tragedies, but systemic failures that shape the development of children's emotional worlds and increase the likelihood of violence being perpetuated (YEF 2020).
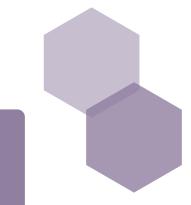
Many participants emphasised how important it is to understand parental mistrust of services, and sometimes resistance to mental health support, not as an individual failing, but as a legacy of marginalisation, of systemic neglect, and sometimes of harm by those in positions of authority. Parents expressed deep frustration at what they saw as institutional gatekeeping and punitive responses that they faced when advocating for their children.

> *"The hardest part has been feeling like I'm fighting against school all the time...we're really reliant on the information...but it's usually me chasing something up...we'll have had a meeting and we'll have discussed loads of things, and then we won't have heard anything... we can't get in touch with them via phone call, unless they call us, because we can never get through"*
>
> –Parent, South West

> *"She's supposed to be the pastoral support manager that supports my daughter and helps me...I wasn't swearing, I wasn't rude. I just said, 'I'm really sorry, the school just don't seem to understand kids with these issues'. And she put the phone down on me...I know loads of parents having the same issue. I heard about one young person who was self-harming and couldn't go to school, her parents got taken to a tribunal and fined because of it"*
>
> –Parent, London

> *"When I have been to the GP to say that my son is still not getting over his anxiety, they referred him to CAMHS. We're now months down the line for CAMHS support. We went back to the GP to ask for medication...I fought for antidepressants but it's just a no-go area. They just won't give them to him because they say it needs to be CAMHS. But it's a Catch 22 because of the waiting list for CAMHS"*
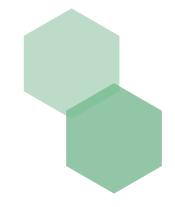>
> –Parent, South West

The cumulative effect of systemic poverty, trauma, and under-resourced services makes healing difficult. We've previously highlighted that even when children access therapy or other forms of support, the lack of a stable home-life, shaped by social conditions, can undermine progress. It is clear that cycles of violence are not solely caused by family dysfunction, but result from a broader web of disadvantage. Breaking these cycles requires provision of mental health support to children and young people alongside recognition and response to the social conditions that perpetuate harm and violence, including poverty, systemic racism, austerity-driven cuts, institutional stigma, and inadequate professional training.

As one participant concluded:

> *"We need to stand on the rooftops and scream and shout until the children get what they need... the next generation is what matters, and their children, and their children. If we're not going to progress, then what's the point?"*
>
> –Parent, London

It is necessary to understand youth violence and mental health within their socio-structural context. The challenges families face are not simply the result of individual choices or parenting styles, but are deeply embedded in systems that fail to protect, support, and respond to need, across generations. When services overlook this, they risk pathologising distress and misplacing responsibility, reinforcing mistrust and perpetuating cycles of harm. Meaningful support for children and young people cannot be achieved without recognising the impact of poverty, racism, trauma, and service failures on families' capacity to engage. Addressing youth violence and improving mental health outcomes requires an acknowledgement of the wider systems that shape people's lives and investing in the structural change needed to make stability, and thus healing, possible.

5. Challenges and tensions

This section explores challenges related to data and evidence, service design, implementation, and system capacity. It considers tensions between clinical and relational models of care, the reality of trauma-informed practice, the role and limitations of schools, the constraints of funding, and the structural barriers that limit equitable access. This section does not attempt to resolve these tensions, but aims to acknowledge them, explore their implications, and highlight the difficult but necessary questions they raise for policy, commissioning, and frontline practice.

5.1 Data and evidence

- Evidence hierarchies can shape what gets funded, in some cases privileging interventions that are easiest to measure.

- The current model of evidence-based practice sidelines relational, flexible, and community-embedded approaches.

- Poorly designed or rigid evaluation frameworks create additional burdens for services and distort practice.

- Evaluation models can exclude many grassroots and community-led organisations from funding opportunities.

- Structural flaws in administrative data undermine our ability to monitor access, equity, and outcomes.

- The absence of linked data across domains (health, education, justice, social care) limits strategic decision-making.
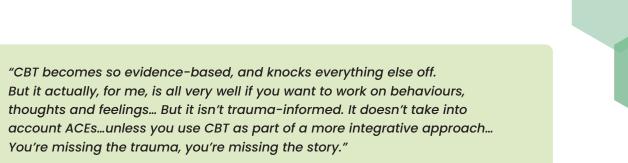
A recurring tension throughout this project has been the role of data and evidence in shaping the mental healthcare landscape for children and young people involved in or at risk of serious youth violence. While data is essential for understanding need, demonstrating impact, and informing policy, our research highlighted several limitations in how evidence is generated, interpreted, and used.

5.1.1 Evidence-based practice and therapeutic modalities

Ongoing evaluation is essential for understanding how services and interventions improve outcomes and drive meaningful change (Baker 2009). However, several concerns exist regarding the current evidence base for psychological and psychosocial interventions in this area.

One theme that emerged from the interviews was the tension between the dominance of evidence-based approaches, particularly Cognitive Behavioural Therapy (CBT), and the complex, individualised needs of children and young people affected by serious youth violence. CBT is often the default intervention, but several participants questioned whether its prevalence is due more to its evaluability than to its appropriateness for this group.

Practitioners pointed out that CBT is often considered the 'gold standard' because it is manualised and relatively easy to study through Randomised Controlled Trials (RCTs), the favoured method for establishing clinical efficacy.

> *"CBT becomes so evidence-based, and knocks everything else off. But it actually, for me, is all very well if you want to work on behaviours, thoughts and feelings... But it isn't trauma-informed. It doesn't take into account ACEs...unless you use CBT as part of a more integrative approach... You're missing the trauma, you're missing the story."*
>
> –Professional, National Professional Body for Mental Health Specialists, London

It has been argued that manualised, time-limited treatments like CBT are easier to evaluate than complex interventions, which may contribute to their overrepresentation in evidence bases shaped by RCTs (Bader et al., 2023; Cohen et al., 2023; Wilson, 2007). The dominance of RCTs as the gold standard can create a feedback loop, directing funding toward interventions that fit this model and reinforcing their visibility (Deaton & Cartwright, 2018; Falk Delgado & Falk Delgado, 2017). However, RCTs often use psychometric tools and Routine Outcome Measures that may not reflect meaningful change for young people with complex needs, especially those in environments detrimental to mental health where changes on clinical measures may not be detected (Batty et al., 2012; Jacob et al., 2017). As a result, interventions that produce meaningful improvements in young people's lives but are less amenable to measurement through RCTs may be undervalued and receive less funding or policy attention.
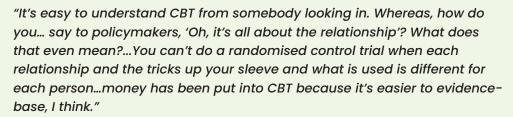
Practitioners expressed frustration that therapies grounded in relationships, flexibility, and responsiveness are disadvantaged by these standards. While valuing evidence-based practice, many noted that RCTs, which often require uniform delivery, conflict with the individualised care needed for this group (Hein & Weeland, 2019; King et al., 2014). As a result, flexible, multi-component approaches are often excluded from the literature. That being said, whilst RCTs have traditionally tested structured, manualised interventions, they have been used to test more flexible interventions too, particularly in more recent years (Multi-site trails | Youth Endowment Fund).

While CBT has demonstrated effectiveness and remains a valuable tool, practitioners highlighted its greatest impact comes when used alongside other approaches tailored to the needs of each young person.

> *"I find CBT very useful, and I continue to use it consistently throughout my work with children and young people...none of our teams use manualised interventions, but they use CBT as a broad basis in combination with other approaches that help structure something based on that young person's presentation".*
>
> –Professional, Youth Justice and PRU CAMHS, London

Some interviewees suggested that resistance to CBT may reflect its status as "the flavour of the past few years," driven by its inclusion in NICE guidance. However, it was also clear from the interviews that CBT is not always appropriate as a stand-alone intervention for this cohort. Research shows that CBT often overlooks the specific traumas, stressors, and life contexts of vulnerable young people (Larden et al., 2021; Ringle et al., 2016). Practitioners noted that CBT's dominance is shaped not only by methodological convenience but also by funding and policy drivers. In England, for instance, where NICE guidelines heavily influence commissioning, therapies backed by RCTs and easily quantifiable outcomes tend to receive greater investment, they noted.

> *"It's easy to understand CBT from somebody looking in. Whereas, how do you... say to policymakers, 'Oh, it's all about the relationship'? What does that even mean?...You can't do a randomised control trial when each relationship and the tricks up your sleeve and what is used is different for each person...money has been put into CBT because it's easier to evidence-base, I think."*
>
> –Professional, National Professional Body for Mental Health Specialists, London

Previous research supports these findings, highlighting that interventions supported by robust research are more likely to be funded (Forman et al., 2009), however the challenge of evidence-based therapies is that studies are often based on narrow inclusion criteria and may not be generalisable to "the challenges of engaging under-resourced families facing multiple forms of adversity in 'real-world' mental health programs" (Kagan et al 2023).

This is an example of a paradox at the heart of this project's findings: the system for support is focused on clinical models of care and standardised processes, but young people often require support that is flexible, relational, culturally competent, and embedded in the realities of their lives. Professionals value evidenced-based practice, but emphasised that with this cohort it cannot be applied in rigid or narrow ways; they highlighted how therapies often need to be adapted, integrated with other approaches, and delivered flexibly and responsively to young people's lived realities.

Practitioners advocated for alternative ways of evaluating impact. Several expressed enthusiasm for integrating methods such as realist evaluation , and more flexible outcome measurement approaches. Realist evaluation is an approach to impact evaluation which asks how or why an intervention works, for whom, and in what circumstances (Westhorp 2014). Participants saw this as better suited to complex interventions because it places context at the core. They emphasised the importance of capturing meaningful change from the perspective of the young person, something not easily achieved through standardised metrics. One described how goal-based outcomes provide a more relevant frame for therapy:
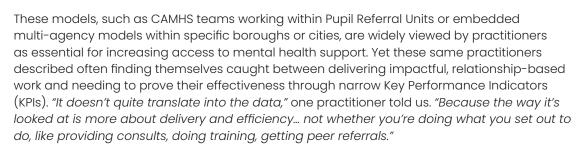
> *"Sometimes they don't know [what they need], and that's when using goal-based outcomes has been a really good way of assessing how impactful therapy is. You can get a child that says 'I want to be a YouTuber.' That's my goal. And you have to really work hard to find out, actually, what they'd really like is to have a better relationship with their stepdad."*
>
> –Professional, NHS Vanguard, West Midlands

Overall, there was a shared sense that the current evidence hierarchy privileges what is easiest to measure, not necessarily what works best for young people with complex trauma and lives shaped by systemic disadvantage. Practitioners expressed a clear desire for evaluation models that are more responsive, relational, and grounded in the lived realities of the young people they support.

5.1.2 Evidence, outcomes and the links to funding

A related, but distinct challenge emerged when considering how we measure the effectiveness of services and how those measurements, in turn, often influence what gets funded, sustained, or scaled. Participants described how current funding models often prioritise services that can demonstrate outcomes through standardised, quantifiable data. While this approach may be appropriate for some types of care, it creates significant problems for more complex, embedded, and relational models of support, particularly those designed to reach the most marginalised children and young people.

These models, such as CAMHS teams working within Pupil Referral Units or embedded multi-agency models within specific boroughs or cities, are widely viewed by practitioners as essential for increasing access to mental health support. Yet these same practitioners described often finding themselves caught between delivering impactful, relationship-based work and needing to prove their effectiveness through narrow Key Performance Indicators (KPIs). *"It doesn't quite translate into the data,"* one practitioner told us. *"Because the way it's looked at is more about delivery and efficiency... not whether you're doing what you set out to do, like providing consults, doing training, getting peer referrals."*

The emphasis on standardised, outcome-driven approaches was seen by several participants as having intensified with the rollout of the Children and Young People's IAPT (Improving Access to Psychological Therapies) programme, which, they said, shaped CAMHS into a system increasingly driven by throughput and clinical efficiency. As one participant explained: *"All the current issues with CAMHS stem from the IAPT initiative,"* which they felt had entrenched a narrow focus on eligibility and clinical outcomes, at the expense of more flexible, holistic, or preventative models of care.

Professionals described how embedded models of service delivery often involve activities that are not easily captured in routine outcome measures: informal consultations, reflective supervision, joint formulations with schools or youth workers, capacity building, and non-stigmatising engagement. These are time-consuming but vital components of care for young people who are least likely to engage through conventional routes. Yet these efforts were highlighted as often falling outside standard recording systems and overlooked in funding decisions. *"We never were very good at capturing what we do,"* one professional reflected. *"Because every method is built around a generic CAMHS model... so we're using the wrong data tool to capture it."*

To secure ongoing funding, many teams have to adapt their work to fit existing data structures, or build time-consuming workarounds. In one case, a team created a "dummy client" system to log consultations that fell outside formal cases, just to produce countable outputs for commissioners.

> *"We've created a dummy client to fall into one of the KPIs... because they're not on open cases, but they're using time. At least I can present something to my clinical director."*
>
> -Professional, Youth Justice CAMHS, London

This kind of administrative retrofitting takes time away from direct work with young people and raises questions about how evaluation frameworks can better reflect what effective embedded support actually looks like.

The pressure to demonstrate efficiency was also seen to contribute to the instability of many of these services. Embedded and outreach-based interventions are often funded as pilot projects or short-term initiatives, and their continuation can depend on showing impact within narrow metrics. This creates a cycle in which some of the most promising models, particularly those focused on access, trust, and long-term engagement, struggle to survive. As one practitioner summarised:

> *"It was great. That worked in many ways, but it was an island in the middle of a vast sea of different models, and it wasn't sustainable... because it doesn't have robust outcomes."*
>
> -Professional, Youth Justice and PRU CAMHS, London

This challenge also extends to voluntary and community sector organisations. Monitoring and evaluation of interventions is time-consuming and expensive, which can prevent small,

often community-led, organisations from measuring the effectiveness of the services they provide, particularly as monitoring and evaluation is not always funded by commissioners. Practitioners noted that this in turn can limit the amount of funding for which organisations are eligible. The disparity in resources for evaluation, combined with the focus on RCTs, manualised treatments, and clinical outcomes, may lead to a research bias, where certain interventions are overrepresented, and certain services, programmes and organisations receive a disproportionate share of resources.

The challenge is not only about data, but about what kinds of care are valued, supported, and have systems built around them. The most marginalised children often need flexible, persistent, and relationship-based approaches. Yet these are the models that struggle to meet funding criteria shaped by outcomes, KPIs and narrow definitions of measurability. Addressing this tension will require rethinking data collection, as well as which outcomes are recognised as meaningful.

5.1.3 Limitations in administrative data
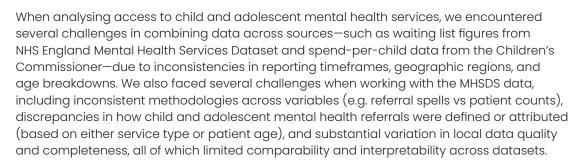
As part of this project, we conducted a secondary analysis of publicly available administrative datasets to explore access to mental health services for children and young people across England and Wales. This analysis proved valuable insights but also exposed limitations in the availability, consistency, and granularity of administrative data that make it difficult to draw meaningful comparisons, identify inequities, or inform policy and commissioning decisions with confidence.

One significant challenge was the lack of standardisation within and across datasets, particularly in geographic coverage. With multiple datasets often reporting similar thematic areas, particularly around risk factors for serious youth violence, but also on youth offending and access to mental health support, a lack of standardisation creates challenges when attempting to compare. Data were often reported at inconsistent levels, some national, some regional, others by Integrated Care Board (ICB), local authority, or parliamentary constituency. Even within a single data source, levels of aggregation varied. This inconsistency prevented more detailed analyses, obscuring within-region variation. For example, while London was ranked among the worst regions for serious youth violence and related risk factors, we were unable to explore how this varied across boroughs despite wide differences in deprivation, service access, and population demographics. More granular and consistent geographic data would allow for richer and more accurate identification of trends and needs at the local level.

This was compounded by inconsistencies in how key demographic variables such as age, sex, and ethnicity were collected and reported across data sources. These inconsistencies hindered our ability to identify which groups of children and young people were most likely to experience poor access to support. Similarly, mismatched timeframes (e.g. some datasets covering calendar years, others financial years or even monthly data) complicated comparisons and undermined the reliability of trend analysis.

The inability to link datasets across domains such as education, social care, youth justice, and health was another key limitation. Ideally, administrative data would allow for the tracking of individual children across systems in order to answer pressing questions such as whether those most at risk of serious violence are receiving adequate mental healthcare. Currently, datasets remain siloed, inconsistently structured, and difficult to cross-reference. There are valid concerns around privacy and data protection, but these could be addressed through careful ethical and technical design.

Disparities in data availability between England and Wales added further complications. In many cases, data were available only for England, particularly from the Department for Education and NHS datasets. Where alternative data were available from the Welsh Government, they often used different indicators, definitions, or age ranges, rendering them incompatible. For example, data on mental healthcare wait times were reported differently across the two nations, preventing us from including comparable Welsh data in our analysis of CAMHS access.

When analysing access to child and adolescent mental health services, we encountered several challenges in combining data across sources—such as waiting list figures from NHS England Mental Health Services Dataset and spend-per-child data from the Children's Commissioner—due to inconsistencies in reporting timeframes, geographic regions, and age breakdowns. We also faced several challenges when working with the MHSDS data, including inconsistent methodologies across variables (e.g. referral spells vs patient counts), discrepancies in how child and adolescent mental health referrals were defined or attributed (based on either service type or patient age), and substantial variation in local data quality and completeness, all of which limited comparability and interpretability across datasets.

Without high-quality, consistent, and linked administrative data, we cannot fully understand who is accessing support, where gaps lie, or whether services are effectively reaching the children and young people who need them most.

5.2 Early intervention and the role of schools

- Schools are well placed to acts of sites of early intervention, but they cannot respond alone.

- Without training, resources, and external support, schools risk becoming overwhelmed and under-effective.

- Behavioural concerns are often viewed through an academic lens, which can obscure unmet needs in some cases.

- Strong school mental health provision depends on leadership buy-in, staff capacity, and cultural alignment.
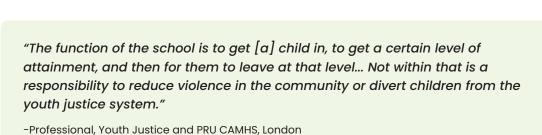
Another recurring theme in our interviews was the idea that schools are uniquely positioned to play a central role in early intervention. As the place where most children spend a significant part of their day, schools are often the first, and sometimes the only, service in sustained contact with young people. At the same time, as discussed in previous sections, a tension that arises is that schools can also be sites that create and fuel distress: bullying, discrimination, academic pressures and exclusions were all factors cited in our interviews. Nonetheless, this proximity to children and young people makes schools a logical site for identifying mental health needs early, building trusting relationships, and intervening before these identified issues escalate. As one participant put it,

"Where else are children? They're at home, they're at school or they're in the community. And who would pick [things] up? It's school, I guess."

-Professional, NGO, London

There is strong evidence to support this idea. For example, school connectedness, particularly a sense of connection to teachers, has been shown to protect against a range of adverse outcomes including substance use, anxiety, depression, and suicidal ideation and attempt (Dunne, 2018). A school environment where students feel seen, supported, and understood can play a vital protective role, particularly for those experiencing adversity elsewhere in their lives: a strong sense of belonging at school, rooted in safety, identity, and relationships with teachers, has been linked to improved wellbeing, reduced exclusions, enhanced agency, and greater resilience, especially among disadvantaged and marginalised pupils (Riley et al, 2020).

The tension lies in what schools are designed and resourced to do. Participants emphasised that while schools are often expected to function as *de facto* mental health or safeguarding hubs, their primary mandate remains academic attainment.

> *"The function of the school is to get [a] child in, to get a certain level of attainment, and then for them to leave at that level... Not within that is a responsibility to reduce violence in the community or divert children from the youth justice system."*
>
> -Professional, Youth Justice and PRU CAMHS, London

In this context, behavioural issues are often framed narrowly through an educational lens as disruption, non-attendance, and low attainment, rather than as potential signs of unmet needs, trauma, or neurodiversity. This framing can contribute to punitive responses such as exclusion or isolation, which as we have discussed, increases young people's vulnerability to exploitation, disengagement, and serious youth violence.

While schools are commonly identified as key sites for prevention and early intervention, research highlights that implementation of mental health support in educational settings is often hindered by practical and structural challenges. These include insufficient staff training, inadequate resources, and weak integration between mental health services and the school environment (Gee et al., 2021; Gondek et al., 2017). Forman et al. (2009) argue that for evidence-based interventions to be effective in schools, several preconditions must be in place, including support from school leaders and staff, alignment with school philosophy and goals, financial and training resources, and systems to manage staff turnover. Without these foundations, mental health provision in schools may remain fragmented or underused.

At the same time, schools are under significant pressure. Many staff feel they are already *"on their knees,"* overstretched and under-resourced. Asking them to take on more without additional support may contribute to burnout and resistance. *"How can we do any more?"* one interviewee reflected. *"We're already doing as much as we can."* This is not to suggest that schools do not care about wellbeing; participants highlighted that many individual teachers and leadership teams are deeply committed, but rather that without system-wide changes and sustained investment, the current model is ill-equipped to meet the scale or complexity of need.

Recent evidence emphasises that successful mental health provision in schools requires collaborative planning and buy-in across multiple levels. Gee et al. (2021) recommend involving both education professionals and young people in the design and selection of school-based interventions to ensure they are contextually appropriate and practically deliverable. School staff must also be provided with high-quality, ongoing training, while senior leadership should play a visible role in championing mental health and creating a culture that values emotional wellbeing.

There was widespread agreement that solutions lie not in asking schools to do more alone, but in reimagining how other services can work with schools. Mental Health Support Teams (MHSTs), were often raised as an example, a model that involved embedding mental health expertise within education settings. However, participants highlighted that they are currently limited in capacity and scope, often working at lower tiers of need and struggling to support those young people at highest risk.

> *"The children we're working with are far beyond [MHST] thresholds... and the ones they're working with are far below what we typically see."*
>
> -Professional, Youth Justice CAMHS, North West

Participants suggested a more embedded, system-wide approach, which doesn't place full responsibility on schools, but ensures they are supported by multi-disciplinary teams who can *"hold the complexity"* together. In smaller settings such as PRUs, where staff–student ratios are lower, this shared holding was felt to be more feasible. But replicating that in large mainstream schools will require a model that brings health, social care, and education into

closer partnership, backed by shared responsibility, sustained investment, and a shift in how we view the role of education in prevention. As one practitioner noted,

> *"The only route to get schools [on board] is making them feel like their burden is lessened, because resources are added and support is shared."*
>
> -Professional, Youth Justice and PRU CAMHS, London

5.3 Formal vs informal therapeutic support

- Many young people affected by serious youth violence fall between service thresholds.
- Clinical mental health models are often too rigid, individualised, and diagnostic to respond to complexity.
- Relational, culturally competent, and non-clinical support is often the gateway to therapeutic engagement, but is undervalued.

Another tension running through our findings is the mismatch between the formalised, clinical models of mental healthcare embedded in statutory services, particularly CAMHS, and the kinds of support that children and young people involved in or at risk of serious youth violence actually need and are able to engage with.

Participants repeatedly described how these young people often fall through the cracks of existing service thresholds: their needs are too complex for lower-tier services, yet do not meet the criteria or do not present in the "right" way to access higher-tier clinical support. Many professionals noted that the clinical model underpinning CAMHS, including diagnostic criteria and treatment pathways, simply does not account for the complex and intersecting realities of these young people's lives.

At the same time, the participants also presented a counter-narrative: that for many of these children and young people, therapeutic change does not necessarily begin with therapy, but with relational connection. Youth workers, trusted adults, mentors, and culturally competent practitioners were consistently described by both young people and professionals as playing a pivotal role in enabling trust, safety, and eventual engagement. However participants noted thst these informal or "pre-therapy" relationships are rarely recognised, resourced, or formally counted within the mental health system, despite this perceived importance to engagement and outcomes.

The report also captures the frustration of professionals who see young people being turned away or bouncing around services because their needs don't align with standardised service models. This phenomenon was seen to be particularly acute when neurodiversity and trauma overlap. This disconnect was thought to indicate a deeper structural issue: the mental health system, as currently configured, is not built to accommodate complexity, cultural nuance, or relational engagement outside of standard therapeutic encounters. But, professionals highlighted, these are precisely the conditions under which many young people can begin to trust, reflect, and heal.

The professionals and young people we spoke to raised an important challenge for service design and commissioning. How can non-clinical, relational, and informal forms of support be better recognised and resourced as legitimate, valued components of a mental health support ecosystem? How can commissioning frameworks and evaluation metrics evolve to reflect the real-world conditions under which many young people begin their therapeutic journeys, not in clinics, but in youth centres, schools, or through conversations with trusted adults?

5.4 The reality of trauma-informed practice

- Trauma-informed care is widely endorsed in principle, but inconsistently understood in practice.
- Without clearer frameworks and systemic support, trauma-informed care risks becoming tokenistic.
- Economic constraints undermine the foundations of trauma-informed practice.
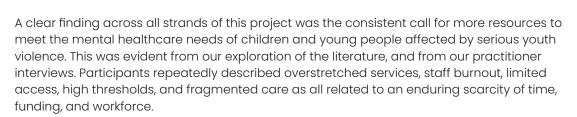
Trauma-informed care was one of the most commonly cited principles across our interviews. Practitioners frequently described their services as being "trauma-informed" or striving toward trauma-informed practice. However, despite the term being widely used, there was broad agreement that the system as a whole does not truly embody trauma-informed principles. On the one hand, the importance of trauma-informed approaches was universally acknowledged, particularly given that many young people affected by or at risk of serious youth violence have experienced trauma. On the other hand, practitioners consistently questioned how meaningfully this concept was being implemented across services.

Reflecting on the data, a broader challenge became clear: despite widespread endorsement of trauma-informed approaches, there remains a lack of clarity and often, shared understanding, about what trauma-informed practice actually looks like in day-to-day service delivery. As researchers, we observed that while nearly every professional referenced trauma-informed principles, they often described very different models, tools, or behaviours. This ambiguity partly reflects the fact that trauma-informed practice must look different depending on the setting, population, and context. It cannot be reduced to a single protocol or training session. However, this flexibility also creates a tension: how can services operationalise trauma-informed care meaningfully and consistently, while still allowing for contextual adaptation? Without clearer guidance, shared frameworks, and systemic support, there is a risk that trauma-informed practice becomes a diffuse aspiration rather than a concrete standard.

In addition, despite near-universal support for trauma-informed care among professionals interviewed, the evidence base for its direct impact on outcomes such as crime and violence remains limited and inconclusive (YEF 2021). This may reflect a mismatch between what trauma-informed practice is intended to do and how it is evaluated. Rather than being a treatment model in itself, trauma-informed practice is an essential lens through which professionals can recognise children who may need additional support, build trust, and avoid retraumatisation in the process of accessing care. Its value lies in creating relationally safe, culturally sensitive environments that enable meaningful engagement and lay the groundwork for effective therapeutic intervention, particularly for those who might otherwise disengage or be excluded from services. However, because it must be tailored to different settings and populations, it can be challenging to define and measure consistently, contributing to a weaker formal evidence base.

5.5 The funding paradox: how do we do more with what we have?

- Professionals widely agreed that current resources are inadequate, but new investment seems unlikely.
- Some practitioners argued for bold reallocation of existing resources.
- Risk-averse commissioning practices and rigid performance metrics may block innovation.
- Without strategic shifts or new investment, exclusion will persist by design.

A clear finding across all strands of this project was the consistent call for more resources to meet the mental healthcare needs of children and young people affected by serious youth violence. This was evident from our exploration of the literature, and from our practitioner interviews. Participants repeatedly described overstretched services, staff burnout, limited access, high thresholds, and fragmented care as all related to an enduring scarcity of time, funding, and workforce.

However, many acknowledged that the required resources were unlikely to materialise any time soon. As one participant put it,

> *"I don't think any money is coming soon. The way the wind is blowing… it doesn't seem like any more money is arising."*
>
> -Professional, Youth Justice Service, North West

Even well-evidenced, successful pilot services are struggling to secure continued funding. A youth-focused CAMHS pilot described as having *"very good data"* was due to be decommissioned despite its apparent impact.

This gives rise to one of the most significant tensions identified here: if additional funding is not forthcoming, is it possible for systems to meaningfully improve access and quality of support for young people?

Some practitioners, while acknowledging that resource limitations are real and acute, also argued that part of the solution lies in more courageous and strategic reallocation of existing funding. This would require services to step back, assess their own access data, and ask hard questions about where need is greatest and whether the structure of current provision reflects that need.

> *"Either you keep doing what you're doing, which doesn't change the situation, or you need to look at reallocating the current resource you have… which is a very painful decision."*
>
> -Professional, Youth Justice CAMHS, London

Rather than defaulting to reactive responses such as allocating more resources to high-risk waitlists, some participants advocated for greater upstream investment within existing budgets. Some suggestions included embedding clinicians in schools, youth justice settings, and community spaces, or creating more flexible roles that allow clinicians to split time across outreach and clinical teams. These approaches, while difficult to sustain without new funding, could offer more accessible and relevant forms of support to young people who are currently excluded from formal systems.

However, as participants saw it, these decisions often run counter to institutional habits and risk-averse commissioning logics. As one professional noted, services are still judged by clinical KPIs and response times, not by how well they reach and support the young people most at risk of falling through the cracks. Without the mandate or resources to redesign models of care, many local areas continue to operate in crisis mode, reinforcing the very patterns of exclusion they hope to disrupt. In the absence of new investment, services and systems must be willing to question how existing resources are structured and used. Otherwise, as one practitioner warned, *"It will just remain the same. Which is how it continues."*

6. What does this mean overall and for the various sectors?

This section brings together evidence from all strands of the project to summarise cross cutting themes and surface features of good practice – at either the system or service level - emerging from the evidence. These are presented as a synthesis (not prescriptive recommendations) and are intended to inform subsequent guidance.

6.1 Overall

The mental health system is often structurally ill-equipped to meet the needs of the children and young people most at risk of violence

Across every strand of this project, our findings point to the fact that those most in need are least able to access or remain in support, not because they are 'hard to reach' but because systems are designed in a way that often exclude, misunderstand or fail to engage them.

Significance: This challenges dominant narratives and reframes the problem as a structural and systemic failure rather than an individual or community deficit. It demands a shift in responsibility from the young person to the system.

Suggested good practice elements emerging from the evidence that could address this:

- **Broaden the conception of mental health to include social, cultural, and structural determinants.**

  Our qualitative work repeatedly highlighted that frameworks and services should recognise mental health as deeply embedded in social and structural contexts by addressing the wider risk factors for distress such as housing insecurity, community violence, poverty, school exclusion and structural racism, rather than focusing only on symptoms and diagnoses.

- **Design for the specific context of serious youth violence**

  The literature shows that interventions focused on clearly defined groups are more effective than universal models, particularly when they are rooted in an understanding of the community, cultural norms and lived experiences (Hendriks et al., 2018; Lester et al., 2017; Hikmat et al., 2024; Klymkiw et al., 2024), while universal offers often lack cultural competence and struggle to meet the needs of more marginalised groups (King et al., 2014). Our qualitative work underscored this. There was a clear call for services that can hold risk as an integral part of the work, not use it as a reason for exclusion; young people involved in or at risk of violence need consistent, relational, holistic care and should not be viewed as "too risky" to support. This is a system-design issue that requires care pathways, commissioning structures and support models that understand the specific vulnerabilities and barriers faced by this group.

  Gap signalled by our service mapping: fewer than one-third of psychosocial offers by the voluntary and community sector organisations that we identified are tailored specifically to young people at risk of violence/offending, highlighting a need to expand context-specific provision.

- **Rebuild trust through co-design and participation.**

  Young people and families affected by serious youth violence have often experienced exclusion, surveillance, or harm at the hands of systems. In our qualitative work, participants reflected that genuine partnership is therefore central to engagement. This means co-production of policies, and feedback mechanisms that give real power to lived experience. Discussions highlighted how such approaches foster ownership,

improve service relevance, and align interventions with the realities of young people's lives. Participation should be embedded at all levels of system design and evaluation.

- **Adopt youth-led and youth-informed approaches.**

  Participatory and youth-informed approaches are consistently highlighted in the literature as good practice when working with children and young people (Foulkes & Stapely, 2022; McGorry, 2022). Involving children and young people in the decision-making, design and implementation of services ensures that interventions are more relevant, effective, and responsive to their needs. By giving young people a central role in shaping services, organisations can foster a sense of ownership, increase engagement, and improve retention (Viksveen et al., 2024). Youth-led approaches also promote trust and transparency, reduce stigma, and ensure that responses reflect young people's lived realities (Coats & Howe, 2014). This is particularly crucial for those at risk of serious youth violence, where systemic barriers and social determinants intersect with mental health challenges.

  Gap signalled by our service mapping: just under a quarter of the organisations we identified that offer psychological interventions and around one-fifth of those offering psychosocial interventions engaged with young people in an advisory capacity, based on publicly available information. This suggests scope for significant improvement in embedding youth voice.

Access barriers exist at every level, and they compound

Barriers to access emerged at multiple levels including the individual, the family / community, at the level of services and at the level of the system. What is clear however is that they all intersect in complex, cyclical ways and are all driven by systemic factors, even down to what would appear as "individual" barriers (e.g. internalised stigma).

Significance: This is not a set of isolated challenges but a systemic pattern. Solutions must therefore be multi-layered and intersectional rather than piecemeal.

Suggested good practice elements emerging from the evidence that could address this:

- **Strengthen multi-agency collaboration and embed multi-disciplinary teams across settings.**

  Young people at risk of serious violence are often in contact with multiple services simultaneously, however our qualitative work suggests that addressing stressors in isolation is ineffective. Teams that combine clinical staff, youth workers, social workers, and educators, as just some examples, can respond early and holistically to complex needs. A multi-systemic approach that integrates services across domains and fosters effective collaboration can help avoid duplication, close gaps between traditionally siloed services, and ensure that the whole context of the young person is considered, allowing for interventions that are more precisely tailored to the needs of at-risk youth (Appleby et al., 2023; Gwata et al., 2024; Ofsted et al., 2020).

  Embedding multi-disciplinary teams in schools, alternative provision units, youth justice services, NHS emergency departments, and community hubs, among others, brings care closer to where young people already are. This was validated in our qualitative work, with practitioners also highlighting that multi-disciplinary teams helped reduce professional overload for young service users. Successful working examples involved collaboration, and efficient referral processes between organisations, to ensure that young people could seamlessly transition between services when necessary, rather than being "bounced" between them.

- **Lower thresholds and create flexible, inclusive entry points.**

  High thresholds and rigid referral criteria exclude many young people from accessing mental health support, particularly those with complex, overlapping needs who don't fit neatly into diagnostic categories. Findings from our qualitative work highlighted that by lowering thresholds and recognising a wider range of entry points such as referrals from youth workers, community mentors, or education staff, systems can intervene earlier and more appropriately. Participants also expressed that flexible access means valuing non-

clinical forms of engagement. Relationships with trusted adults often serve as gateways to formal help, especially for young people with histories of trauma, exclusion, or institutional mistrust. Supporting and resourcing these "pre-therapy" roles was seen to be critical to making services more reachable

- **Invest in early identification and timely support.**

Relying on crisis presentations or justice involvement as gateways to care creates delays to accessing support. Our qualitative work highlighted that investing in early identification, particularly through schools and community-based organisations could enable timely support before issues escalate. Participants noted that a more preventative and less reactive system that can engage young people before distress becomes entrenched would also require funding flexible, low-threshold services that do not depend on clinical diagnosis or high-risk categorisation. In addition, they emphasised the importance of early work with children facing known risk factors for later involvement in violence, such as having a parent in prison or exposure to domestic abuse. Intervening early in childhood, and prioritising, embedding and funding early intervention not just in education, but across health, social care and community systems, was seen as vital.

- **Address physical and logistical accessibility**

Participants in our qualitative work highlighted the range of physical and logistical barriers to accessing services and that good practice should recognise and address these challenges in order to not only support initial engagement, but sustained access over time. Suggestions to reduce such barriers included free or low-cost services at the point of access, multiple referral routes (including self-referral), multiple modes of engagement (online, drop-in, home-based, community-based), and clear, transparent information about availability, eligibility and waitlists. Blended offers, combining digital and in-person options, were seen as good options to widen reach, but must be accompanied by non-digital alternatives to avoid reinforcing inequity for those in digital poverty.

Gap signalled by our service mapping: Information from the organisations that we identified about how to access services was frequently unclear. Websites were often complex, with limited transparency about whether waitlists were in operation or whether self-referral was possible. This lack of clarity creates additional barriers for young people and families already struggling to navigate fragmented systems. By contrast, organisations that provided simple, transparent information and multiple access points, including digital and blended options, appeared better placed to reach and sustain engagement.

Equity and inclusion are core to effective mental health support

Findings across this project highlight that factors such as racism, classism, poverty, and adultification shape both the risks young people face and the ways they are perceived and responded to by services. Marginalised young people, particularly those from Minority Ethnic or low-income backgrounds, are more likely to experience discrimination, exclusion, and misinterpretation, and less likely to receive culturally competent care. These systemic inequities amplify distress, create mistrust, and compound barriers to access.

Significance: Without addressing equity at the structural level, these harms will continue to be reproduced. Equity and inclusion must therefore be integrated into policies, service planning and design, workforce practices, and service delivery from the outset.

Suggested good practice elements emerging from the evidence that could address this:

- **Address structural racism and classism through workforce and policy reform.**

Participants in our qualitative study suggested that workforce diversification, culturally competent training, and leadership and decision-making that reflects the populations being served are essential to counter misinterpretation, under-service, and over-criminalisation of young people from Minority Ethnic and low-income backgrounds. They highlighted the need for broad, structural changes to make services more inclusive and responsive to the needs of marginalised groups, for service frameworks to be reformed, such as through reducing rigidity and high thresholds, in order to actively challenge

inequitable access, and for the introduction of accountability structures to monitor equity in both access to services and outcomes among population groups.

- **Ensure inclusion of marginalised groups.**

  Both our qualitative work and the literature have highlighted how young people from marginalised communities are disproportionately likely to be involved in, or at risk of, serious youth violence, (Gov.uk, 2024), and are more likely to experience discrimination and lack of culturally competent care from services. Ensuring that services are specifically designed with these young people in mind emerged as an essential element of good practice. Culturally competent, community-rooted, and context-sensitive approaches are essential for engagement and trust (Williams et al., 2020). This was reflected by practitioners, parents and young people in our qualitative work. As one parent work put it: *"…they can bond, and the therapist is going to understand where the boy is coming from. I think they can relate in a better way… So it's quite important for someone to have that understanding of what your son is experiencing."* Participants also emphasised that meaningful cultural competence requires more than brief training; it involves sustained efforts to embed local knowledge of communities – demographics, histories, patterns of harm and healing - into service design and delivery.

- **Adopt trauma-informed and culturally competent care.**

  Trauma-informed care emerged as a critical element of good practice across our research. Participants consistently emphasised the need for services that recognise how trauma can shape behaviour, engagement and wellbeing. They reflected that a trauma-informed approach seeks to create emotionally and physically safe environments by building trust, reducing the need to retell traumatic experiences, and offering consistent, relationship-based support. It also calls for flexibility in delivery, recognising that clinic-based models may not meet the needs of young people affected by trauma (Sweeney et al., 2016; Griffiths et al., 2022; Isobel et al., 2020). For marginalised groups, trauma-informed practice must also be culturally competent and gender-responsive, acknowledging how racism, poverty, and discrimination compound trauma. Effective trauma-informed care is identity-affirming and rooted in cultural and community contexts (Ranjbar, 2020; Williams et al., 2020; Gila, 2023; Herrmann et al., 2024).

Relational working is essential

Trusted relational connections with peers, youth workers, mentors, or community workers, as some examples, were highlighted in our findings as often being the first, and only sources of trusted, emotional support for children and young people. However, these frontline-workers stated that the relational and 'pre-therapy' support they offer is rarely recognised, funded, or integrated into mental health systems.

Significance: This re-frames the notion of engagement for children and young people most at risk. It tells us that the system's formal model of access (e.g. referral > CAMHS > therapy) may be misaligned with the needs of this cohort and how they engage with care.

Suggested good practice elements emerging from the evidence that could address this:

- **Prioritise relationship and trust-building as a core method**

  The literature and our qualitative work underscore that relationship and trust-building are essential for this cohort of children and young people, and that peer and mentor relationships were seen to offer a safe, familiar space to seek guidance and support (Frederick et al., 2023; Open Innovation Team 2023; Theodosiou et al., 2020). Mentorship and peer support were highlighted in qualitative interviews as being able to act as bridges into clinical spaces, helping young people engage with therapists they might otherwise distrust. Stable, consistent figures, such as youth workers, peers or teachers, were repeatedly cited as vital for sustained engagement.

- **Embed services within existing support networks**

  Participants in the qualitative interviews consistently called for more embedded models highlighting that when, for example, mental health professionals are co-located in schools,

youth justice settings, or community hubs, they are better positioned to build trust, respond to local needs, and provide seamless wraparound care, particularly as embedded models allow for informal consultation and shared learning. Schools and the community were particularly discussed as important sites for embedded support services in order to build stronger connections to families, increase relevance and accessibility, and enable the recognition of mental health needs at critical, early stages (Settipani, 2019; Cohen et al., 2023). The introduction of the UK Government's *Young Futures Hubs*—co-located wellbeing services embedded in communities—may offer a valuable opportunity to apply and scale place-based, relationship-centred approaches (Youth Access, 2025).

Significance was also placed on family engagement and family-focused approaches in both our qualitative work and the literature, particularly as the target population are dependents, often living in the family home. Adverse family circumstances, such as parental conflict, substance use/misuse and socio-economic background, are found to increase the likelihood of involvement in violence (HM Inspectorate of Probation, 2023). Multi-component approaches that formalise the engagement of families within service provision, such as offering access to peer group sessions for parents, along with 1:1 support, have been positively described (Toole-Anstey et al., 2023).

- **Deliver flexible, person-centred care.**

  Both our qualitative work and the literature strongly suggested that flexibility in service provision is essential for this cohort of children and young people. Support must adapt to the circumstances and preferences of each young person, including adaptable entry points, session timing, or meeting location, willingness to accommodate missed appointments or last-minute changes, and openness to blend different therapeutic approaches depending on need, with freedom of choice being a cornerstone of person-centered care (Hughes et al., 2018; Georgiadis et al., 2020; WHO, 2021; National Children's Bureau, 2021; Isobel et al., 2020). Many professionals highlighted the need to "meet young people where they are"- emotionally, practically, and developmentally. Choice and agency were seen as key to engagement, particularly for those with complex needs.

There are promising models but they are fragile, fragmented, and under-recognised

Innovative, trauma-informed, embedded models do exist. These are multi-disciplinary, relationally led and often more carefully rooted in the local context and/or young people's lives. However, they lack consistent funding, strategic support or visibility in the wider system.

Significance: the system isn't starting from zero; it already has examples of effective provision, but they need to be invested in, scaled and systematised.

Suggested good practice elements emerging from the evidence that could address this:

- **Commissioning that prioritises relational, community-based and continuous care**

  Qualitative interviews discussed how short-term, outcome-driven commissioning cycles undermine the continuity, trust, and cultural safety that are essential to supporting children and young people affected by serious youth violence. Many of the innovative and community-embedded services we spoke with were operating on short-term funding with little integration into statutory systems. Their fragility limited their ability to expand, retain staff, or maintain continuity of care. Participants highlighted that longer-term funding arrangements would allow services, particularly community-based and voluntary and community sector organisations that often work with young people who may mistrust statutory services or feel alienated by clinical environments, to build sustained relationships with young people, adapt to local needs, and invest in staff development. Additionally, commissioning practices that prioritise relational outcomes, flexibility, and the inclusion of smaller, culturally competent providers were seen to enable a more responsive and equitable ecosystem of care. This approach can help stabilise service provision, reduce duplication, and create more coherent and trusted local pathways for mental health support.

Data systems and evaluation frameworks are failing to support service transformation

This project highlights that there is inadequate data on mental health outcomes for children

and young people at-risk of serious youth violence; there is a lack of standardisation and integration across administrative datasets that prevents us from seeing the full picture; there is poor visibility of voluntary and community sector impact due to a lack of resources for evaluation and narrow evidence-based criteria; and there is a focus on efficiency, KPIs, and outcomes within the statutory sector that prevents non-traditional models from being able to demonstrate impact and retain funding.

Significance: policymakers and commissioners are making decisions on data that represent a small proportion of the full picture. We need better data, broader definitions of evidence and more joined-up systems to inform appropriate investments.

Suggested good practice elements emerging from the evidence that could address this:

- **Commit to ongoing evaluation and transparent reporting.**

  Robust monitoring and evaluation are essential to demonstrate what works, ensure accountability, and drive learning (Baker, 2009; Bader et al., 2023). Good practice involves publishing full and up-to-date evaluations, including impact reports and comprehensive data on reach and outcomes. Some organisations we identified through our service mapping illustrate what is possible by making comprehensive evaluations publicly accessible, often complemented by case studies.

  Gaps identified by our service mapping: Only a small proportion of voluntary and community sector organisations supporting this cohort had published evaluations of their interventions, with psychological therapy providers generally having stronger evidence bases than psychosocial ones. This mirrors gaps in the wider literature and limits the system's ability to learn from promising but under-documented practice.

- **Expand the definition of credible evidence.**

  Our qualitative work highlighted how current hierarchies of evidence can undervalue particular types of provision, such as psychosocial, community-based or multi-component interventions, that may be harder to measure through more traditional evaluation methods and standardised outcome frameworks. Participants suggested that a wider range of evidence should be considered by funders and commissioners, including placing more value on qualitative data and recognising methods such as goal-based outcomes, realist evaluations, and innovative approaches that capture the complexity of multi-component, tailored services.

- **Resource smaller organisations to monitor and evaluate.**

  Qualitative interviews also highlighted how voluntary and community sector organisations are often closest to young people at risk of serious violence, yet lack the funding and capacity to conduct meaningful evaluations. Increasing investment for their monitoring and evaluation work is crucial to generate credible, practice-based evidence, reduce duplication, and bring their impact into view.

Ethical practice and workforce capacity are critical foundations for effective support

Our findings show that children and young people at risk of serious youth violence often mistrust professionals, fearing that confidentiality will be broken or that disclosures will trigger punitive responses. At the same time, practitioners across sectors reported gaps in training, supervision, and support, leaving them under-prepared to meet the needs of this group and vulnerable to burnout. Together, these weaknesses undermine both access and quality of care.

Significance: Without robust ethical safeguards and a well-equipped, well-supported workforce, services cannot build trust or provide safe, consistent, and effective support. Ethical practice and comprehensive training are essential conditions for working with this cohort.

Suggested good practice elements emerging from the evidence that could address this:

- **Adherence to an ethical framework.**

  Our findings underscore that an essential element of good practice is the commitment of services to safeguarding each young person's safety, dignity, and rights through robust

ethical frameworks (NSPCC, 2024). This includes clear safeguarding policies, online safety standards, whistleblowing mechanisms, and procedures for recognising and responding to abuse. Confidentiality should be boundaried but transparent, agreed at the outset and revisited regularly, allowing disclosures to be managed with both trust and safety in mind (BACP, 2023). The Gillick principle affirms under-16s' rights to consent to confidential treatment, but tensions between applying the Gillick principle and safeguarding responsibilities must be navigated with care (NSPCC, 2022). This tension becomes particularly acute in cases involving children and young people detained under the Mental Health Act, where there is a risk that their voices and decision-making rights are doubly marginalised, both due to their age and assumptions about their mental capacity. The Children and Young People's Mental Health Coalition calls for greater attention to the rights of children and young people in such settings (Children and Young People's Mental Health Coalition 2025). Young people in our interviews voiced concern that confidentiality was not always respected, underscoring the need for nuanced, trust-preserving procedures.

- **Comprehensive training, supervision, and support for providers.**

  Our qualitative findings in particular point to widespread gaps in professional understanding, particularly around trauma, neurodiversity and cultural competence, and a need for ongoing supervision and support structures that can hold the complexity of this work. Improving access to mental health services for at-risk children and young people requires a workforce that is technically skilled, reflexively trained and systematically enabled. Practitioners in our qualitative study and the literature highlight that training must go beyond awareness-raising. It should equip staff to distinguish trauma responses from neurodiversity, understand cultural expressions of distress, and work flexibly with young people whose needs fall outside traditional diagnostic categories (Gwata et al., 2024). Several participants in our study also described how systemic racism and adultification shaped clinical decision-making. They suggested that sustained training in cultural humility, anti-racism, and systemic bias should be embedded and coupled with reflective supervision, rather than delivered as one-off sessions.

Participants also discussed that whilst training is essential, so too is the provision of practical tools to support the complex decisions that professionals must make. However, there is currently a proliferation of assessment tools, many Trust-specific, leading to inconsistency and fragmentation. Standardising the use of evidence-based trauma screening and assessment tools, particularly across youth justice, education, and health settings, would improve continuity of care, reduce duplication, and enhance early identification. For example, emerging international evidence supports trauma screening for all young people in youth justice systems as standard practice (Branson et al., 2017).

- **Supervision and emotional support as standard.**

  The emotional toll of working with highly vulnerable young people was a recurring theme across interviews. Practitioners described holding immense responsibility, often with little access to supervision, emotional support, or space for reflection. This lack of support not only contributes to burnout and attrition, but undermines the quality of care that professionals can offer. Practitioners in our study called for regular reflective spaces and trauma-informed supervision, with some describing how the absence of support drove them to leave the profession. Supervision models should be expanded to all frontline professionals working with high-risk young people, including those in education, youth work, or voluntary sector roles, not just clinicians. Embedding clinical psychologists or trauma specialists within multi-agency teams was suggested as one effective way to support reflective practice and peer learning.

The findings of this research reveal a complex interplay of structural, socio-cultural and interpersonal barriers that prevent children and young people at risk of serious youth violence from accessing mental health support. These barriers cannot be tackled by one agency alone. Addressing them requires coordinated, cross-sectoral action. The following sections outline what the findings mean for key sectors, where change is needed, what good practice might look like, and how each sector can play a transformative role.

6.2 Health Sector (NHS CAMHS)

Key messages:

- Participants described clinical thresholds and referral criteria as too narrow, often excluding children with complex, overlapping needs—particularly when those needs presented as externalising or behavioural.

- Challenging behaviour was highlighted as frequently misunderstood, with limited recognition of its roots in trauma or distress. This is despite NICE guidance placing responsibility on health services to support children with conduct problems and antisocial behaviour.

- Children with high or complex needs were described as frequently passed between services, with no single agency willing to take responsibility— referred to as a 'hot potato' effect. CAMHS were seen as increasingly risk-averse and reluctant to "hold" complex or unstable cases.

- Participants reported that non-engagement was often misinterpreted as lack of need, when it may reflect systemic barriers, trauma histories, or lack of culturally competent, accessible support.

- The "missing middle" was highlighted as a major gap, leaving children whose needs fall between prevention and specialist care with no appropriate support.

- Participants emphasised the need to resource community-based, early-stage, and pre-therapy support, and to build relational, culturally competent services that engage young people before crisis hits.

These findings suggest that the current mental health system is not equipped to meet the needs of children and young people affected by serious youth violence, particularly those with complex, overlapping challenges. Referral pathways, risk management approaches, and engagement models are shaped by clinical and bureaucratic logics that exclude many of the young people who need support most. Addressing these gaps will require systemic shifts: expanding who is seen as eligible for care, how risk is understood and held, and where and how support is delivered. The following implications point to practical changes that could begin to realign the system with the needs and realities of this group.

Implications:

- Ensure referral criteria explicitly include children with behavioural difficulties, trauma-related distress, or overlapping needs - aligned with NICE guidance on anti-social behaviour and conduct disorders11.

- Create shared risk protocols so CAMHS are supported (and expected) to hold complex cases, rather than excluding them due to perceived instability or risk.

- Address the "missing middle" by developing or supporting existing intermediate services or pathways that sit between low-level and specialist care.

- Reframe 'non-engagement' as a systemic signal that services need to adapt, e.g. through assertive outreach, co-located support in multiple spaces, and relationship-led approaches.

- Redesign service pathways in partnership with young people and key practitioners, to prioritise continuity, trust, and accessibility over step-down and discharge models.

- Embed partnerships with the voluntary and community sector into NHS commissioning structures to extend the reach, flexibility, and cultural relevance of care.

- Strengthen cultural competence and trauma-informed practice across all mental health staff, particularly in frontline and triage roles.

6.3 Education Sector

Key messages:

- Participants described schools as often being the first point of contact for children in distress, but highlighted that staff frequently lacked the training, resources, and systemic support needed to play a meaningful early intervention role.

- Several participants reflected that exclusion could represent a missed opportunity to understand and support children whose behaviours may in some cases be linked to distress, trauma, or unmet mental health or neurodevelopmental needs.

- Participants highlighted a need for more trauma-informed and relational approaches in schools, noting that current behaviour policies are sometimes experienced as punitive and can prioritise compliance over understanding the underlying causes of distress.

- Participants noted that schools are well-placed to identify children with emerging needs, but their ability to intervene is constrained without clear referral pathways and collaboration with external services.

- Participants called for more comprehensive, embedded mental health support in schools - delivered by dedicated practitioners - so that teachers are not expected to carry responsibilities that go beyond their role or expertise.

The findings underscore the pivotal role that schools play in identifying and responding to children's emerging mental health needs. Participants highlighted education settings as one of the most critical sites for early intervention, but also one of the most stretched. At the same time, current systems - particularly exclusion policies and behaviour management approaches - were seen by some participants to compound vulnerability rather than mitigate it in certain contexts. Rather than placing further pressure on educators, participants called for a more balanced model: one that strengthens schools' ability to support mental health through embedded provision, system-wide collaboration, and a shift toward more relational, trauma-informed school cultures. The following implications suggest practical steps toward achieving that.

Implications:

- Strengthen and invest in embedded school-based mental health support by expanding the remit and clinical capacity of existing teams (such as MHSTs) or introducing additional roles who are consistently present, clinically trained, and integrated into the wider school community. These roles should be equipped to support children with moderate to complex needs, including some risk where appropriate, while operating within a multi-agency model of care and maintaining clear clinical supervision and escalation pathways to CAMHS and specialist services.

- Support a shift, where appropriate, from punitive or compliance-based behaviour management approaches toward whole-school, trauma-informed models that prioritise safety, relational trust, and understanding of underlying need.

- Equip school staff with training to recognise signs of psychological distress and trauma - not to act as clinicians, but to respond supportively and escalate concerns through appropriate pathways.

- Strengthen local systems of collaboration between schools, CAMHS, and voluntary and community sector providers, including clear referral pathways, joint protocols, and co-location or partnership models that ease the burden on schools.

6.4 Youth Justice System

Key messages:

- Participants expressed concern that young people with unmet mental health or neurodevelopmental needs or experiences of trauma - particularly from minoritised backgrounds - are disproportionately criminalised.

- Participants highlighted missed opportunities for mental health intervention at key points in the justice process - especially for young people on non-statutory or out-of-court disposals.

- Participants described how, in some cases, young people only accessed mental health support once they were in contact with the youth justice system, raising concerns about delayed intervention and the role of criminal justice pathways in unlocking support that should have been available earlier.

- Access to mental health provision within the youth justice system was described as inconsistent, with participants highlighting that support often depended on whether CAMHS or other therapeutic services were embedded within local Youth Offending Teams - raising concerns about equity and postcode variability.

Findings suggest that many young people enter the youth justice system with significant, longstanding mental health or neurodevelopmental needs that have not been recognised or addressed earlier in their journeys. Practitioners described how, in the absence of timely therapeutic intervention, behaviours linked to trauma or distress often escalated to criminalisation. The system was described as a site of last resort - one where some young people finally access help, but where others continue to fall through the cracks due to variability in local provision and high caseloads. The implications below outline practical ways to address these gaps and strengthen the role of youth justice as a point of therapeutic support.

Implications:

- Embed mental health professionals across all stages of the youth justice system, including early stages like Liaison & Diversion[12].

- Prioritise trauma-informed and developmentally appropriate responses to distress and challenging behaviour over punitive approaches - particularly for Minority Ethnic and neurodiverse young people who are disproportionately at risk of criminalisation.

- Divert young people away from custodial and formal justice processes wherever possible, ensuring access to therapeutic alternatives that recognise the role of unmet need, trauma, and structural disadvantage.

- Address geographic disparities in access to mental health support within the youth justice system by ensuring consistent, embedded provision across all Youth Offending Teams.

6.5 Local Authorities

Key messages:

- Participants described how local commissioning structures often reinforced fragmentation and short-termism, limiting the ability to build stable, integrated support pathways for children and young people.

- Participants raised concerns about a disconnect between local needs - particularly in high-risk areas - and the availability or configuration of commissioned mental health support, with some describing a mismatch between who is most in need and where support is actually available.

- Participants reported that the lack of strategic coordination and shared accountability across local agencies often left young people with complex needs falling between services, reinforcing the need for stronger leadership and integrated planning at the local level.

Access to support is deeply shaped by where a young person lives. Our mapping shows that some regions with the highest levels of risk have the least access to support. Participants described how funding cycles are often short-term, siloed, and shaped by narrow definitions of evidence or outcomes. There was a strong sense that commissioning is not a neutral process - it has the power to either entrench inequality or drive transformation. To better meet the needs of young people facing multiple, intersecting risks, local authorities must lead the way in creating integrated, equitable, and sustainable models of care.

Implications:

- Commission integrated, long-term, and multi-agency responses rooted in local context.

- Centre the voices of young people and marginalised communities in service design and funding decisions.

- Support joined-up systems that allow for shared risk-holding and continuity across sectors.

- Address "postcode lotteries" by investing in areas with the greatest need and least access.

- Develop commissioning frameworks that support flexibility, innovation, and relational models of care - beyond narrow clinical or outcome-based metrics.

6.6 Voluntary and Community Sector

Key messages:

- Participants described voluntary and community organisations as among the most trusted by young people and families, particularly where services were culturally rooted or community-led. Despite this, these organisations were frequently underfunded and overlooked in strategic planning and commissioning.

- Participants highlighted that statutory services often relied on the relationships and outreach capacity of voluntary and community sector organisations to engage young people.

- Many participants emphasised the critical role of these organisations in offering flexible, trauma-informed, and identity-affirming support - models often described as more accessible and responsive than statutory services.
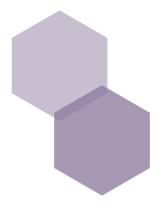
Voluntary and community sector organisations were consistently described by participants as trusted, accessible, and responsive - particularly for young people disengaged from or excluded by statutory services. These services are often the first-place young people talk about their mental health, especially when support comes from trusted adults, youth workers, or peer mentors. Yet despite their critical role, they are frequently underfunded, undervalued in commissioning, and siloed from mainstream provision. Without meaningful investment and integration, they cannot be expected to carry the full weight of complex or high-risk cases. Unlike other sectors in this report, the VCS operates without statutory authority or commissioning power. For this reason, we include two sets of implications: one for system leaders and commissioners, and one for VCS organisations themselves.

Implications for voluntary and community sector organisations:

- Strengthen partnerships and referral pathways with statutory services to ensure young people can access appropriate clinical or safeguarding support when needed, while maintaining trusted relationships and continuity of care.

- Invest in trauma-informed, culturally competent, and identity-affirming practice across the workforce, recognising these as core strengths that distinguish community-based support and build trust with marginalised young people.

Implications for system leaders and commissioners in relation to voluntary and community sector organisations:

- Secure stable, long-term funding for voluntary and community sector organisations as essential and trusted components of the mental health support ecosystem, particularly for young people who are disengaged from or underserved by statutory services.

- Recognise and commission 'pre-therapy', relational, and culturally embedded models of support as valid and vital forms of early intervention, not just "add-ons" to clinical services.

- Involve voluntary and community organisations in strategic planning and system design, not just frontline delivery, to ensure services reflect the needs and realities of the young people they support.

- Invest in youth work and community youth spaces as critical entry points for mental health support and early intervention, especially for those who do not access care through schools or statutory pathways.

- Establish clear referral pathways and information-sharing agreements between voluntary organisations and statutory services (such as CAMHS, social care, and schools), so young people can transition seamlessly across the system without falling through the cracks.

7. Conclusion and Recommendations

This report reflects the findings of a substantial, multi-strand research project delivered over a short timeframe, from August 2024 to May 2025. During this period, we secured ethical approval, established an advisory board, and carried out an ambitious programme of work, including secondary analysis of administrative data, rapid evidence reviews, national service mapping, and extensive qualitative research with 100 participants across England and Wales.

The evidence offers a comprehensive and grounded account of how mental health support systems are currently falling short for children and young people affected by serious youth violence. It highlights not only the deep misalignment between service structures and young people's lives, but also the opportunities for change already emerging across the country.

Throughout the research it became clear that children and young people with the greatest need are often those least able to access timely, appropriate, or meaningful support. This is not due to individual failings, but to systems that are stretched, fragmented, and too often designed without the voices of those most affected. Trauma, neurodiversity, and behavioural distress remain poorly understood. Risk is individualised, while structural drivers, such as poverty, exclusion, and racism, often go unaddressed. Meanwhile, the community-rooted, relational approaches that were highlighted by participants as essential, appear to remain on the margins.

Our research included the voices of practitioners, families, and young people to better understand these barriers and what is needed. We also identified services already modelling what more inclusive and responsive ways of working. Building on these insights, the following priorities emerged from the findings as critical to creating a mental health support system that meets the needs of children and young people affected by serious youth violence:

1. Invest early, flexibly, and holistically.

Shift resources toward early, low-threshold and community-embedded support that engages children and young people before crises escalate. This includes embedded provision in schools and communities, wraparound approaches, and non-clinical "pre-therapy" roles that act as bridges into formal services.
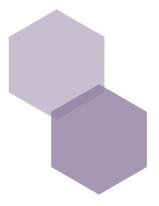
2. Redesign systems around equity, inclusion and clarity of access

Address structural drivers of poor mental health and violence - poverty, racism, exclusion, and ableism - as core risk factors. Broaden the definition of mental health to include the varied and often complex presentations of trauma, neurodiversity, and behavioural distress, and ensure these are recognised and resourced in policy, commissioning, and practice. As a practical enabler of equity, simplify the navigation and language of services: require plain, accessible English in all communications (especially from statutory services), standardise key terminology across sectors, and co-design user-friendly websites and referral pathways with children, young people, and their families.

3. Embed relational and culturally competent practice.

Trusted relationships are the foundation of engagement for young people affected by violence. Commissioners, organisations, and practitioners should prioritise relational continuity, trauma-informed care, and culturally competent approaches that reflect the lived experiences of marginalised communities.

4. Strengthen integration and collaboration.

Fragmentation leaves young people falling through the cracks. Multi-agency and multi-disciplinary approaches should be embedded across education, health, youth justice, and community sectors, with shared outcomes, clear referral routes, and interoperability of data and practice.

5. Involve young people and families in decision-making.

Young people and families affected by violence must be genuine partners in shaping support. Co-production should be resourced at all levels - from policy to service design to frontline practice - with youth advisory structures, lived experience roles, and participatory evaluation.

6. Reform commissioning and evaluation.

Commissioning must move away from short-termism and narrow outcome metrics that sideline community and preventative provision. Long-term, flexible funding should support models that have shown promise. Evaluation frameworks should expand definitions of evidence to include lived experience, qualitative data, and measures of engagement and trust.
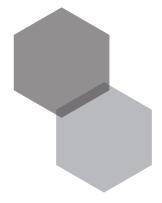
7. Equip and support the workforce.

Practitioners across sectors need sustained training, supervision, and reflective practice in trauma, neurodiversity, cultural competence, and ethical practice. Workforce wellbeing must be prioritised to reduce burnout and support continuity of care.

The findings presented here point to the need for more joined-up, flexible, and inclusive approaches to mental health support for children and young people affected by serious youth violence. Improving access will require changes not only to service delivery, but also to how mental health need is defined, how support is commissioned and evaluated, and how the perspectives of young people, families, and frontline practitioners are embedded in planning and design.

While this project offers a robust foundation, further work is needed, especially to improve data systems, elevate underrepresented voices in research, and evaluate access over time. The findings presented here are an evidence-informed contribution to the wider effort to ensure that all children and young people affected by serious youth violence can access timely, meaningful, and compassionate mental health support.

End notes
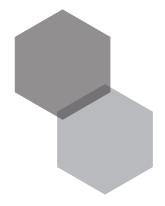
1. Definition from the Centre for Mental Health
2. Whilst we recognise that 18-year-olds are legally classed as adults in England and Wales and eligible for adult services, we chose to include them in this research as this age marks a critical transition point between child and adult provision. Several of our findings relate directly to the challenges of navigating this transition, making their inclusion important to the study.
3. Key Facts About Violence | Youth Endowment Fund
4. Children, Violence and Vulnerability 2023 | Youth Endowment Fund
5. Human Development Report 2023/2024 Technical Notes: https://hdr.undp.org/sites/default/files/2023-24_HDR/hdr2023-24_technical_notes.pdf
6. https://the-sra.org.uk/
7. International Territorial Level 1 is the ONS regional classification with the UK broken down into 12 regions. The current project utilised the 9 England ITL1 regions + Wales
8. A legal document that outlines the special educational, health, and social care needs of a child or young person aged up to 25 who requires more support than is typically available in mainstream settings
9. Tier 3 CAMHS (Child and Adolescent Mental Health Services) provides specialist, multi-disciplinary support for children and young people with severe or complex mental health difficulties. These difficulties might include psychosis, depression, eating disorders, or severe anxiety, among others. Typically delivered within local community settings, such as clinics or mental health centers, these multi-disciplinary teams often include professionals like psychiatrists, psychologists, nurses, and social workers. They provide specialist assessments, treatment plans, and interventions for children and young people with more complex or persistent mental health difficulties.
10. Tier 2 CAMHS (Child and Adolescent Mental Health Services) provides targeted support for children and young people experiencing mild to moderate mental health difficulties, often referred from Tier 1 services or directly. These services are typically delivered in community settings like schools, GP clinics, and youth services, by professionals such as counsellors, psychologists, and therapists. Tier 2 aims to address issues like anxiety, depression, and behavioral challenges before they escalate to more complex needs.
11. NICE (2023). Antisocial behaviour and conduct disorders in children and young people: recognition and management. https://www.nice.org.uk/guidance/cg158/chapter/recommendations
12. Liaison and Diversion (L&D) in youth justice aims to identify and support young people with vulnerabilities (like mental health issues, learning disabilities, or substance misuse) who come into contact with the criminal justice system. It focuses on early intervention and diversion from the formal court process, ensuring young people receive appropriate health and social care to address their needs and reduce reoffending. https://www.england.nhs.uk/commissioning/health-just/liaison-and-diversion/about/

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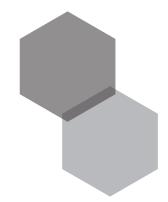
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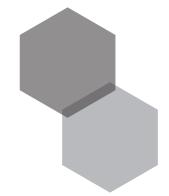
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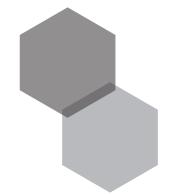
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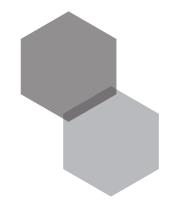
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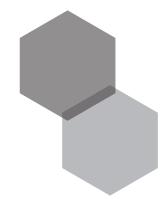
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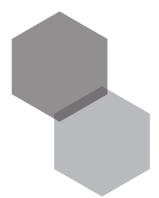
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Annex

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Impetus | Home Office

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