PBE Economics to improve lives

The happy childhood dividend:

The value of reversing a decade of decline in children's mental health

By Rachel Gomez and Jon Franklin

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About PBE

We use economics to improve lives. Through analytical expertise and our close connection with the social sector, we help charities, funders, firms and policymakers tackle the causes and consequences of low wellbeing. Our analysts, researchers and economists work on a wide range of issues related to low wellbeing, including mental health, education, employment, financial security, poverty, disability, inequality, volunteering and civil society. Working with over 600 volunteer economists, we have supported over 600 charities since 2009.

About Place2Be

Place2Be is a leading children's mental health charity providing school-based support and in-depth training programmes to improve the emotional wellbeing of pupils, families, teachers and school staff. The charity currently provides an embedded mental health service in over 650 UK primary and secondary schools, supporting a school community of around 350,000 children and young people.

Acknowledgements

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Key takeaways

1. Overall, the mental health of children in the UK steadily worsened between 2011/12 and 2021/22.
2. Reversing this trend could improve total GCSE attainment by 0.1-1.6 grades, reduce the likelihood of needing SEN support by 0.1-1.1 percentage points (ppts) and reduce the likelihood of being excluded from school by 0.1-0.4 ppts.
3. Improving mental health could deliver lifetime economic benefits of £51 billion through improved earnings, avoided exclusion costs and redistributed SEN support.

Summary

Wellbeing boosts life chances. When children feel mentally well, they do better at school, build stronger relationships and reach their life-long potential. This report provides new evidence and analysis of the long-term economic benefits of investing early in children's mental health.

Families, schools and communities are struggling to manage and respond to the severity of the problem of children's mental wellbeing. Currently, around one in five children aged 8-16 are likely to have a diagnosable mental health issue, according to the latest NHS Digital evidence. The problem is getting worse. Using the Strengths and Difficulties Questionnaire (SDQ), the Understanding Society dataset demonstrates that, overall, children's mental health has declined in the decade between 2011/12 and 2021/22. These statistics summarise a series of profound personal crises for individual children and their families, and systemic challenge for schools, children's services and our NHS.

Undoubtedly, there is a moral imperative to reverse this downward trend in children's mental health. Those working in policy and implementation agree that earlier access to support is key but is persistently difficult to implement. The Government's plan for public services and the NHS includes multiple commitments on prevention, including investment in Mental Health Support Teams (MHSTs) within schools and colleges, and funding for Early Support Hubs. However, in 2023/24, only 36% of the referred children and young people received mental health support within the NHS's four-week target and 34,000 went for two years without being seen. While MHSTs have expanded the reach of in-school support, 40% of school leaders state that staff capacity has blocked them from making the most of this offer. In a stretched system with demand for crisis support outstripping supply, the capacity of new and existing services remains a critical barrier to delivering the full impact of earlier intervention and approaches to prevention that support schools.

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It is time for a robust, up-to-date understanding of the long-term economic impacts of children's mental health to deliver a persuasive case for the value of investing in this area.

Our analysis of the Millennium Cohort Study (MCS) - a long-term research project tracking early and later-life outcomes for a group of people born in 2000-2002 - suggests that even small improvements in children's mental health could boost GCSE attainment, and reduce their probability of being excluded from school or requiring Special Educational Needs (SEN) support in secondary school. Putting this into context, taking steps to reverse the decline in children's mental health, could:

- boost GCSE attainment by 0.1-1.6 grades per child;
- reduce the likelihood that a child requires secondary school SEN support by 0.1-1.1 percentage points (ppts); and
- reduce the likelihood of a child being excluded in secondary school by 0.1-0.4ppts.

Improving children's mental health could also generate long-term economic benefits. Our analysis suggests the long-term benefits of improved childhood mental health stretches into adulthood through higher take home pay, tax revenue and lower demand on public services. Reversing the last decade of decline could generate economic benefits of £5,300 per child over the course of their lifetime, or £51 billion across all children at school in a given year. This is made up of additional economic benefits of £50 billion from employment outcomes, £17 million from the reduced costs of exclusion, and £606 million from SEN support costs. We need urgent, effective action to unlock these long-term social and economic benefits.

The NHS is a vital partner and provider in achieving this change, but it simply cannot deliver it alone. Intervening earlier, and acting to boost positive mental health and prevent problems emerging, is a cross-sector responsibility. The evidence backs up what children themselves tell us: childhood mental health is intertwined with life at school, at home and day-to-day experience in the community.

We need more effective support, with the private, public and social sectors working together to achieve this. Many charities such as Place2Be work alongside, and with, government-funded support to reach as many children as possible. They offer school-based counselling, family support, and training and assistance to those working with children and young people. By offering accessible support in various forms, charities in the children's mental health space are vital to helping reverse this trend, especially for children in need of help who don't meet the threshold for statutory clinical support. By effectively drawing on insights and skills of school leadership, combining public and charity sector forces, embedding whole school approaches, and connecting those who urgently need help now to mental health services, we should ensure every child can get the support they deserve.

Children's mental health has been getting worse

Children's mental health has declined and waiting lists for support have grown. According to the latest NHS data in 2023, around one in five children aged 8–16 are likely to have a diagnosable mental health condition — up from one in eight in 2017.[1]

Sleep problems, self-harm and disordered eating have also persisted alongside poor overall mental health. This highlights a continued interplay between these conditions in young people and the need for specialist support to respond to this complex mix of needs. In 2023, 77% of those with probable mental health disorders reported having problems with sleep at least three nights in the preceding week – the statistic remained high at 38% when broadened out to all 8-16 year olds.[2] Self-harming attempts were made in the preceding four weeks by 2% of children, and about one in 11 (9%) had attempted to self-harm at some point previously. In secondary schools, 4% of girls and 1% of boys were diagnosed with an eating disorder. However, the actual number of children experiencing a difficult relationship with food may be considerably higher, with NHS data suggesting 12% of young people screened positive for possible eating disorder, with girls, in particular, at 15%.

In addition, our analysis of the Understanding Society dataset[3] suggests that, between 2011/12 and 2021/22, school children reported worse mental health, with the average child reporting a higher Strengths and Difficulties Questionnaire (SDQ) score of 1.2 points on average (ranging 0.3-2.2 depending on age). Covid has added to mental health concerns considerably, with various evidence pointing to how children struggled during and after lockdown.[4] However, as illustrated in Figure 1, children's mental health started deteriorating long before the pandemic started.

1 Mental Health of Children and Young People in England, 2023 - wave 4 follow up to the 2017 survey. NHS England Digital (21 November 2023).

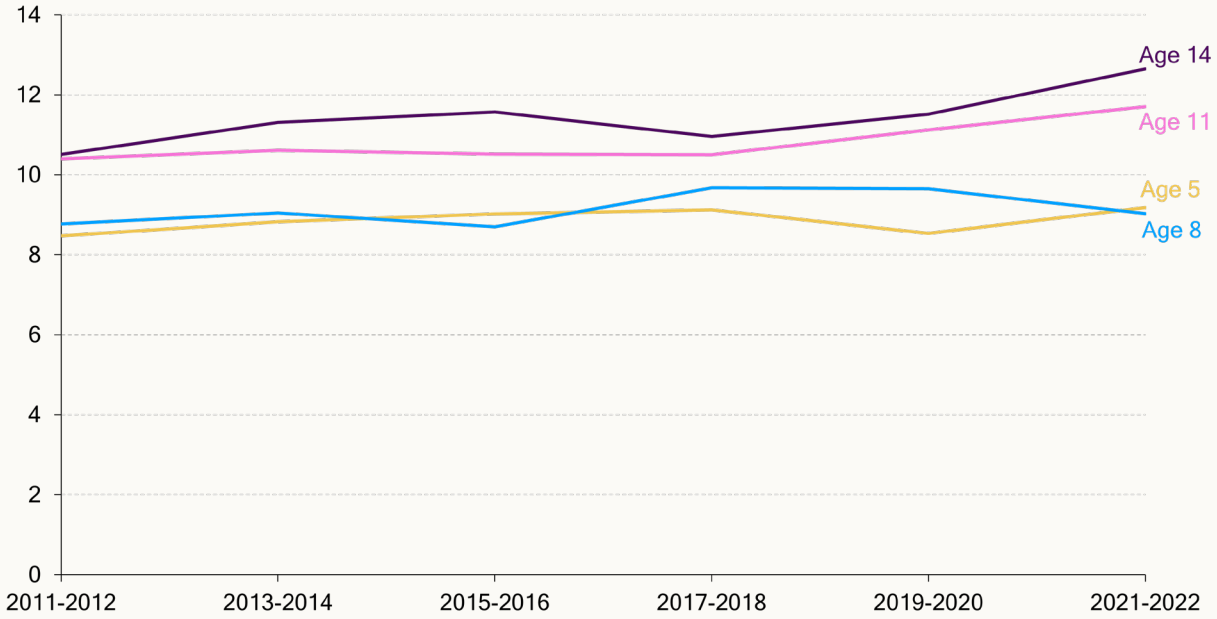
2 Mental Health of Children and Young People in England, 2023 - wave 4 follow up to the 2017 survey. NHS England Digital (21 November 2023).

3 Understanding Society: Waves 1-14, 2009-2023 and Harmonised BHPS: Waves 1-18, 1991-2009. [data collection]. 19th Edition. University of Essex, Institute for Social and Economic Research. UK Data Service (2025). Understanding Society is a UK longitudinal household study following over 40,000 households since 2009. It covers topics including income, health, education, and wellbeing, with a dedicated youth survey for ages 10–15. Please see Annex for more detailed methodology.

4 See, for example: COVID-19 mental health and wellbeing surveillance: report. Office of Health Improvement and Disparities (8 September 2020). See also: Rosie Mansfield et al., The impact of the COVID-19 pandemic on adolescent mental health. Department for Education (March 2022).

Figure 1. Declining mental health predates Covid for all ages, and is steeper for older children

Average parent-reported SDQ score by age group; a higher SDQ score indicates a higher level of behavioural and emotional difficulty in the child.



Notes: PBE analysis of the average SDQ score for children over time by age. A selected number of ages are shown for illustration.

Source: PBE analysis of Understanding Society (2025).

The government is taking action. The NHS Long Term Plan committed to providing mental health support for an additional 345,000 children and young people by 2023/24,[5] and NHS-funded Mental Health Support Teams (MHSTs) are rolling out to schools and colleges to offer help in non-clinical settings.

However, NHS mental health support services are under strain. In 2023/24, more than 910,000 young people were referred to Child and Adolescent Mental Health Services (CAMHS), but only 36% received support within the NHS's four-week target.[6] Almost 79,000 waited over a year to be treated and, of these, 34,000 went for two years without being seen.

MHSTs reached 52% of students in 2024/25, with a target of 62% by the end of 2025/26,[7] but there have been concerns around the speed and spread of assignment; even schools and institutions that are assigned an MHST report some barriers to effective support for their pupils, with 40% of them stating that staff capacity has been a barrier to being able to make full use of the offer.[8]

Despite efforts to extend mental health support to children across the country, it is clear that many children are still missing out.

Key takeaways

910,000

The number of young people **referred to (CAMHS)** in 2023/24

52%

The percentage of students reached by MHSTs in 2024/25

36%

The percentage of the 910,000 who received support within **NHS's four-week target.**

62%

The target percentage of students MHSTs aim to reach by the end of 2025/26

5 The NHS Long Term Plan. NHS (7 January 2019).

6 Increase in youth waiting over a year for mental health support. YoungMinds (7 March 2025).

7 Transforming Children and Young People's Mental Health Implementation Programme. Department for Education (May 2025).

8 Mental health support team school and college survey. Department for Education (October 2023)

When children feel mentally well, it boosts their life chances

If we could reach all children in need of mental health support, we could help them achieve their potential in various areas of their lives.

Helping children manage their mental health could help them thrive at school and in their childhood relationships. A 2021 study suggested that children diagnosed with depression between the ages of nine and 14 tended to be less likely to achieve 5 GCSE A*-C grades (including maths and English)[9].

Beyond attainment, mental health impacts how much children can enjoy and engage in school. Only 35% of secondary school children with probable mental health disorders enjoy learning compared to 71% of their peers, who are unlikely to have a mental health issue.[10] Feelings of belonging and safety are also higher among children who are unlikely to have a disorder. These feelings of inclusion and engagement also reflect in evidence suggesting that children with a probable disorder miss more school on average, with one in nine missing more than 15 days in autumn 2022 compared to one in 67 unlikely to have a disorder.[11] Relatedly, as school is a key part of a child's relationship network, evidence suggests that improving mental health might improve peer relationships.[12]

Better childhood mental health is linked to better health in adulthood. Childhood indicators of mental health, including emotional health, have been linked to better mental health in adulthood.[13] In contrast, many persistent mental health issues begin by the age of 14 and the mind–body connection means that children's mental health is also linked to physical health later in life. Recent evidence suggests that a child with poorer mental health has a higher likelihood of experiencing health issues such as diabetes, hypertension and obesity after age 30.[14]

9 Alice Wickersham et al., Estimating the impact of child and early adolescent depression on subsequent educational attainment: secondary analysis of an existing data linkage. Cambridge University Press (25 November 2021). Achieving five GCSEs graded A*-C in the previous system would be roughly equivalent to having five GCSEs graded 4-9 in the current system at time of writing.

10 Mental Health of Children and Young People in England, 2023 - wave 4 follow up to the 2017 survey. NHS England Digital (21 November 2023).

11 Mental Health of Children and Young People in England, 2023 - wave 4 follow up to the 2017 survey. NHS England Digital (21 November 2023).

12 Carolina Guzman Holst et al., What Happens to Children's Mental Health and Peer Relationships During Periods of Restricted and Unrestricted Social Interactions? Results From the Co-SPACE Study in Primary School-Aged Children. JAACAP Open (5 June 2023).

13 Alissa Goodman et al., Social and emotional skills in childhood and their long-term effects on adult life. Early Intervention Foundation (11 March 2015).

14 Lin Liu et al., Childhood psychosocial adjustment and midlife obesity, diabetes and hypertension: prospective study from two birth cohorts. The British Journal of Psychiatry (10 October 2024)

A happier childhood could also make for better prospects for the individual and their family later on. A wealth of research suggests that better mental health in childhood boosts a person's likelihood of entering the work force, increases their family income and hourly wage, and thereby improves their chances of financial security.[15] Evidence also suggests that a child is more likely to have a mental health disorder if at least one of their parents has experienced symptoms themselves. Similarly, some evidence suggests that better maternal mental health could be linked to better early years development, and children of mothers with brief episodes of ill-health had noticeably better emotional, social and behavioural development than those of mothers with longer-lasting illness.[16]

Therefore, compared to what we might have expected for them just 10 years prior, the deterioration in young people's mental health means that young people today might face worse educational, health, social and financial outcomes.

Figure 2. A snapshot of why children's mental health has lasting impacts

Relationship diagram of children's mental health and other experiences

15 See, for example: Alissa Goodman, Robert Joyce, and James P. Smith, The long shadow cast by childhood physical and mental problems on adult life. PNAS (28 March 2011)

16 Louise Marryat and Claudia Martin, Growing Up In Scotland: Maternal mental health and its impact on child behaviour and development. The Scottish Government (29 April 2010)

We need to strengthen the case for investment

It is urgent and crucial to understand what support is most effective so we can give children who are struggling with their mental health the help they need. To do so, we need to review how we measure mental health and understand its impact, allowing policymakers to evaluate and compare different approaches in their decision making to help meet the needs of these children. Previous research has paved the way for this. It is time for a more up-to-date understanding of the long-term economic impacts of children's mental health.

Previous estimates of the long-term impacts of improving children's mental health exist. However, the work often relied on older data or could only look at static SDQ scores, not changes over time. For example, there is evidence that early differences in SDQ scores are linked to different long-term outcomes and economic returns.[17] These findings support the value of investing in early interventions to enhance children's social and emotional development. However, the estimates are based on data from a group of people born in 1958[18] and mapped an older mental health outcome (the Bristol Social Adjustment Guide, or BSAG) to more modern measures, which adds to the uncertainty.[19] Investigating the relationship between SDQ and GCSEs for a more recent cohort would allow us to account for the fact that childhood, with technology changes and policy changes, looks different now compared to what it did half a century ago. In addition, the evidence uses the difference in mental health outcomes **between different children at the same age** as a proxy for the difference in mental health outcomes for the **same child over time.**[20]

More current estimates do exist for the short-term economic value of the improvement in the quality of life or wellbeing of young people. The C-WELLBY framework from the London School of Economics (LSE) and State of Life suggests quantifying children's wellbeing in economic terms – in other words, monetising the value of changes in quality of life.[21]

17 Gillian Paull and Xiaowei Xu, Study of Early Education and Development (SEED): The potential value for money of early education. Department for Education (July 2017).

18 Pedro Carneiro, Claire Crawford and Alissa Goodman, The Impact of Early Cognitive and Non-Cognitive Skills on Later Outcomes. Centre for the Economics of Education (October 2007).

19 Paull and Xu (2017) approximated standard deviations in BSAG to roughly equal those of SDQ.

20 See: Pedro Carneiro, Claire Crawford and Alissa Goodman, The Impact of Early Cognitive and Non-Cognitive Skills on Later Outcomes. Centre for the Economics of Education (October 2007). In this paper, level BSAG scores at age 11 are linked to later outcomes, rather than improvements in BSAG score over time being linked to later outcomes. See also: Neil R Smith et al. Adolescent mental health difficulties and educational attainment: findings from the UK longitudinal study. BMJ Open (25 July 2021). According to this study, young people with high levels of mental health difficulty, as measured by the SDQ, were more likely to have lower academic performance than their peers. While this looked at more recent data for 2009-2012, it could not look at the relationship between the change in SDQ and later outcomes.

21 Isaac Parkes, The C-WELLBY: Towards a Universal Measure of Children's Wellbeing for Policy Analysis. Centre for Economic Performance (15 April 2025).

According to their guidance, a one-point SDQ improvement translates to about 0.037 C-WELLBYs per year. Given that 1 C-WELLBY, which represents one year lived in a state of higher wellbeing, is valued at £13,000, this suggests that a one-point reduction in SDQ generates a value of £480 in wellbeing benefits. While this is a very welcome and important step to ensure children's wellbeing changes are inherently valued in economic evaluations, this does not aim to address the long-term benefits associated with a wellbeing improvement in childhood.

Against this backdrop, our analysis of the Millennium Cohort Study (MCS) provides fresh, timely insights into how improvements in mental health, during both primary and secondary school years, impact educational success and economic outcomes today.[22] These findings offer a compelling case for policymakers and funders; supporting children's mental health is an investment that pays off for children and society. Incorporating this into our evaluations of mental health support is key to ensuring that we design and deliver effective programmes to help young children to cope and thrive.

An overview of the SDQ

The Strengths and Difficulties Questionnaire (SDQ) is a brief behavioural screening tool used internationally to assess the emotional and behavioural wellbeing of children and adolescents aged two to 17 years.[23] It helps identify concerns early, so that families, schools and professionals can act before problems escalate. This multi-item tool can help generate a "total difficulties score" that shows how many challenges a child might be facing. The higher the score, the more difficulties the child is believed to be experiencing.

The SDQ examines five key areas of a child's development:

1. Emotional symptoms, such as worry, sadness, or fear
2. Conduct problems, including anger, defiance, or aggression
3. Hyperactivity/inattention – signs of restlessness or difficulty concentrating
4. Peer relationship problems, such as social isolation or conflict with peers
5. Prosocial behaviour – positive traits such as empathy, kindness and cooperation

The first four categories combine to form a Total Difficulties Score, which offers a general measure of mental health difficulties. A higher score indicates a greater level of challenge.[24]

The SDQ can be filled out by parents, teachers or the child themselves (aged 11 or older).

22 We have also found some evidence of other relationships between smoking, crime, health outcomes and SDQ improvements, but not to the extent where we include them in our main results. See Annex D for more information.

23 Robert Goodman, The Strengths and Difficulties Questionnaire: A Research Note. Journal of Child Psychology and Psychiatry (July 1997).

24 SDQ: Information for researchers and professionals about the Strengths & Difficulties Questionnaires. Youthinmind (September 2016).

Archie's story

Archie's mum was worried about his low mood since lock down and felt as though Archie had shut himself away from his friends and any social activities. Archie was referred into counselling with a view to building self-esteem and resilience, and enhancing Archie's emotional wellbeing. Archie stated during assessment that he struggles with low mood and is extremely self-conscious about his looks and what others think about him.

During a parent partnership session with his mum, she commented on how Archie used to enjoy school but doesn't seem to like it anymore and that she struggles to get him up in the mornings to go to school. Teachers said that Archie is quite a bright boy, but his poor school attendance is starting to affect his work and that they have concerns for him regarding his GCSEs later this year.

Archie worked with Rachel, his counsellor, who provided a space for Archie to open up and be honest and vulnerable about how he was feeling. Archie was initially quite shy but as the therapeutic relationship developed, Archie experienced empathy and understanding with his counsellor. Having the opportunity to speak openly to a professional helped Archie to experience his thoughts and feelings without judgement and with lots of empathy and understanding.

Archie began to make better eye contact and was more upbeat in his sessions as he talked about school life and friendships, and how he had developed motivation to come to school. Archie started attending school more regularly during his time in counselling. On completion of counselling, Archie's teacher said that he had noticed significant improvement in Archie's class work, stating his attendance and focus in lessons had improved.

* Archie's name has been changed to protect the identity of the child

Improvements in mental health lead to better attainment

Our analysis of the MCS data suggests that small improvements in children's mental health could lead to better GCSE results. Using data from the MCS, we find that just a one-point improvement in the SDQ score between the ages if five and 15 can raise GCSE attainment by 0.2 to 0.6 grades, depending on the age of the child (see Figure 3). This may seem modest, but the ripple effects on lifetime earnings are substantial, as we will explore later in the report. Additionally, as can be seen from the table below, if a child or young person experiences a bigger improvement in their SDQ score (for example by having targeted mental health support) the improvement in their GCSE scores is much greater.

The impact on GCSE attainment depends on the child's age

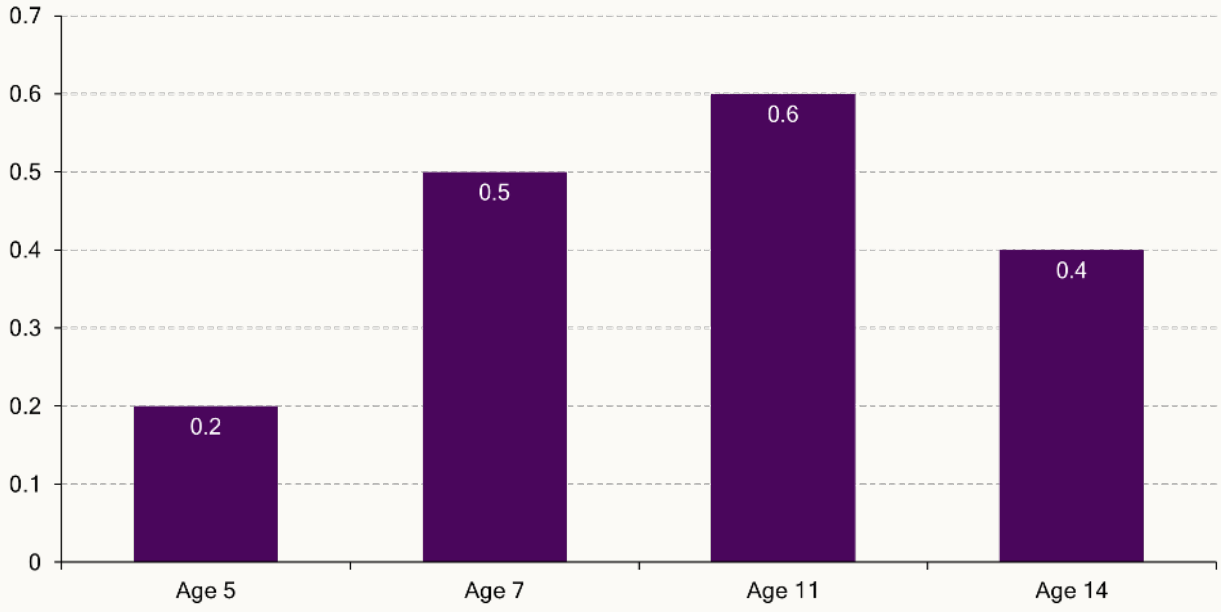
The strength of the relationship between improved mental health and attainment appears to peak at around age 11. Here is a comparison below:

Age of Child	GCSE Grade Increase per one-point SDQ Improvement	Equivalent Grade Improvement for five-point SDQ Improvement
5 years	+0.2 grades	+1 grade
7 years	+0.5 grades	+2 grades
11 years	+0.6 grades	+3 grades
14 years	+0.4 grades	+2 grades

For example, an 11-year-old who improves their SDQ score by five points could see three of their subjects go up by one GCSE grade each, while a five-year-old would expect a boost in one subject.

Figure 3. Depending on the child's age, a one to five point SDQ improvement could boost total attainment by one grade

Assumed impact of a one-point SDQ improvement (reduction) on GCSE total grade attainment



Notes: The MCS data is restricted to understanding the parent-reported SDQ of children at ages five, seven, 11 and 14 (although teacher-reported and self-reported SDQs are available in one sweep each, therefore not allowing for analysis of their change over time). The GCSE point score improvement associated with a SDQ improvement at age 11, for example, represents that associated with a mental health improvement seen somewhere between age 11 and age 14.

Source: PBE analysis of MCS data (2025)

Perhaps unsurprisingly, our findings paint the picture of how the impact of mental health improvement on attainment grows between the ages of five and 11, for those who took their GCSEs in the decade up to 2022. This is because the younger the child, the further away they are from taking their GCSEs and, therefore, the greater the potential for other factors to influence their mental health (and academic performance) in the intervening period.

We then find that the relationship between mental health improvements and GCSE attainment weakens from age 14. This smaller estimated link may be driven by the timing at which older children's mental health is recorded in the MCS.[25] Additionally, it may be that, as the child gets very close to sitting their GCSEs, any mental health improvements have less opportunity to positively affect their learning and, therefore, boost their attainment.

Our updated evidence ensures that the estimated relationship reflects more closely the experiences of young people today.[26] Despite this, it is interesting and reassuring to note that our findings are fairly similar in magnitude to those from the Paull and Xu study, and complement their findings, despite the different methodology. Therefore, our new findings improve our confidence in understanding the relationship between mental health improvements and attainment today using much more recent evidence.

The Millennium Cohort Study

The MCS tracks around 19,000 children born in the UK between 2000 and 2002. Managed by University College London, it gathers data at key stages — from infancy through adolescence — covering health, education, family and social factors.

Its diverse sample includes children from ethnic minorities and disadvantaged backgrounds, offering rich insights into how early life shapes long-term outcomes such as wellbeing, academic success and economic opportunity. Policymakers use MCS findings to design better interventions to address social inequalities and improve children's lives across the UK. The study remains a vital tool for understanding childhood development today.

25 GCSEs are taken, typically, at 15 or 16 years of age. For older children, the MCS data only allows us to see the mental health of a child at 14, and then again at 17. Therefore, the change in mental health experienced by a child in the dataset after 14 takes place at some point before their interview at age 17, but we cannot be sure of when. It is possible that part of the mental health improvements estimated from the MCS might actually be taking place **after** these exams. This introduces some uncertainty about which effect (attainment or mental health improvement) happens first for those in the MCS.

26 Some limitations remain as the MCS focuses on people born in 2000-2002, meaning they are, at the time of writing, in their 20s.

Earlier intervention could reduce the need for SEN support later

Our findings show that improving children's mental health can lower the likelihood that a child needs SEN support in secondary school.[27] This further demonstrates the business case for early intervention and the value of supporting younger children with low and moderate mental health needs to prevent more acute needs as children grow.

Our analysis of the MCS suggests that a one-point improvement in SDQ score could reduce the probability of needing SEN support by 0.2-0.4 percentage points (ppts). While this may be a small range, it is, nonetheless, a significant and confident finding from our research. Additionally, the data only allows us to estimate when a child moves from a state of no SEN support to SEN support in secondary school; the relationship between mental health improvements in younger years and the likelihood of needing SEN support in primary school may be different.

Special Educational Needs support

In the UK, SEN support is provided for children and young people who have learning difficulties or disabilities that make it harder for them to learn compared to their peers. Most children with SEN receive help through the SEN Support system, which is accessed through mainstream schools and early years settings without needing an Education, Health and Care Plan (EHCP).[28]

SEN support follows a graduated approach using a four-stage cycle – Assess, Plan, Do, Review – to understand and address children's needs. Support can include adapted teaching methods, additional adult assistance (e.g. teaching assistants), small group or one-to-one interventions, and access to specialist resources or technology.

If a child's needs are more complex and cannot be met through SEN Support alone, families or schools can apply for an EHCP. This is a legal document that outlines the child's educational, health and care needs and the support required to meet them.

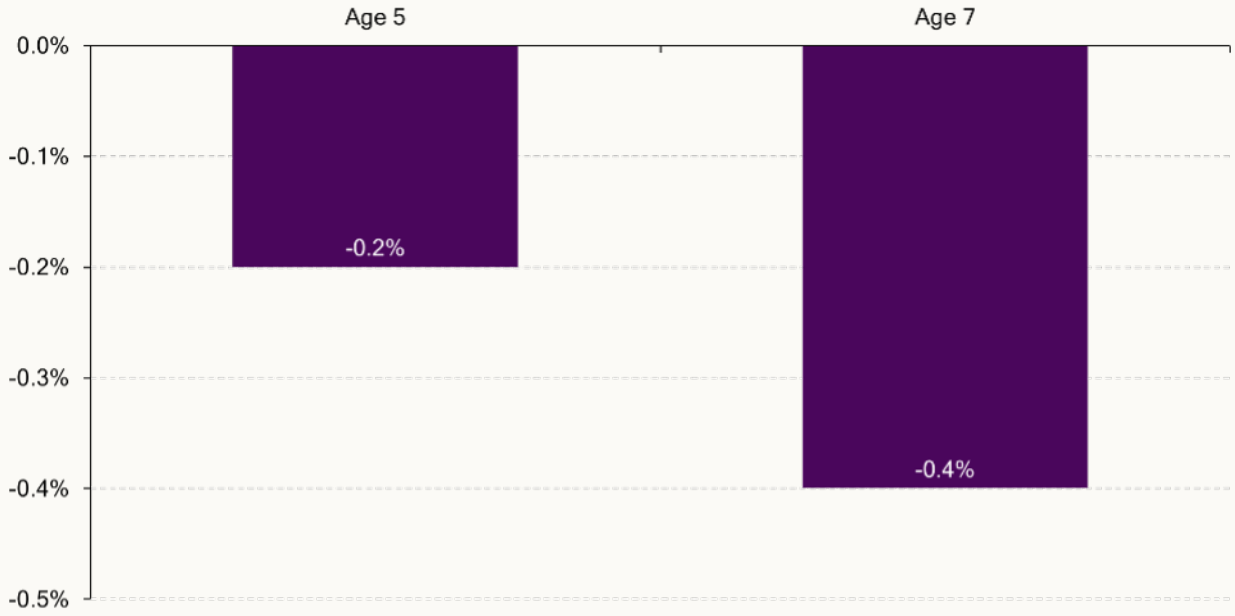
27 The IFS suggests that the rise in SEN plans has been driven mainly by the fact that more children are identified as having ASD, SEMH and speech, language and communication needs. See: Luke Sibieta and Darcey Snape, Spending on special educational needs in England: something has to change. IFS (10 December 2025).

28 SEN Support (also known as the 'graduated approach'). Sen-help (2025).

As with our GCSE findings, the older the child gets, the more strongly mental health improvements and likelihood of requiring SEN support in secondary school move in opposite directions. Figure 4 illustrates this.

Figure 4. A small change in children's mental health has a small but consistent impact on the need for SEN support

The change in probability of needing SEN support in secondary school given a one-point SDQ improvement experienced by age



Notes: The MCS data is restricted to understanding whether a child goes from a status of not being identified by their school as having SEN to being so between the ages of 11 and 14. Therefore, we are only able to look at the relationship between SDQ changes in earlier ages to SDQ support in secondary school.

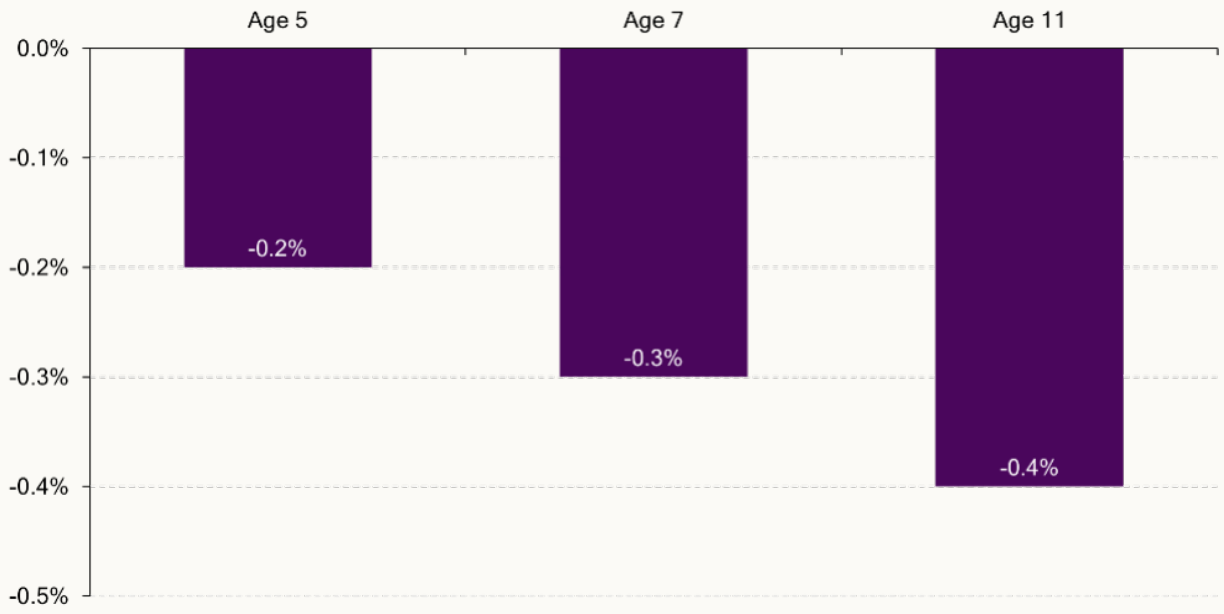
Source: PBE analysis of MCS data (2025)

Improvements in mental health reduces the likelihood of exclusion

Our analysis of the MCS suggests that a one-point improvement in SDQ score could reduce the probability of being suspended by 0.2-0.4ppts. As before, this effect is stronger the older the child, as illustrated in Figure 5.

Figure 5. Exclusions could be reduced if we helped children to cope with their mental health

Change in probability of suspension in secondary school given a one-point SDQ improvement



Notes: The MCS data is restricted to understanding whether a child has been excluded at least once by age 14. It is not possible to tell from the data when and how many times. Therefore, we can only look at the relationship between SDQ changes at earlier ages and being excluded by secondary school.

Source: PBE analysis of MCS data (2025)

School exclusions

In the UK, school exclusion is a disciplinary measure to be used when a pupil seriously breaches school behaviour policies.[29] There are two main types:

- **Suspension (fixed-term exclusion)**: The pupil is temporarily removed from school for a set number of days (up to 45 days per academic year). They must be provided with school work during this time and are expected to return afterwards.
- **Permanent exclusion**: The pupil is removed from the school permanently. This is used for serious or repeated misconduct, or where the pupil poses a threat to others. The local authority must arrange alternative full-time education from the sixth day.

Schools must follow strict legal guidelines to ensure exclusions are fair and lawful. Parents must be notified promptly and have the right to challenge the exclusion. For permanent exclusions, they can request a review by an Independent Review Panel.

29 Suspension and permanent exclusion guidance Department for Education (August 2024)

Mental health improvement unlocks a range of economic benefits

Better attainment, reduced need for SEN support and reduced exclusions are all inherently valuable results of improved children's mental health. They add to the economic case for early intervention in mental health.

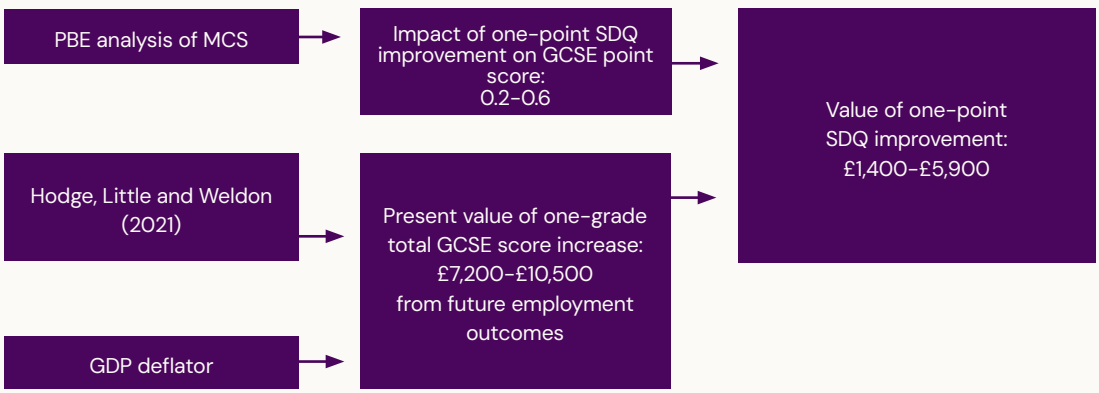
GCSEs and earnings

Better GCSE results directly link to higher lifetime earnings. The Department for Education (DfE) estimates that even a single grade increase in one subject corresponds to a £7,200 to £10,900 present value boost in lifetime earnings (in 2025 prices), for a child between the ages of four and 15.[30]

Combining these figures with our SDQ findings, we estimate that a one-point SDQ improvement could raise lifetime earnings by £1,400 to £5,900 per child. Roughly 57% of this benefit goes directly to the individual, increasing take-home pay by £820–£3,400 over their lifetime depending on age. The remaining 43% benefits the government through higher tax revenues and reduced welfare spending — about £620–£2,500 per child.

Figure 6. Using MCS and DfE evidence to estimate the economic value of a one-point SDQ improvement on GCSE attainment

Flow diagram of methodology

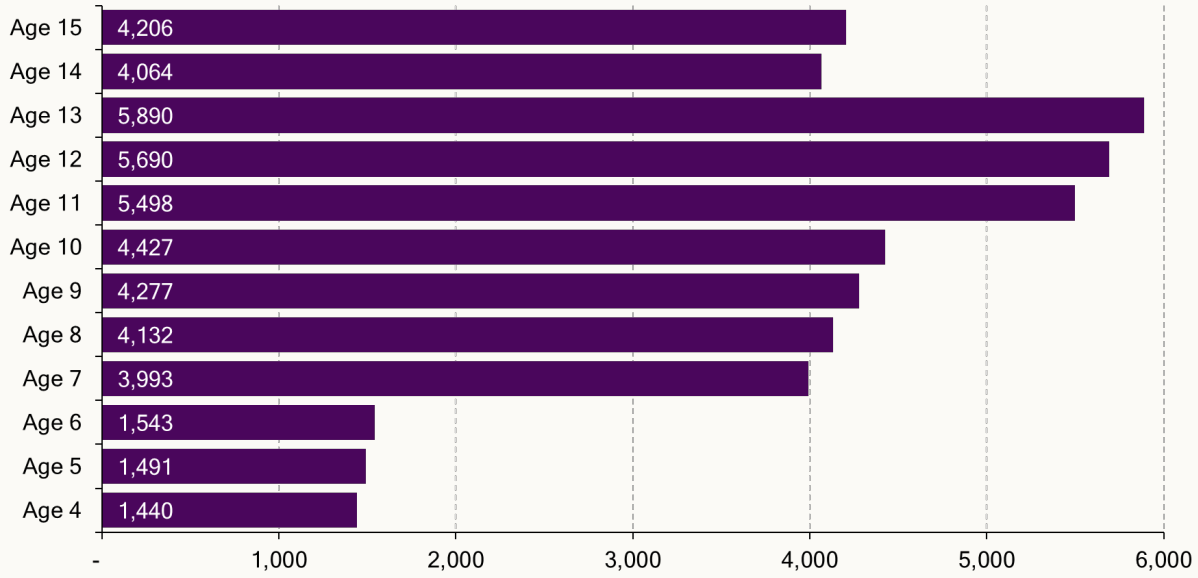


30 Louis Hodge, Allan Little and Matthew Weldon, GCSE attainment and lifetime earnings. Department for Education (June 2021)

The value of the SDQ change impact on GCSE attainment depends on the age of the child for two reasons. Firstly, as discussed earlier, the relationship between SDQ change and GCSE attainment varies according to a child's age. Secondly, an older child has to wait for a shorter period before they start to receive the associated benefits from improved earnings, therefore, valuing the benefits higher than the younger child. In other words, the actual employment outcomes boost from a one-grade GCSE improvement is about £29,000 in 2025, meaning the boost from a one-point SDQ improvement is about £5,800 to £17,500, depending on the child's age. But we "discount" these earnings to reflect the fact that the average person values an outcome now higher than they would if they were to receive it next year. This means that, the younger the child, the longer they have to wait to enjoy the benefits of improved earnings, as they are further away from working age. Therefore, the values shown here take into account how benefits are valued higher if they are felt sooner. Figure 7 illustrates how the value of the impact of SDQ changes on GCSEs differs by age.

Figure 7. A small change in SDQ can generate economic benefits worth thousands

Economic benefits (£) of a one-point SDQ improvement (reduction) on GCSE point score, by age of child



Notes: All in 2025 prices

Source: PBE analysis of MCS (2025)

Our results show that even early intervention can impact attainment at GCSEs, which then has knock-on effects for earnings and government spending, meaning that investing in children's mental health is not just good for them, but for society in the long term.

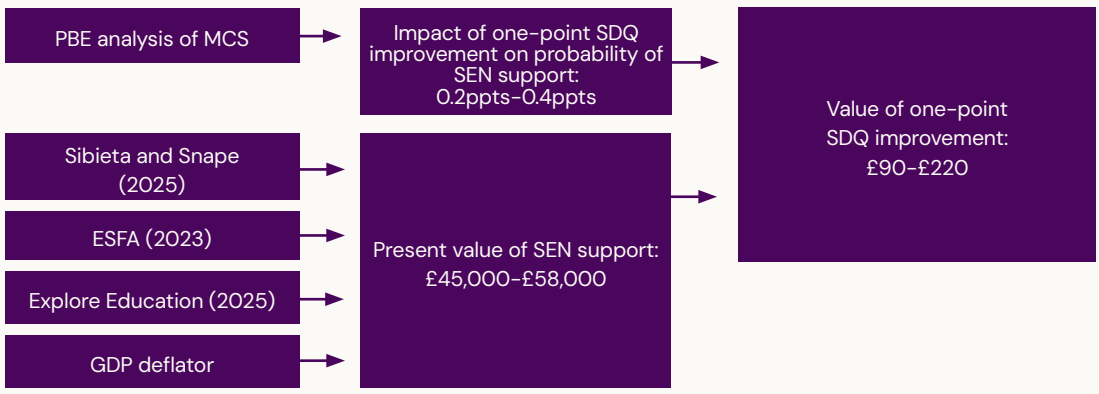
SEN and value of support

SEN support includes some costs to the local authority and school. The nature of SEN support required and delivered to each child differs significantly according to their needs; therefore, it is difficult to confidently estimate an average cost of SEN support per child receiving it. That being said, we have drawn upon various sources to estimate that the value of the cost of SEN support from age 11 onwards could be between £45,000 and £55,000 per child with SEN. We estimate a one-point improvement in SDQ could reduce the probability of SEN support by 0.2-0.4ppts.

Note that need for SEN support currently outweighs supply, with evidence suggesting that, in 2024, more than 20,000 children waited over 20 weeks for a support plan, with hundreds waiting over a year.[31] Therefore, if one child avoids needing SEN support, this is unlikely to lead to any service provision savings, as that support would be simply transferred to another child on the waiting list. However, we can consider that there is value in this service being "freed up" to go to another child. Our research suggests that a one-point SDQ improvement could free up this service for another child, which could be valued at an estimated £90-£220.

Figure 8. Using MCS and various evidence to estimate the economic value of a one-point SDQ improvement on the value of reduced SEN support need

Flow diagram of methodology



31 Richard Adams and Morgan Ofori, Hundreds of children with special needs wait a year for support in England. The Guardian (18 February 2024)

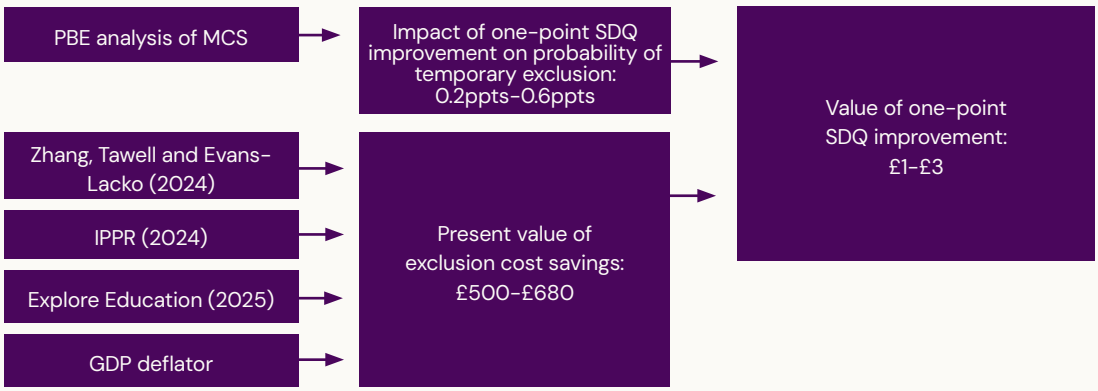
Exclusions and public sector costs

Both suspension and permanent exclusion create costs to the local authority and to schools in terms of administrative fees, review costs, youth justice costs and alternative provision costs. Due to limitations of the data, we have had to assume that a child who is suspended only experiences suspension once, and that only 1% of children who are suspended are permanently excluded.[32] This limits the value we can put on the impact of exclusions to society.

While the costs of being excluded per child vary on a case-by-case basis (i.e. depending on how many times the child is excluded, for how long, and whether the case goes to review), we estimate that, on average, for each child who experiences suspension, the generated costs of exclusion (suspension and permanent exclusion combined) could be £490–£720 per child.[33] If a one-point SDQ improvement reduces the probability of being suspended by 0.2ppts to 0.4ppts, this means that the potential value of reduced exclusion associated with a one-point SDQ improvement would be £1–£3. This relatively small figure takes into account how the probability of any given child, on average, being suspended or permanently excluded is very small in the UK. However, it is worth noting that, if we were evaluating an effective intervention to improve mental health for thousands of children across the country, this economic benefit would quickly become substantial, as we will explore later in this report.

Figure 9. Using MCS and various evidence to estimate the economic value of a one-point SDQ improvement on reduced exclusion costs

Flow diagram of methodology



32 Suspensions and permanent exclusions in England. Department for Education (21 November 2024).

33 This is far lower than the full cost of exclusion estimated elsewhere. This is because we do not incorporate the impact of exclusions on future earnings of young people as this would be double counting effects already estimated via impacts on GCSE attainment.

What is the overall picture?

In summary, we find that improved mental health in childhood is associated with improved GCSE attainment (and, thereby, employment outcomes), reduced probability of being excluded (thereby avoiding those costs to society) and reduced likelihood of needing SEN support (thereby unlocking the value of that support for another child).

Taking our results together, we find that a one-point SDQ improvement could generate economic benefits of between £1,500 to £6,100, as illustrated in Figure 10.

Figure 10. The bulk of the economic benefits associated with mental health improvements are through GCSE attainment

Economic benefits of a one-point SDQ improvement (reduction) via different impacts

Age	Via GCSE attainment (£)	Via SEN support (£)	Via exclusions (£)	Total economic benefits (£)
Age 4	1,440	91	1	1,532
Age 5	1,491	94	1	1,586
Age 6	1,543	97	1	1,641
Age 7	3,993	201	2	4,195
Age 8	4,132	208	2	4,342
Age 9	4,277	215	2	4,494
Age 10	4,427	223	2	4,652
Age 11	5,498		3	5,501
Age 12	5,690		3	5,693
Age 13	5,890		3	5,892
Age 14	4,064		3	4,067
Age 15	4,206			4,206

Notes: All in 2025 prices

Source: PBE analysis of MCS (2025). See Annex A, B and C for more information.

We cannot ignore that the economic benefits estimated in this report grow until the age of 14, at which point the estimated benefits drop noticeably, driven by how the relationship between SDQ improvements and GCSE attainment appears to peak between the ages of 11 and 14. However, we acknowledge that the scope of our report does not include the benefits (or their persistence) of the improved quality-of-life value experienced by the child when they feel better. Additionally, we recognise that early intervention is, in general, more affordable than it is during the teenage years, as interventions tend to get more complex as the child ages. Therefore, it would cost the same for more children to be reached at a younger age as it would if action was taken during the teenage years only.[34]

Alongside research to understand the short-term valuable impact of improved SDQ in childhood with the development and implementation of the C-WELLBY, our results evidence the long-term economic benefits associated with mental health improvements in childhood. Therefore, our findings further strengthen the case for early intervention as being beneficial not only for children and young people but also for wider society through the economic benefits generated.

34 Emily Stapley et al. Conducting economic evaluations of mental health and wellbeing early intervention and prevention programmes. UCL (January 2022).

Mohammed's story

As a child, Mohammed experienced significant anxiety and used to struggle to leave his house. Having one-to-one counselling in primary school helped him to build his confidence and talk openly about his feelings. Now a teenager, he looks back on his experience.

"In primary school I was really nervous and shy. I wouldn't do a lot of things and I had a lot of anxieties. I also didn't really like going out of the house. I thought that school counselling would be quite dull, and that it would be just talking. But it wasn't.

My counsellor was really nice, and I could tell her anything about myself and she wouldn't tell anyone. I knew it would be confidential. The Place2Be session was really good in the way that I could just release everything. I could let everything go. It made a difference to me afterwards. I told my counsellor about anything that was on my mind, but I realised that I could tell other people too, like my mum.

It gave me more confidence, and I was more comfortable about being around loads of people. I could go out and stay with my friends. It also made a difference to my schoolwork. I was able to answer more in class. I'm smart in maths but I used to not want to put my hand up, even though I knew the answer to a question. I didn't like people looking at me. I sat there thinking don't pick me. But I don't mind it now.

In my first year of secondary school, I found a new confidence to stick up for myself. I used to let people walk all over me, but this doesn't happen now because I've got the confidence to stop it."

* Mohammed's name has been changed to protect the identity of the child.

Reversing the decline in children's mental health could be worth £51 billion

These findings could be used to incorporate the longer-term impacts of improvements of children's mental health in future evaluations. They also bring to life the stark consequences of the declining mental health in children outlined at the beginning of this report.

Because children reported worse mental health in 2021/22 compared to 2011/12, they experienced worse day-to-day life quality, and are missing out on valuable life-long opportunities to their own and society's cost. Compared to just 10 years prior, we would expect that, as a result of their lower SDQ scores, young people in 2022 would have worse employment outcomes, and be more likely to be excluded and require SEN support in secondary school.

It is not too late to act and help thousands of children to enjoy happier childhoods and futures. If we effectively reverse this trend by bringing children's mental health back to levels seen 10 years previously, we could improve children's lives in the long run, which has benefits that reverberate throughout society. For the average child, this could mean generating economic benefits to society of almost £5,300. Multiplied by the total number of school-age children and young people, we estimate that society could see additional economic benefits of £50 billion in their employment outcomes, £17 million from reduced costs of exclusion, and £606 million from avoided SEN support costs stemming from better mental health today. In total, therefore, if we bring mental health levels back to those of 10 years earlier, society will be £51 billion better off.

Focusing specifically on exclusions, we estimate that reversing the decline could avoid 6,700 cases of suspensions, and 80 cases of permanent exclusion. Therefore, despite our modest £1-£3 estimate of the per child economic value of reduced exclusion costs associated with a one-point SDQ improvement, we could save thousands of children from being excluded if we committed to restoring mental health levels.

Conclusion

The economic and social costs of poor mental health in children are significant, with long-term consequences for individuals, families and society. This report has shown that early mental health improvements can lead to better employment outcomes via improved attainment and a reduced need for exclusion and SEN support. Investment in early intervention and support is not only essential for children's wellbeing but also economically beneficial.

The UK government has taken steps to improve children's mental health through key policy frameworks, but, undoubtedly, there is considerable room for improvement, and we need as much effective mental health support as possible to reach children in need. This must be a cross-sectoral issue; different sectors bring their own insights and specific capabilities to give children the network of support they need. Schools are a key part of this, with the overwhelming majority of children reporting that they want mental health discussion to be normalised in the classroom.[35] While school life undoubtedly plays a huge part in children's mental health and wellbeing, we need to go further to ensure that children feel safe and supported when sharing their mental health concerns, as some report feeling reluctant to share their struggles with school staff, even if there is sufficient support in the first place.[36] Clearly, schools can lead the charge to ensure they are a safe space for children in need of mental health support.

What's more, schools don't have to do it alone. Many organisations in the charitable sector deliver school counselling, family support and mental health education, often reaching children who are ineligible for NHS treatment, and/or children who might feel alienated or excluded from statutory services. With its one-to-one counselling spanning over 45,000 children in 660 schools in 2023/24,[37] Place2Be's various services work to meet the needs of children and young people nationwide. Moreover, Place2Be's continued research, including a longitudinal study of their one-to-one counselling services in schools, makes a valuable contribution to the evidence of what is effective in children's mental health interventions. Evidence like this will enable us to understand how impactful different mental health support offers are and, ultimately, help policymakers decide which of those need to be prioritised to reverse the last decade's decline of children's mental health through support in schools, in the community and in more clinical settings.

35 School students call for mental health education in the classroom. Anna Freud (15 March 2021).

36 Children's views on well-being and what makes a happy life, UK: 2020. Office for National Statistics (2 October 2020).

37 Impact Report, Place2Be (2024); the impact report mentions "over 40,000 pupils" via Place2Talk – the updated 45,000 figure in this report is informed by Place2Be directly. We acknowledge that Place2Be reach as many as 350,000 children and young people in the locations in which it works through its whole-school mental health services.

Annex A. Methodology of analysing longitudinal study

In this technical annex, we explain the steps we took to explore whether there is a link between a marginal change in SDQ and any later adolescent outcomes, which, in turn, could be linked to economic benefit. The tables referred to in the Annex can be found here.

What is the MCS?

We chose the MCS as it could give us a relatively recent snapshot of the relationship between the change in SDQ and other outcomes, which we know have been linked to economic benefit.

The MCS is a large-scale longitudinal birth cohort study that follows the lives of around 19,000 children born in the UK in 2000–2002.[38] The data is collected in sweeps (waves), and its structure reflects its longitudinal, multi-domain and multi-level design.

There have been multiple sweeps so far at the time of writing:

- Sweep 1 (MCS1): Around 9 months old
- Sweep 2 (MCS2): Age 3
- Sweep 3 (MCS3): Age 5
- Sweep 4 (MCS4): Age 7
- Sweep 5 (MCS5): Age 11
- Sweep 6 (MCS6): Age 14
- Sweep 7 (MCS7): Age 17

Each sweep includes new data collected via interviews, questionnaires and assessments. At each sweep, data may be collected from: the cohort member (when age-appropriate), the main parent (usually the mother), the partner of the main parent, teachers, health professionals and interviewers.

Data is organised into thematic modules, including family background and household structure, education and childcare, cognitive and physical development, health and wellbeing, parenting and discipline, economic activity and income, housing and environment, and identity and social relationships.

38 Millennium Cohort Study. Centre for Longitudinal Studies (2025)

Each sweep, typically, consists of multiple datasets/files, organised in the following order of granularity:

- Level: Individual-level, household-level, etc.
- Instrument: Mother interview, partner self-completion, child questionnaire, etc.
- Topic: Education, income, health, etc.

Each file contains a unique identifier (such as MCSID) to link data across files and sweeps. The study also provides derived datasets or variables that are computed or cleaned by the data producers (CLS), to make analysis easier (e.g. total household income, derived cognitive scores). To account for sampling design and non-response, each sweep includes sampling weights (cross-sectional and longitudinal), which are critical for producing representative estimates.

Why did we use the MCS?

Previous work, such as Paull and Xu (2017), looked at the relationship between a level of children's mental health (using SDQ) and the probability of certain outcomes, the benefits of which were then monetised. However, there were some key limitations of these studies:

1. They did not look at whether improvements in SDQ were correlated to these outcomes and benefits – this is more relevant to evaluating the impact of children's mental health interventions.
2. Due to the availability of evidence at the time the study was completed, they used longitudinal data and secondary evidence that could now be considered outdated – with some evidence stemming from longitudinal data of a cohort of people born in 1958.[39]

The MCS collects data on GCSE attainment, SEN status, exclusions, mental health, physical health, and smoking – all of which Paull and Xu used to link to economic benefits using various secondary evidence sources. Its longitudinal nature, and the fact that SDQ (reported by parents) is included at each sweep, allows us to address the two limitations above. Additionally, we were interested in applying our findings specifically to children of school age; the MCS sweeps 3-7 allow us to look at the relationship between improved mental health in school years and monetisable benefits.

39 Gillian Paull and Xiaowei Xu, Study of Early Education and Development (SEED): The potential value for money of early education. Department for Education (July 2017)

Our regression analysis

We ran various specifications of OLS regression models in our aim to see if there is a "best fit" relationship between the independent variables (marginal change in SDQ Total Difficulties Score between the ages of five and seven, seven and 11, 11 and 14, and 14 and 17, respectively) and GCSE attainment. Tables A3-A6 present the regression tables.

Similarly, we ran various specifications of logistic regression models of needing SEN support in secondary school, on the marginal change in SDQ Total Difficulties Score between the ages of five and seven, seven and 11, and 11 and 14, respectively. Tables A7-A11 present the regression tables. Note that our findings are based on data derived from whether the school identified the child as having SEN, rather than whether they had a statement of SEN, as the non-response rate of the latter was much higher. We looked at what the findings suggested in terms of the probability of going from a state of "non-SEN-recognised" to "SEN-recognised" between the ages of seven and 11, and 11 and 14. The first two tables look at the relationship between SDQ changes and probability of change in SEN-recognition between age seven and 11, and the last three tables look at the relationship between SDQ changes and probability of change in SEN-recognition between age 11 and 14.

Finally, we ran various specifications of logistic regression models of being excluded by age 14 on the marginal change in SDQ Total Difficulties Score between the ages of five and seven, and seven and 11, respectively. Tables A12-A14 present the regression tables. Note that our findings are based on data derived from whether the school identified the child as having been suspended, rather than whether they had been permanently excluded, as the non-response rate of the latter was much higher. The dependent variable represents the probability that a person experiences suspension.

From these regressions, we found that the coefficients for change in total SDQ score against each key dependent variable tended to cluster. Table A15 summarises the estimated impact size of a marginal SDQ change on each outcome, by age of child.

Annex B. Estimating the long-term economic values of impacts

GCSEs

Hodge et al. (2021) uses England's Longitudinal Educational Outcomes (LEO) dataset – linking school records with tax-based earnings – to quantify how small improvements in GCSE performance at Key Stage 4 impact lifetime earnings.[40] By examining individual subject grades and pupil characteristics, the report reveals that marginal grade increases yield significant returns, with variations across subjects and demographics They found that a one-grade improvement in overall GCSE attainment is associated with an average increase in the present value of lifetime earnings of £8,500 in 2021 prices, from the perspective of a 16 year old.

We discounted this present value to account for how this benefit is, in present value, lower for younger children, as they have a longer time to enjoy the benefits of the lifetime earnings.[41] Then, we used the GDP Deflator to bring these values up to 2025 price levels.

By multiplying the impact sizes in Annex A by these economic benefit values, we were able to estimate the economic benefit associated with a one-point improvement in SDQ at various school ages, via GCSE attainment and earnings. The results are summarised in Table A16.

Exclusions

A 2024 study investigates the full economic costs of school suspension in England, Scotland, and Wales.[42] Through five in-depth case studies based on stakeholder interviews – including school staff, specialist professionals, and parents – the authors reveal that costs extend far beyond alternative education. They encompass staff time, specialist interventions, and unpaid parental labour (often through lost income). We estimated that, in 2025 prices, the cost of one case of suspension would be £187 (from the point of view of a 14 year old). Note that we took the conservative approach of only including administrative costs to the school, and not parental time.

We estimate the likely impact on permanent exclusions by assuming that there is around one permanent exclusion for every 100 suspensions (based on DfE statistics). We estimate the economic costs associated with permanent exclusion by drawing on a 2025 IPPR paper that

40 Louis Hodge, Allan Little and Matthew Weldon, GCSE attainment and lifetime earnings. Department for Education (June 2021).

41 Green Book supplementary guidance: discounting - GOV.UK. HM Treasury (21 April 2013).

42 Kyann Zhang, Alice Tawell and Sara Evans-Lacko, The costs of school exclusion: a case study analysis of England, Wales and Scotland. Oxford Review of Education (11 October 2024).

included an estimation of the costs of youth justice and alternative provision associated with permanent exclusion. From the perspective of a 15 year old, these were estimated to be £31,728 and £12,533 in 2025 prices, respectively. Note, this excludes the cost of lost earnings from permanent exclusions as we do not wish to double count the potential benefits incorporated against changes in GCSE results.

To account for the schooling age range, we discounted this for younger children. Table A17 summarises our findings.

SEN

Our regression analysis results only inform about the relationship between being identified as having SEN (by the child's school) and SDQ improvements. In actuality, many of the monetisable costs of requiring SEN support arise when the local authority and schools need to offer the support outlined in an EHCP, tailored to each individual child. It is challenging to find a per-student average cost of SEN support, as individual children require different levels and types of support; however, we have drawn on recent IFS and government papers to estimate an average cost of SEN support in secondary schools.

First, to understand the difference between the percentage of children identified as having SEN and those with an EHCP, we looked to DfE statistics, which suggested that 39.3% of children that were identified as needing SEN support had an EHCP.[43]

Additionally, a recent IFS report suggested that, on average, a local authority pays mainstream schools £19,800 as top-up support for each child with an EHCP.[44] Mainstream schools are expected to fund the first £6,000 of requisite support outlined in the EHCP from their core funding. Taken together, it suggests that, on average, the number of mainstream school children requiring SEN support costs £25,800 (2024 prices) if they have an EHCP.[45]

A working paper from the government suggests assumed average support costs of £3,000 (funded by the school from their core funding) for children without an EHCP. Therefore, taking into account how most children requiring SEN support do not have an EHCP, we estimate the average cost of a year of SEN support for the average child with SEN to be £11,968, in 2024, or £12,348 in 2025 prices. Table A18 summarises our estimates.

The data cannot tell us at what age exactly a child in the MCS goes from a state of being recognised as not having SEN to having SEN. Therefore, we assume that: a) for those students currently in primary school, the support costs begin at the start of secondary and continues until the end of secondary school; and b) for those students currently in secondary school, costs start in the current year and continue to the end of secondary school.

43 Explore our statistics and data - Explore education statistics. Department for Education (2025).

44 Luke Sibieta and Darcey Snape, Spending on special educational needs in England: something has to change. IFS (10 December 2025).

45 We think it is reasonable to assume the children experiencing a change in their SEN status in secondary school are most likely in mainstream school, as those with more complex needs would most likely be identified earlier, and potentially be in specialist schools.

Annex C. Estimating the cost of mental health decline

Understanding Society (USoc) is the UK's largest longitudinal household panel study, following over 66,000 individuals in, approximately, 40,000 households annually since 2009. It collects rich data on income, education, health, family, employment and social attitudes. Crucially, for child development research, USoc includes the Strengths and Difficulties Questionnaire (SDQ) – a validated behavioural screening tool completed by parents for children aged four to 17. Our analysis of the average SDQ score by age and year is summarised in Table A19.

As explored in this report, our findings summarise what has been an overall steady worsening of children's mental health over a decade. This informs our thought experiment: what would the economic benefits be if we could successfully help children to be as successfully healthy now as they were 10 years ago?

To do this, we use official population estimates of children by age across the UK.[46] By multiplying this population by the 10-year SDQ gap, and then by the economic benefits of a marginal SDQ improvement in Annex B, we reach our conclusion that the economic benefits could be as much as £51 billion over the lifetimes of children in school during one academic year. These calculations are presented in the summary in Table A20.

46 Estimates of the population for the UK, England, Wales, Scotland, and Northern Ireland. Office for National Statistics (8 October 2024).

Annex D. A note on mixed evidence elsewhere

In addition to the results presented above, we explored the relationship between SDQ and smoking, crime and health outcomes. Our results for these outcomes were more mixed and, therefore, were not included in our final estimates of economic costs:

- Smoking: while we found some evidence of smoking at least "often" was less likely if a child improved their mental health when they were younger, in line with Paull and Xu findings, the impact was small. Additionally, recent evidence suggests that young people are increasingly moving away from smoking and into vaping, making this outcome less relevant for today's children.[47] Current understanding of the costs associated with vaping is limited, hence why we have not elected to include this in the scope of our research.
- Crime: there is some evidence in the MCS linking improved mental health to reduced likelihood of self-reporting (at age 17) experience with at least one of the following: carrying a knife, being cautioned, being questioned or being arrested. However, the small sample size of responses for these questions, and the fact that none of these are actual crimes that we can map using the Home Office's "The economic and social costs of crime" guidance, have stopped us from including these results in our economic analysis.[48] We have chosen not to make assumptions about actual criminal activity from this data, not least because bias (such as racial profiling) might mean that some children engage with the police even if they have not committed a crime.
- Health outcomes: we find weak evidence of improvements in mental health leading to reductions in hospital visits and mental health treatment/diagnosis when the child is 14 and 17. Again, response rates are low to the extent that it is difficult to say much with confidence here.

These mixed findings point to the need for further research to understand the relationship between improved mental health in childhood and these outcomes, rather than disputing that any such relationships exist.

47 Use of vapes (e-cigarettes) among young people in Great Britain. ASH (July 2024).

48 Matthew Heeks et al., The economic and social costs of crime. Home Office (July 2018).

Economics to improve lives

Rachel Gomez
rachel.gomez@pbe.co.uk

@pbe
@pbe.co.uk
www.pbe.co.uk
020 3632 2668