Detailed response to Independent Review into prevalence and support for mental health conditions, ADHD and autism in England

The Royal College of Psychiatrists | November 2026

Executive summary

Last month, the UK Government published the findings of an independent review into the prevalence of mental health and neurodevelopmental conditions in England. The review's final report makes 10 priority recommendations for government and local systems. This document responds to each of these recommendations in the sections below, setting out practical considerations to be accounted for in the implementation of the recommendations.

The College supports the review's ambitions to improve prevention, early intervention, access, and support for people with mental health and neurodevelopmental-related needs. A move towards a "needs-led" system has the potential to ensure people with severe impairment are prioritised while reducing barriers to care and support for people with mild to moderate presentations while they wait for formal assessment. These ambitions can only be realised if:

1. **Psychiatric expertise is embedded within or joined up with all the different "front doors" to a needs-led system**. This would be in line with the review's proposed 'expert at hand' model and would mean that people with severe presentations could be efficiently identified and prioritised for early assessment and treatment regardless of their entry point into it (schools, hubs, workplaces, primary care, social care or community services).
2. **Mental Health Community Centres are designed and resourced to support people with severe and enduring mental illnesses across the country**. All community-based support, including new neighbourhood centres, should align with the adoption and implementation of the Community Mental Health Framework.
3. **NICE-recommended innovative treatments predominantly for people with SMIs are commissioned more consistently**. Medications like clozapine, lithium and metformin, for example, should be available in every area of England. Mental Health Community Centres provide the perfect opportunity to embed these treatments in communities across the country. Mental health research also requires investment to fund the development of new innovative treatments to address longstanding treatment gaps.
4. **Neurodevelopmental expertise is augmented and embedded within existing mental health services and the specialist mental health workforce is expanded.** Neurodevelopmental capability needs to be scaled up across the mental health system to ensure everyone who is referred to secondary services receives a comprehensive, biopsychosocial psychiatric assessment that includes consideration of all relevant co-occurring neurodevelopmental conditions. At the same time, specialist services will need more staff if they are to immediately see people who are prioritised via the 'shared needs assessment' and still provide a pathway for those with less severe presentations[1]. Any review of existing waiting lists must be clinically led, individualised, and focused on improving capacity; no child or adult should be removed from a waiting list without appropriate assessment or care.
5. **The availability of open-access provision for babies, children, young people and young adults is mapped, and the pathways between CAMHS and adult services are identified, in every area in England.** Understanding the availability of mental health support teams in schools, family hubs, early support hubs, and Young Futures hubs would allow us to identify gaps, and focusing on pathways between services as young people become young adults would begin to address the "cliff edge" that exists between services.

[1] Such a pathway for those with more moderate presentations would still be important as diagnosis, particularly for conditions like ADHD, is often essential for accessing some types of evidence-based treatments such as medication

The review did not find evidence of misdiagnosis or overdiagnosis at scale. We support the review's recommendation that more frequent national prevalence studies take place and data collection on mental health, ADHD and autism is improved. We would also like to see under 5s included in the Mental Health of Children and Young People in England (MHCYP) survey series. We support the review's recommendation that all ADHD and autism assessment activity is regulated by the CQC; it is our view that private providers delivering NHS-funded ADHD and autism assessments should contribute data to support a national picture of need.

We wish to note, as the review itself does, that neurodevelopmental conditions are not limited to ADHD and autism. The clinical classification of neurodevelopmental disorder extends to conditions like fetal alcohol spectrum disorder (FASD), tic disorders, dysgraphia, speech and language disorders, dyslexia, dyspraxia, and intellectual disability. The increased focus on ADHD and autism is welcome, but this should be accompanied by more attention on the wider landscape of neurodevelopmental need, including intellectual disability. To this end, and to further support babies, young children and their parents as early as possible, tracking of neurodevelopmental milestones should be improved through the Personal Child Health Record (PCHR) – the 'Red Book' parents and carers receive to record a child's health and development – alongside other developmental milestones that are already recorded.

We are pleased that the UK Government has committed to an overhaul of mental health provision in England in the forthcoming Mental Health Strategy. As the report itself does not provide figures on the investment its recommendations require in order to be implemented, this strategy needs to be costed. It should also set out clear actions, accountability arrangements and contain within it a formal mechanism for assessing the mental health impacts of public policy across all sectors. To build capacity and capability across the system as this review suggests, it is also vital that the UK Government provides a detailed plan outlining how the mental health workforce will be effectively retained and recruited to meet the scale of need.

Response to recommendations

Recommendation 1: *Tackle the drivers of mental distress and ill health through an ambitious approach to prevention, early intervention and improving public mental health and wellbeing.*

Preventing the causes of mental ill-health

Mental illnesses disproportionately affect children and young people, with 63% arising by the age of 24. The report attributes rising levels of mental distress in children and young people to "a constantly changing world they have almost no control over." We wish to note however that social adversity is one factor among several; mental illness in children arises through biological vulnerability, genetic and developmental factors, psychological experience and social circumstance together, and it occurs with and without obvious adversity.

The review found that an increase in diagnoses has come with no decrease in severity or impairment across the population. Mental illness in children is real, as it is in adults, can be severe, and needs early and thorough assessment and treatment.

Open access capability and availability

The report points to school-based interventions to prevent enduring mental ill-health for children and young people who are at increased risk and calls for the delivery of full national coverage of open-access provision. To achieve this, mental health support teams in schools must be joined up with their local specialist child and adolescent mental health service (CAMHS) so that the school-based service is then able to determine what a young person's clinical need is, whether a school-based setting is appropriate, or if they need to be referred on to the local specialist service.

This kind of coordination and collaboration should take place between open-access settings of all kinds (family hubs, early support hubs, Young Futures hubs) to embed psychiatric capability within every service. This will ensure that those with the most complex mental health and neurodevelopmental presentations are able to access the specialist service they need in a timely manner.

More broadly, the UK Government should map the availability of open-access provision (including all teams in schools and hubs in the community) across England to identify gaps in provision. The purpose of this exercise should be to ensure that open-access provision is available in every area of the country with clear accountability across integrated care boards (ICBs), local authorities and the UK Government.

Local and national planning on wider determinants of mental health

To see real improvement in population-level mental health, it cannot be viewed in isolation as a health issue.

We therefore welcome the report's recommendation to improve access to sport, creative arts, play and green spaces. For this recommendation to be implemented, local and national strategies, and any subsequent guidance, must be designed to meet the needs of people with the most severe mental illnesses, intellectual disabilities, neurodevelopmental and neuropsychiatric conditions. Practically, this would look like:

- green spaces and play areas designed so that they are accessible for all children and adults with disabilities;
- ensuring offers of social prescribing are accessible to everyone regardless of condition or need

- recreational programme staff provided training to support children with complex needs; and
- expanding peer support networks so that people who find it more difficult to engage with new environments are provided with 'buddies.'

We also welcome the report's recommendation that action is required on appropriate housing, which is particularly important to ensure that young people and adults alike are not spending longer than is appropriate for them in inpatient settings. Specifically, in our view, the UK Government, NHS England, Homes England and the Greater London Authority need to commit to long-term, sustainable funding for supported housing, greater rent flexibility and stronger integration of housing into national and regional mental health policy.

As part of ensuring that there is appropriate prioritisation of local planning activities, the Prevention Concordat for Better Mental Health in England should also be strengthened and ICBs should again be required to include clinical mental health expertise at senior decision-making level.

At a national level, all domestic government departments have a role to play in preventing the onset of mental illnesses, reducing the likelihood of relapse and supporting people to live well. (Well-established models suggest that clinical care accounts for 20% of health outcomes while socioeconomic factors and physical environments make up 50%.) For there to be accountability, there must be public commitments for each department to fulfil as part of the forthcoming cross-Government Mental Health Strategy. The DHSC has already developed a 'mental health and wellbeing impact assessment tool' to support national policymakers to consider the mental health and wellbeing impacts of all policies, but it was never implemented. In theory, there is no reason why this could not be further rolled out to support local decision makers as well.

Recommendation 2: *Move from a 'diagnosis-dependent' to a 'needs-led plus diagnosis' system by developing a digitally and AI-enabled shared needs assessment and prioritisation framework for people with mental health and neurodevelopmental needs.*

A "needs-led system" for mental health and neurodevelopmental conditions

The review did not find evidence of overdiagnosis at scale and found that misdiagnosis comes from remote assessments under pressure. What is clear is that underdiagnosis, misdiagnosis and overdiagnosis coexist. This is a case for increasing specialist capacity, not against formal assessment.

The report recommends a new "needs-led" neurodevelopmental system that is underpinned by a "no wrong front door" approach. That is, whether a person presents with neurodevelopmental need for the first time at school or their workplace; through primary care, community services, mental health services, social care, youth or family hubs; or via a digital platform, they can enter the system from there.

The report proposes the development of a "shared needs assessment" – an integrated and consistent cross-sector approach to triaging people who present through any of these trusted routes – which can be relied on to prioritise those with the most severe functional impairment for formal assessment and treatment while those with more mild to moderate impairment receive treatment, support and reasonable adjustments while they wait for a formal assessment.

We agree with the review that a person's care and treatment should not strictly depend on a formal diagnosis and that a move towards a "needs-led" system could ensure that:

- those with severe presentations are prioritised; and
- help to reduce barriers for others who are deemed to have mild to moderate impairment while they wait for a formal assessment.

However, for such a system to work, there must still be a timely pathway to formal assessment for those who are deemed by a shared needs assessment to have mild to moderate mental health or neurodevelopmental needs. This is particularly important where certain treatments are only available following formal assessment; for example, a child, young person or adult with ADHD can only begin medication – which many rely on as a core part of their treatment alongside other forms of care such as psychological therapy – following a formal assessment and diagnosis. It is also important to note that mild to moderate presentations can become more severe over time.

If the proposed shared needs assessment and associated prioritisation framework are going to be relied upon to appropriately triage and then expedite assessment and treatment for people with more severe mental health and neurodevelopmental needs, then, much like open-access provision, psychiatric capability will need to be embedded at each potential 'front door' across the system. Staff across all relevant sectors will need mental health and neurodevelopmental training specific to this new kind of assessment. Specialist mental health, intellectual disability[2], ADHD and autism services will also need to be joined up with those working at the wide range of entry points to the system. This will be a significant undertaking to develop the required training and set up the necessary links across the system, but it will be necessary to ensure that people are not lost and that referrals to secondary care are not rejected.

[2] Neurodevelopmental disorders also include conditions like fetal alcohol spectrum disorder (FASD), tic disorders, dysgraphia, speech and language disorders, dyslexia, dyspraxia, and intellectual disability.

Embedding psychiatric capability across the different access points to a needs-led system in this way would be particularly important to ensure that severe mental illness (SMI) can be detected early and prioritised. SMIs are often more difficult to detect; we know, for example, that on average it takes nearly ten years for a person to get an accurate bipolar diagnosis. Those with severe and enduring mental illnesses need to be central to the development of the 'no wrong front door' approach, shared needs assessment and the prioritisation framework.

Additionally, neurodevelopmental capability needs to be augmented and embedded across specialist mental health services to ensure everyone who is referred to adult mental health services, CAMHS, ADHD and autism services, and learning disability services receives a comprehensive, biopsychosocial psychiatric assessment that includes consideration of all relevant co-occurring neurodevelopmental conditions, including intellectual disability. This would ensure differential diagnoses are considered and that the relevance of neurodevelopmental disorders is considered for each patient.

Presently, due in large part to the strain on the system, access to formal ADHD assessment and then treatment through a shared care agreement can be fragmented and difficult to navigate for patients and carers. The new, needs-led pathway should follow clear evidence-based steps which are laid out for patients and carers prior to any assessment or treatment so that they know what to expect and 'what good looks like.'

As part of the report's proposed review of existing ADHD and autism waiting lists, the number of clinicians currently trained to conduct these assessments needs to be examined with a view both to address existing long waiting lists but also to build capability necessary for a needs-led system to be in place. Furthermore, waiting list and medication reviews must be clinical and individual; no child or adult should be removed from a list without assessment.

If diagnosis is not essential to access certain interventions, this approach should be reflected in access to mental health occupational health services; support into work where appropriate and where a person is able; and to benefits. (If systems rely on a mental health or neurodevelopmental diagnosis to access support and benefits, then the proposed needs-led system would be undermined.)

The Royal College of Psychiatrists would welcome the opportunity to collaborate where possible with government and stakeholders in the development of a shared way of assessing and describing need from mental health, ADHD and autism service perspectives.

Recommendation 3: *Commission and deliver integrated, digitally-enabled mental health and neurodevelopmental assessment and support that is age-appropriate and responds to the needs of local communities.*

A neighbourhood mental health model and the Community Mental Health Framework
It is encouraging to see the report outline actions to ensure people can access support in their local community, close to home.

Any investment in integrated, community-based support should align with the adoption and implementation of the Community Mental Health Framework, which has been shown to work by improved patient outcomes in Somerset and Tees, Esk and Wear Valley. This framework clearly sets out how multidisciplinary teams (MDTs) and voluntary, community and social enterprise (VCSE) partners should be included in its delivery.

Specifically, there is a real opportunity for Mental Health Community Centres to become a 'gold standard' for community mental healthcare, but this will only be possible if they are designed and resourced to support people with SMIs; assertive outreach also needs to be re-established for this population as they are less likely than those with more common mental health conditions to engage with these new neighbourhood centres. Whether or not an area has the capacity to implement a centre in this way, the Community Mental Health Framework offers guidance to improve community provision in ways possible for all commissioners. Regardless of whether a place is implementing a Community Centre or other community interventions, they should be provided with support and guidance to do so.

The neighbourhood health approach, based on the Community Mental Health Framework, can play a key role in delivering this support and alongside other organisations to address people's housing, financial and other social needs. The move to a neighbourhood health model must, however, also be replicated for babies, children and young people, co-locating with physical health services or local community ones like libraries to reduce stigma and improve communication between primary and secondary care.

Improving outcomes for babies, children and young people into adulthood
Two age groups that often fall through the cracks of the mental healthcare system are:

- babies and young children under the age of five (and their families); and
- young adults up to 25 years old.

We are pleased that the report recognises the importance of the first five years. Mental health conditions and neurodevelopmental differences may emerge in the early stages of a child's life. To support babies, young children and their parents as early as possible, it is our view that tracking of neurodevelopmental milestones should be improved through the Personal Child Health Record (PCHR) – the 'Red Book' parents and carers receive to record a child's health and development – alongside other developmental milestones that are already recorded.

We are also grateful to the review team for their focus on young people moving into adulthood, and specifically the "cliff edge" that exists between services for children and young people and adult services. To begin to bridge the gap between child and adult services at a national level, the UK Government should:

- develop metrics to collect and publish data on the proportion of young people who successfully transition to adult mental health services after ageing out of CAMHS; and
- map pathways and identify variances in thresholds between CAMHS and adult services in each area of the country to inform joint commissioning.

Locally, adult services should reflect the length of time a young person has already waited to be assessed and treated when they 'age out' and transfer from a CAMHS waiting list to an adult one. (This step should be taken at least until such time as waiting times for young people are reduced.) Transition plans, including details of conversations held about their transition, and relevant clinical information should be provided in writing to both the young person and the service they are transitioning to. To support the sharing of information between services in this way, joint working protocols should be developed between CAMHS and adult mental health services; this could be supported through a 'community of practice' approach which gives practitioners a forum to share knowledge and best practice to develop a more complex understanding of the issues facing young people and young adults.

The review emphasises the importance of measuring a child or young person's life in school, family and relationships, in their community, not in the number of contacts with services. If participation in education and work is going to be core individual-based outcome of mental health and neurodevelopmental care, then participation in volunteering and other community activities should be included within this. There also needs to be an acknowledgement that even with care that is timely, effective and appropriate, that some people will not be able to engage in work or education. NHS England and DHSC should commission ICBs and providers to adopt outcomes metrics which are linked to progress, similar to the data Talking Therapies collects; this would help us better understand how services are supporting children to remain in meaningful activities and in turn ensure the right services are available in each area.

Recommendation 4: *Close treatment gaps while protecting, strengthening and investing in specialist services to improve access and outcomes for those with the most severe, complex and enduring needs, including specialist support delivered in the community, and crisis and inpatient services.*

Investing in innovative mental health interventions

We warmly welcome the report's recommendation to close the treatment gap for those with the most severe, complex and enduring needs across community, crisis and inpatient services. People with SMIs should be supported to thrive, not simply survive.

Research enhances clinical mental healthcare and improves outcomes for patients. But mental health has seen over a decade of sub-par funding compared with physical health, resulting in a relative delay in the development of new drugs, and clinical treatments for mental health conditions. There has also been a paucity of high-quality research into social interventions and epigenetic factors linking genomics with psychosocial variables. The first step in closing the treatment gap for those with the most complex mental health need is increased investment in mental health research. Allocating additional funding for research studies, clinical trials, and technology-driven solutions can facilitate the development of innovative interventions, evidence-based practices, and improve modes of treatment.

There also needs to be an increase in the commissioning of NICE-recommended innovative treatments predominantly for people with SMIs. Currently, not only is there a lack of research into new treatments, those that are available are not consistently available across the country. This must change. Medications like clozapine, lithium and metformin, for example, should be available in every area of England. Neighbourhood Mental Health Centres provide the perfect opportunity to embed these treatments in communities across the country.

All long-term prescriptions should be regularly reviewed and offered as part of a holistic, biopsychosocial treatment plan that includes addressing lifestyle or social factors that may be contributing to a person's presentation, as well as offers of non-pharmacological and psychological options, such as talking therapy. Alongside adapting Talking Therapies for ADHD and autism, psychological therapies for those with SMI and other more complex conditions should also be commissioned.

Early years treatment gap

Only a minority of under 5s with mental health conditions are identified or receive treatment, with negligible coverage of interventions to prevent mental health conditions or promote mental wellbeing and resilience. Similarly, only a minority of parents during pregnancy or with children under 5 years of age receive interventions to prevent or treat mental health conditions. This implementation gap results in population scale preventable suffering, significant impacts across the life course and associated economic costs.

To ensure that babies, young children and their families can access existing treatments, there needs to be investment in a range of evidence-based assessments and interventions (and the workforce needed to deliver them) for under 5s who show early signs of mental ill-health. These include parenting programmes, psychodynamic interventions with young children and their caregivers, parent-child interaction therapy and video feedback.

Recommendation 5: *Overhaul the commissioning, funding, oversight and regulation of mental health and neurodevelopmental services, including making all diagnostic assessments for ADHD and autism Care Quality Commission (CQC) regulated activity and banning direct-to-public advertising of NHS-funded ADHD and autism assessments.*

Regulation of ADHD and autism assessments

We support the report's recommendation that all ADHD and autism assessments should be regulated by the CQC. This is an important step to ensure consistent quality standards across services and assessments.

An ADHD diagnosis requires a comprehensive clinical assessment that considers differential diagnoses, co-occurring conditions and an individual's wider circumstances. Getting this right is essential, as both missing or misdiagnosing ADHD and related conditions can have lasting consequences for patients.

Patients, parents and carers should also receive information about what to expect from an assessment and subsequent treatment, to ensure they can advocate for the best possible care.

People who have ADHD should be provided with a personalised treatment plan which may include a range of different options, including lifestyle changes, organisational skills training, an ADHD coach, therapy or medication. It is vital they receive the combination of support that works best for them and that this is tailored to their individual needs.

Recommendation 6: *Build capacity and capability across the multidisciplinary workforce to deliver more integrated mental health and neurodevelopmental support, backed by investment in training, supervision and career development.*

Building workforce capacity

When implementing this recommendation, government and local systems should invest in the value that psychiatry adds. Psychiatrists are medically trained doctors who are uniquely positioned to address the interplay between mental and physical health. We are medically qualified doctors who treat and help people to manage or recover from a range of mental health conditions, including substance use disorders and severe and enduring mental illnesses. Consultant psychiatrists are often the leaders of the MDT, supervising doctors in training and other mental health staff.

Key to psychiatry is holistic practice, considering all aspects of patients' lives – the role of biological, psychological, social and environmental factors in the development of their illness and presentation of their symptoms – and an ability to understand the risks and benefits of treatments that might be available. It takes a unique skillset to synthesise this information in a way that can make an important difference to people's lives.

Therefore, to build capacity and capability across the system as the review suggests, it is vital that the UK Government invests in the psychiatric and wider mental health workforce and provides a detailed plan which sets out how the mental health workforce will be effectively retained and recruited to meet the scale of mental health and neurodevelopmental conditions.

Within such a mental health workforce plan, we would like to see provision for:

- Comprehensive mental health and wellbeing support for staff alongside assertive action to encourage help-seeking at an early stage and to address the stigma staff with a mental health diagnosis can face.
- Ring-fenced investment that will ensure staff receive administrative support; can access working technology (including digital support to manage caseloads and to support clinical prioritisation); and have adequate space to carry out daily duties (including confidential consultations).
- Bottlenecks addressed in medical training pathways with local medical schools and postgraduate schools supported to create medical school placements in psychiatry.
- Maintenance of commitments to double medical school places, ensuring this is fully costed and delivered, with more medical school places put into schools with a proven track record of delivering consultants in shortage specialties including psychiatry
- Forecasts set out for growing specialties, including psychiatry in the short, medium and longer term. We need to see comprehensive and transparent modelling of postgraduate medical specialty places, including in the range of psychiatry specialties.
- Integration of psychiatry with the wider health and care system, for example, integration of neuropsychiatry in neurology services and further research to improve understanding and treatment of specific associations between neurodevelopment and neuropsychiatric conditions. (Neuropsychiatrists diagnose, treat and support people with primary diagnoses of autism, ADHD, and other neurodevelopmental conditions, and also diagnose and support patients in whom neurodevelopmental disorders have an increased prevalence compared to the general population.)
- Mental health services should also better embed work, benefits and housing support into services, given the need to ensure a biopsychosocial model to support patients.

The review's model for children and young people rests on an "expert at hand." These experts are child and adolescent psychiatrists and paediatricians, but, as of March 2025, around one in six consultant child and adolescent psychiatry posts in England are vacant.

Recommendation 7: *Take an ambitious approach to scaling up safe digital and AI-enabled tools within a digitally enabled and integrated care pathway, while sharing and using data to improve quality of care, efficiency and productivity.*

Digital funding for mental health services

Evidence-based, clinically-led digital interventions should be commissioned on a national basis to ensure consistent access. Additionally, mental health services should be prioritised for digital funding, such as auditory verbal therapy (AVT). This would remove barriers to accessing mental health and neurodevelopmental care and bring us a step closer to parity of esteem with physical health.

Recommendation 8: *Improve data collection and evaluation for mental disorders, ADHD and autism, including through regular population prevalence studies, and update NICE guidelines to strengthen the evidence-base for policy development and implementation.*

Data collection

We agree with the report's recommendation that there should be more regular national population prevalence surveys for mental disorders and neurodevelopmental conditions.

Specifically, we agree that there should be a more regular cycle of the Adult Psychiatric Morbidity Survey (APMS) to provide policymakers and commissioners with up-to-date robust prevalence data. Disaggregation efforts could also build on the recent OHID work to provide SMI estimates at local authority level.

Population prevalence studies on ADHD and autism should also be conducted as part of the APMS. Further, it is our view that providers who are commissioned by the NHS in England to conduct ADHD and autism assessments should be required to share data to help create a national picture of prevalence.

Similarly, robust epidemiological research both for people with intellectual disability and people in prisons is needed. These populations are not captured by the APMS but they experience a high burden of mental disorder, and also high rates of neurodevelopmental conditions, or higher rates of co-occurring neurodevelopmental conditions in the case of people with intellectual disability.

We would also like to see a more regular cycle of the Mental Health of Children and Young People (MHCYP) survey and the introduction of routine, regular government-funded data collection on prevalence of the mental health and wellbeing of under 5s and families.

Recommendation 9: *Commission a national public information and education campaign to help people better understand, support and accommodate neurodevelopmental conditions and manage their mental health, supported by a trusted digital platform providing evidence-based information, tools and support without requiring a diagnosis.*

The College has a catalogue of evidence-based mental health information and resources that should be included in any centralised platform.

Recommendation 10: *Publish a cross-government mental health strategy this year setting out how this report's recommendations will be implemented through immediate actions in the next 12 to 24 months and a 10-year reform plan.*

We are pleased that the UK Government has committed to an overhaul of mental health provision in England in the forthcoming Mental Health Strategy.

As the report itself does not provide figures on the investment its recommendations require in order to be implemented, this forthcoming strategy needs to be costed. It should also set out clear actions, accountability arrangements and contain within it a formal mechanism for assessing the mental health impacts of public policy across all sectors. Additionally, there should be a cross-Government board, co-chaired by DHSC and the Cabinet Office to oversee progress on its agreed commitments.

It is also vital that the UK Government provides a detailed plan outlining how the mental health workforce will be effectively retained and recruited to meet the scale of need.

Mental health care and good population mental health should be seen as an investment rather than a cost. To this end, services should be commissioned to understand the return on investment of different interventions. To ensure that all departments and policy makers consider the impact of their policies on mental health, a 'mental health policy test' should also be rolled out.