Evaluating the implementation of the Transforming Children and Young People's Mental Health Provision Green Paper programme

Findings from surveys of schools and colleges and Mental Health Support Teams (2024)

July 2025

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Ethical approval

This study was reviewed and approved by the LSHTM Research Ethics Committee (LSHTM ethics reference number 29863) and the NHS Health Research Authority (IRAS project ID 326614).

Conflicts of interest

Tamsin Ford's research group receives funding from Place2Be, a third sector organisation that provides mental health training and interventions to schools, for research methods consultancy. Place2Be were not involved in the research reported here. All other authors report no conflicts of interest.

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Summary

In 2018, the Transforming Children and Young People's Mental Health Provision Green Paper programme was launched. This funded the creation of Mental Health Support Teams (MHSTs) to work in schools and colleges across England, and specific training in whole-school/college approaches to mental health and wellbeing for senior mental health leads in schools and colleges. The MHSTs were designed to have three core functions: 1) to provide direct support, through evidence-based interventions (e.g., low-intensity cognitive behavioural therapy), to individual children and young people with 'mild to moderate' mental health problems and/or their parents/carers; 2) to support schools and colleges with their whole-school/college approach to mental health and wellbeing; and 3) to work with education staff and liaising with external specialist mental health services to ensure that children and young people get the support they need. It was intended that each MHST would support approximately 8,000 children and young people across a selection of schools in their local area.

An early evaluation of the pilot wave of the programme ('the Trailblazers') found that the support from MHSTs was welcomed, and many schools and colleges were optimistic about what the programme could achieve. There were several initial implementation challenges, including those related to workforce and delivery, such as gaps in the training for the new Education Mental Health Practitioner (EMHP) role and high staff turnover. Additionally, there were challenges relating to the scope of the support that MHSTs could provide in relation to the needs of children and young people and ensuring that the impacts of the programme were experienced equitably across all who needed support.

In 2023, the longer-term national evaluation of the roll-out of the programme (up to the seventh wave) began. This evaluation comprises several research components, including quantitative and qualitative work. This report presents the findings from the first part of this research – a survey of staff in schools and colleges that are supported by an MHST (n = 1,189), as well as a survey of individuals involved in the local delivery of MHSTs (n = 303) conducted in 2024.

The survey respondents indicated that the core functions of MHSTs were being delivered well, and the majority of schools and colleges were satisfied with the support provided by their local MHST. MHSTs spent around half of their staff time on provision of direct support through evidence-based interventions and splitting their remaining time equally between supporting whole-school/college approach activities and working with education staff and external specialist services. This was consistent with the pattern found in the pilot wave. There was variation in how MHSTs operate, including the number of schools and colleges that EMHPs work with as well as the number of children and young people they deliver interventions to; the time that MHSTs spend in schools and colleges; their way of working with schools/colleges. Both school and college staff and respondents in MHSTs reported broadly good partnership working and integration between the teams and local schools and colleges, although some schools and colleges reported lower levels of MHST integration.

Most respondents in MHSTs reported that their team accepted referrals for children and young people with needs that were outside 'mild to moderate' low mood, social anxiety and common behavioural issues at least some of the time, and in some cases, more frequently. Half of respondents in MHSTs reported that the interventions they used were not suitable for all children and young people, such as those with neurodiversity, special educational needs and disabilities, and those who have experienced trauma. The findings also show that staff turnover was still an issue within MHSTs, especially of EMHPs.

Overall, the two surveys provided a broad overview of how the Green Paper programme was being delivered across the country, including successes and challenges, and showed that there was considerable variation in how the service was delivered across teams and education settings. Inevitably, surveys are limited in depth as they balance participant burden with the volume of questions, and answers options are pre-specified. The ongoing evaluation will probe further with detailed research in six case study MHSTs and the schools and colleges that they work with, covering programme implementation, costs, and outcomes. The surveys will be repeated in autumn 2025, informed by the findings from the case study research. The evaluation will report its full findings from all packages of research in 2026.

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1 Background

In 2018, the Transforming Children and Young People's Mental Health Provision Green Paper programme was launched in England. This programme funded the creation of Mental Health Support Teams (MHSTs) in schools and colleges, and the training of a designated staff member to become the senior lead for mental health within each school/college to oversee the whole-school/college approach to mental health and wellbeing and liaise with MHST staff.

The aim of the programme was to improve prevention and early identification of mental ill health in children and young people (Department of Health & Social Care and Department for Education 2018). This came in response to the growing proportion of children and young people experiencing poor mental health and difficulties accessing specialist support from existing mental health services (NHS England Digital 2023), in addition to an increased emphasis on the role of schools in supporting the mental health and wellbeing of children (Department of Health and England 2015).

1.1 Mental Health Support Teams (MHSTs)

The new MHSTs were initially funded for eight full time equivalent (FTE) staff members: one 0.5 FTE team manager/lead, four 1.0 FTE EMHPs, three 1.0 FTE senior clinical or supervising practitioners, and a 0.5 FTE team administrator. The EMHP role, which was created as a new NHS Band 5 role specifically for the programme, is akin to the already existing Children and Young People's Wellbeing Practitioner (CWP) role. EMHPs are trained through a one-year placement that involves an accredited university course and a clinical placement with an MHST. The university course includes similar modules to that for the CWP qualification as well as specific training in whole-school/college approaches to mental health and wellbeing.

MHSTs receive funding from central government, and the service is provided through the NHS, local authorities, charities/voluntary sector organisations, or in some cases, a combination of providers.

Some teams have also been able to access local sources of funding. Each MHST works with a cluster of schools and colleges in their local area. The programme was designed so that each MHST would support approximately 8,000 children and young people.

MHSTs were expected to deliver the following three core functions:

1. delivering evidence-based interventions (either 1:1 or in a group) to children and young people with 'mild to moderate' mental health issues, and/or to their parents and carers;
2. supporting schools and colleges to introduce or develop their whole-school/college approach to mental health and wellbeing;
3. giving timely advice to school and college staff and liaising with external specialist services, to help children and young people get the right support and stay in education.

The first wave of funding, known as 'the Trailblazers', supported 58 MHSTs that worked in 1,050 schools and colleges, covering 25 Trailblazer areas. Since then, the programme has been rolled out across England in successive waves. With each wave, new EMHPs were trained, additional MHSTs were created or existing ones were expanded, and more schools and colleges joined the programme and started working with an MHST. As of spring 2025, the MHSTs funded in waves 9 and 10 were becoming operational and approximately 600 MHSTs were in place (Department for Education 2025). **Table 1** shows how many MHSTs were funded in each wave, and when they became operational or are expected to become operational, up to and including wave 12.

As the programme progressed, MHSTs adapted to local needs and existing mental health provision. The number of FTE staff members, and the range of roles, within each team, as well as the number of schools and colleges they supported, became more flexible.

In March 2025, the programme formally closed, although funding is committed to waves 11 and 12 which are expected to become operational in April 2026. At that time, approximately 10,100 schools and colleges and 5 million children and young people were supported by an MHST (41% of schools and colleges in England and 52% of children and young people). There were, on average, 8,300 children/young people and 17 schools/colleges per MHST (Department for Education 2025). See the Department for Education's 2025 report data release for more information about the coverage achieved by MHSTs up to an including wave 10 (https://www.gov.uk/government/publications/transforming-children-and-young-peoples-mental-health-provision).

Table 1. Information about the Mental Health Support Teams (MHSTs) in each funding wave of the Green Paper programme

Wave	Number of MHSTs funded*	Year EMHPs began training	Year teams became operational
Trailblazers	58	January 2019	March 2020
1 and 2	125	Wave 1: September 2019 Wave 2: January 2020	March 2021
3 and 4	104	Wave 3: November 2020 Wave 4: January – February 2021	March 2022
5 and 6	111	Wave 5: November 2021 Wave 6: January – February 2022	March 2023
7 and 8	100	Wave 7: November 2022 Wave 8: January – February 2023	March 2024
9 and 10	109	Wave 9: September 2023 Wave 10: January 2024	March 2025
11 and 12	106	Wave 11: September 2024 Wave 12: January 2025	Expected April 2026

Source: Department for Education (2025)**.** *EMHP: Education Mental Health Practitioner*

**Note: Numbers presented here are approximate. They reflect the number of teams allocated funding in each wave. However, the way this funding was used varies between areas. E.g., waves of funding were used to create new teams in some areas, while in other areas they were used to expand existing teams. Furthermore, some teams that were allocated funding may have not become operational due to local issues. Therefore, the number of teams presented in this table differs slightly from the number of fully operational teams.*

1.2 Early evaluation of the Trailblazer MHSTs

In 2020-22, an evaluation of the implementation of the Trailblazer MHSTs (the pilot wave of the programme) was conducted by a team of researchers at the University of Birmingham, the London School of Hygiene and Tropical Medicine (LSHTM), and RAND Europe. This was co-led by Professor Nicholas Mays (LSHTM) and Dr. Jo Ellins (University of Birmingham) and funded by the National Institute for Health and Care Research (NIHR).

The early evaluation sought to:

- understand the context in which the programme was implemented (i.e., existing local mental health services/provision for children and young people);
- describe the various delivery models of the newly created MHSTs and understand how they adapted to the COVID-19 pandemic;
- investigate the experiences of schools and colleges that had started working with an MHST, and the views of MHSTs and wider stakeholders about the set-up and delivery of the new service;
- capture the early impacts of the Trailblazer MHSTs including any unintended consequences;
- identify relevant outcome measures for a longer-term economic evaluation.

This early evaluation found that MHSTs had been implemented well and were able to deliver their core functions, despite the disruptions and increased demand that resulted from the COVID-19 pandemic, which understandably meant that they had to alter their ways of working. MHSTs spent around half of their time on delivering evidence-based interventions to individual children and young people and/or their parent carers (function one), with the remaining time divided roughly equally between supporting whole-school/college approaches to mental health (function two), and liaising with school and college staff and external specialist mental health services (function three).

The Trailblazer MHSTs were making progress towards achieving the programme's goals, including faster access to mental health support for children and young people; strengthening relationships between schools and colleges, mental health services and other local organisations; and improving mental health literacy among education staff. Nonetheless, gaps in the provision of direct support from MHSTs were noted, due to difficulties accessing the service for some groups and/or the interventions (mainly low-intensity cognitive behavioural therapy [CBT]) not meeting the needs of some children/young people referred to the service. These groups included: children and young people with special educational needs and disabilities, children and young people from ethnic minorities or with English as a second language, LGBTQ+ children and young people, those whose mental ill health needs that presented in less overt ways, and others (more information on page 63 of the early evaluation report; Ellins et al. 2023). Furthermore, some children and young people presented with mental health issues too severe to be supported by MHSTs, but not severe enough to be referred to specialist child and adolescent mental health services (CAMHS), leaving them ineligible for either form of support.

There were some teething problems in the set-up of MHSTs. For example, MHSTs found that many EMHPs left their roles shortly after qualifying. This left the teams short-staffed and sometimes unable to provide support to all the schools and colleges that needed it. Furthermore, gaps in EMHP training were identified. Many of the EMHPs interviewed felt that there was a disparity between their training and the reality of delivering interventions to children and young people or their parents/carers, and building relationships with schools and colleges. Some felt that their substantive knowledge was insufficient in some areas (e.g., about specific types of mental health problems, such as eating disorders and self-harm). As a result, supervisors were often required to provide additional training and support to ensure safe practice within the new service (Ellins et al. 2023).

1.3 National evaluation of the Green Paper programme

In June 2023, a 36-month mixed-methods evaluation of the Green Paper programme started. This evaluation was commissioned competitively and funded by the NIHR, and is being undertaken by researchers at LSHTM, the University of Birmingham, and the University of Cambridge. Continuing from the early evaluation of the Trailblazer MHSTs, the evaluation is co-led by Professor Nicholas Mays and Dr. Jo Ellins. The evaluation will report its full findings in 2026.

The evaluation will focus on the first seven waves of the programme, including the Trailblazers and waves 1 – 6 and will involve several work packages using quantitative and qualitative research methods. Our aim is to understand how the programme has been implemented across England and to examine its outcomes for children and young people, parents/carers, schools and colleges, and local mental health provision. An infographic illustrating the various elements is shown in **Figure 1**. You can visit the evaluation's website for more information and updates: https://www.lshtm.ac.uk/research/centres-projects-groups/cypmh-gppe

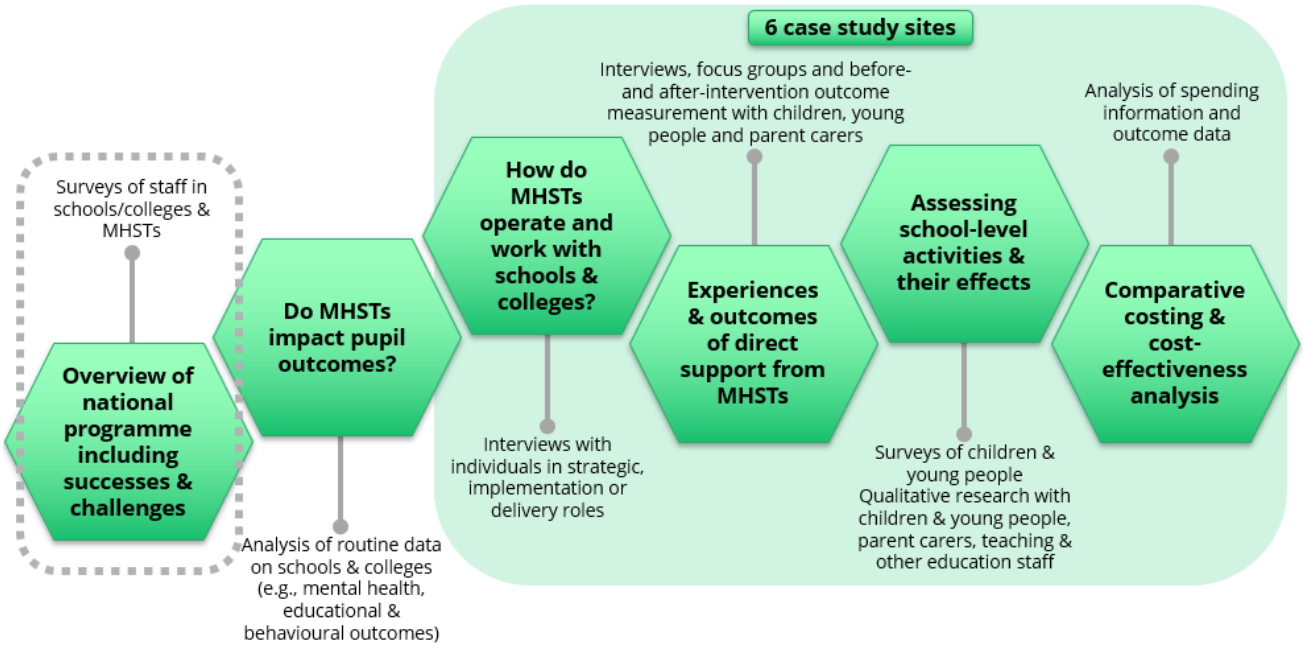


Figure 1. Overview of the packages of research involved in the national evaluation of the Green Paper programme

Note: This report presents the findings from the first set of surveys of staff in schools and colleges and MHSTs (highlighted in the grey box). A second set of surveys of these groups will be conducted in autumn 2025. MHST = Mental Health Support Team

2 About the surveys

In 2024, we conducted two surveys covering the first seven waves of the programme (the Trailblazers and waves 1 – 6). First, we surveyed an education staff member who was involved with the MHST in each school/college in the programme (the schools and colleges' survey). Second, we surveyed individuals who worked in, or closely with, MHSTs (the MHSTs' survey). Following the strategy of the early evaluation of the Trailblazers, we surveyed these two groups to gain complementary perspectives on how the programme was unfolding. The content of these surveys built on the learning from the early evaluation and scoping interviews with key professionals involved in the design of the Green Paper programme (e.g., policy officials with strategic roles within the NHS, Department of Health and Social Care, and Department for Education) undertaken in the initial months of the evaluation.

The aims of the two surveys were to:

- provide an overview of how the programme was being delivered (e.g., different ways that MHSTs delivered their core functions, how they worked with schools and colleges and other services);
- find out what activities MHSTs were doing to support schools and colleges and their pupils;
- hear from schools and colleges about their experiences of working with an MHST;
- understand what was working well and less well, from the perspectives of both education staff and MHSTs;
- understand the successes of the programme and challenges for effective delivery;
- inform priority topics for exploration in the subsequent more detailed case study research in six contrasting local areas served by MHSTs.

Both surveys were conducted online via Qualtrics .

2.1 Schools and colleges' survey

The schools and colleges' survey was conducted in collaboration with the Department for Education because its regular 'MHST experience survey' was scheduled at a similar time. To avoid overburdening respondents, we developed a joint survey that included the Department for Education's questions and questions for the national evaluation. The Department for Education's questions included a core set of questions from their previous MHST experience surveys, and some new ones. We piloted the survey with senior mental health leads and other education professionals, and amended the questions based on their feedback.

One person per school/college was invited to complete the survey. The name and email address of a person in each school/college (usually the senior mental health lead or an equivalent role) was collected by the Department for Education via the MHSTs in January 2024. The survey was sent from the Department for Education to the email address of the person in each school/college in May 2024. Participants were initially given a window of four weeks to complete the survey. However, the survey closed after three weeks due to the start of the pre-election period for the UK general election and rules relating to policy-related activities during the pre-election period of sensitivity (see https://commonslibrary.parliament.uk/research-briefings/sn05262/ for more information).

2.2 MHSTs' survey

The MHSTs' survey was developed and sent out to participants by the evaluation team. We piloted the survey with MHST managers and EMHPs and amended the questions based on their feedback.

The survey was open to anyone involved in the delivery of MHSTs or who had local knowledge of the MHST, excluding trainee EMHPs. To reach intended participants, NHS England provided the contact details of the manager/lead for every MHST in the first seven waves. We then emailed the managers/leads to introduce the national evaluation of the Green Paper programme and our survey. We asked them to contact their team members and other individuals involved in delivery of their MHST(s) to tell them about the survey and invite them to sign up to take part. We gave suggestions to the MHST managers/leads about who could be invited to share their views via the survey, but it was ultimately up to them to decide who to share the opportunity with. We provided a link to a form where the interested individuals could share their contact details with us. We sent out the survey in July 2024 to the MHST managers/leads and all the individuals who had signed up via the online form. Respondents were given a window of four weeks to complete the survey.

See **Supplementary Figure 1** for a flow-chart demonstrating how the two surveys were developed and **Supplementary Table 1** for a summary of information about the survey dates, respondents, sample sizes, and response rates.

2.3 Survey sampling frames

2.3.1 Schools and colleges who worked with an MHST

According to the list of schools and colleges collected by Department for Education via the MHSTs in January 2024, approximately 6,944 schools and colleges work with an MHST established in the first seven waves (the Trailblazers and waves 1 – 6).

2.3.2 MHSTs

According to the same data collected by the Department for Education, there are approximately 336 MHSTs in the first seven waves of the Green Paper programme. The number is approximate and differs to the total number of MHSTs in first seven waves of 398 in **Table 1**. This is because each additional wave funded expansions of existing teams and the creation of entirely new teams. Furthermore, some teams that were allocated funding may have not become operational due to local issues. Therefore, the number of 336 does not represent the number of teams as they are configured operationally.

The Department for Education categorised the MHSTs into 'MHST groups' which represent teams in the same geographic area that share the same name/provider despite their funding coming from different waves of the programme. To assess survey coverage, we used MHST groups as the unit of analysis so that responses that are about same MHST, as configured in practice, are grouped together rather than being split out into component teams funded in different waves. This removes uncertainty about whether individual MHSTs operate as one team or separately. However, because we did not have information on which teams operate separately or operate together, it may be the case that some teams that operate separately are grouped together for the purpose of assessing survey coverage. The 336 MHSTs were categorised into 105 MHST groups.

2.4 Survey samples

2.4.1 Schools and colleges who worked with an MHST

Of the 6,944 schools and colleges working with an MHST in the first seven waves of the programme, 6,175 were invited to participate in the survey (the contact details for some settings were not known and some emails bounced). One staff member in each school/college was invited to take part in the survey. We received a survey response from 1,189 schools and colleges (19% response rate).

Coverage of schools and colleges: We received survey responses from schools and colleges in all seven regions of England, all 42 ICSs in England and 104 out of 106 MHST groups.

Representation of schools and colleges: Compared to all schools and colleges in England that worked with an MHST in the first seven waves of the programme, our survey sample was broadly representative in terms of settings' phase, and the wave and region of their MHST. There were slightly more responses from schools and colleges in the East of England compared to the overall proportion of schools and colleges in the East of England (13% in survey, 10% overall), and a slightly higher proportion of 16+ settings compared to the overall proportion of 16+ settings (2.4% in survey, 1.5% overall). See **Supplementary Table 2** for a full comparison of the sample to all the schools and colleges that worked with an MHST in the first seven waves. **Supplementary Table 3** contains a comparison of those who responded to the survey against those who did not respond.

2.3.2 MHSTs

We sent the survey to 688 individuals, including the MHST managers/leads whose contact details were supplied by NHS England, and individuals who had signed up to participate. Multiple individuals in each MHST were able to respond to the survey. We received responses from 416 individuals (60% response rate). After removing survey responses from individuals who did not progress past the first question or were from an MHST that was funded after wave 6, there were 303 survey responses (48% response rate). Responses from individuals in MHSTs that were funded after wave 6 were excluded because waves 7 and 8 had only become operational one month before the schools and colleges' survey, and three months before the MHSTs' survey, and we felt that this was not sufficient time to report on how the programme was progressing. Respondents were asked the name of their MHST which was then cross-referenced to the MHST and MHST group list provided from the DfE. We received an average of three survey responses per MHST group (range 1 – 13). In terms of respondents' roles, we received responses from a range of roles across the 76 MHST groups (**Table 2**).

Coverage of MHST groups: We received at least one survey response from MHST groups in all seven regions in England. One region (South West of England) had survey responses from all its MHST groups, and four regions had responses from 75% or more of its MHST groups. We received at least one response from MHST groups in 41 out of 42 ICSs. Twenty-nine ICSs (71% of 42) had three-quarters or more of its MHST groups included in the survey, of which 27 ICSs (66% of 42) had all of its MHST groups included. We received at least one response from 76 of the 106 MHST groups (72%). Some respondents' MHST groups could not be identified, therefore it is possible that we received responses from more than 72%. See **Supplementary Tables 4 and 5** for more information about coverage of regions, ICSs, and waves.

Not all respondents answered every question in the survey so denominators vary slightly between questions. Where fewer than five respondents selected an answer, primary suppression has been applied, usually by grouping answers. Where fewer than five respondents selected 'Don't know', these responses have been removed from the per cent.

Table 2. % of Mental Health Support Team (MHST) groups included in MHSTs' survey that had each type of role respond to survey

Respondents' roles	% MHST groups
Senior roles *Including site lead, service lead, team manager/lead, ICS lead, clinical lead, senior responsible officer for the programme*	62%
EMHPs *Including EMHPs, assistant EMHPs, and senior EMHPs*	41%
Supervising practitioners *Including supervising practitioners and trainee supervising practitioners*	21%
Mental health practitioners (non-EMHPs)	29%
Stakeholders *Including stakeholders from the education sector, local authority, voluntary sector, and CAMHS*	9%

Note: CAMHS = child and adolescent mental health services; EMHP = Education Mental Health Practitioner; ICS = Integrated Care System

3 Respondent characteristics

3.1 Schools and colleges' survey

Just over two-thirds (65%) of the respondents in the schools and colleges' survey held the role of the senior mental health lead or equivalent. The other 35% held varied roles including the special educational needs coordinator (SENCo), head teacher, deputy head teacher, or teacher, among others. Of the 1,189 schools and colleges included in the survey, 95% had a senior mental health lead or equivalent role in their setting and 94% had a member of staff currently acting in that role.

3.2 MHSTs' survey

We received responses from a range of roles involved in the delivery of MHSTs or who had local knowledge of MHSTs in their area. These included senior roles (e.g., team managers/leads, service leads, clinical leads), EMHPs, other mental health practitioners (e.g., Psychological Wellbeing Practitioners/Children and Young People's Wellbeing Practitioners), supervising practitioners, and external stakeholders (see **Table 3** for more information about respondents' roles). Most respondents (77%) worked in/were associated with one MHST, and the remaining worked across/were associated with two or three MHSTs. Those who worked across two or three MHSTs were asked to select one MHST to relate their answers to.

Table 3. n (%) roles of respondents to the Mental Health Support Teams' (MHSTs') survey (n = 303)

Role related to MHST	n = 303
EMHP	83 (27%)
Team manager	57 (19%)
Service lead	42 (14%)
Supervising practitioner	24 (8%)
Senior mental health practitioner other than senior EMHP	21 (7%)
PWP or CWP	20 (7%)
Senior EMHP	20 (7%)
Clinical lead	18 (6%)
Mental health practitioner other than EMHP	18 (6%)
Stakeholder	15 (5%)
Project/site lead	12 (4%)
Trainee supervising practitioner	10 (3%)
ICS lead	<5
Assistant EMHP	<5
Senior responsible officer for the programme	<5
Not listed	28 (9%)

Note: Respondents could select more than one role.

CAMHS = children and adolescent mental health services; CWP = Children and Young People's Wellbeing Practitioner; EMHP = Education Mental Health Practitioner; ICS = Integrated Care System; PWP = Psychological Wellbeing Practitioner

4 Survey findings

This section describes the survey findings. The findings are organised into themes. Findings from both the schools and colleges' and MHSTs' survey are reported together for each theme with plots and tables clearly labelled as to which survey they relate to.

4.1 Pre-programme mental health provision in schools and colleges

Just over two-thirds (64%) of respondents in schools and colleges indicated that their setting already had someone who led mental health before their setting started working with an MHST. When asked about which types of mental health support were available before their setting started working with an MHST: targeted support (e.g., 1:1 work with pastoral staff or school counsellor) was available at least to some extent in 73% of settings, selected support (e.g., intervention groups such as social skills groups) was available to at least some extent in 75%, and universal support (e.g., assemblies around mental health) was available at least to some extent in 77% (**Figure 2**). A small minority (16%) said that all three types of support were available to a great extent in their setting, and <1% said that all three types were unavailable in their setting, before they started working with an MHST.

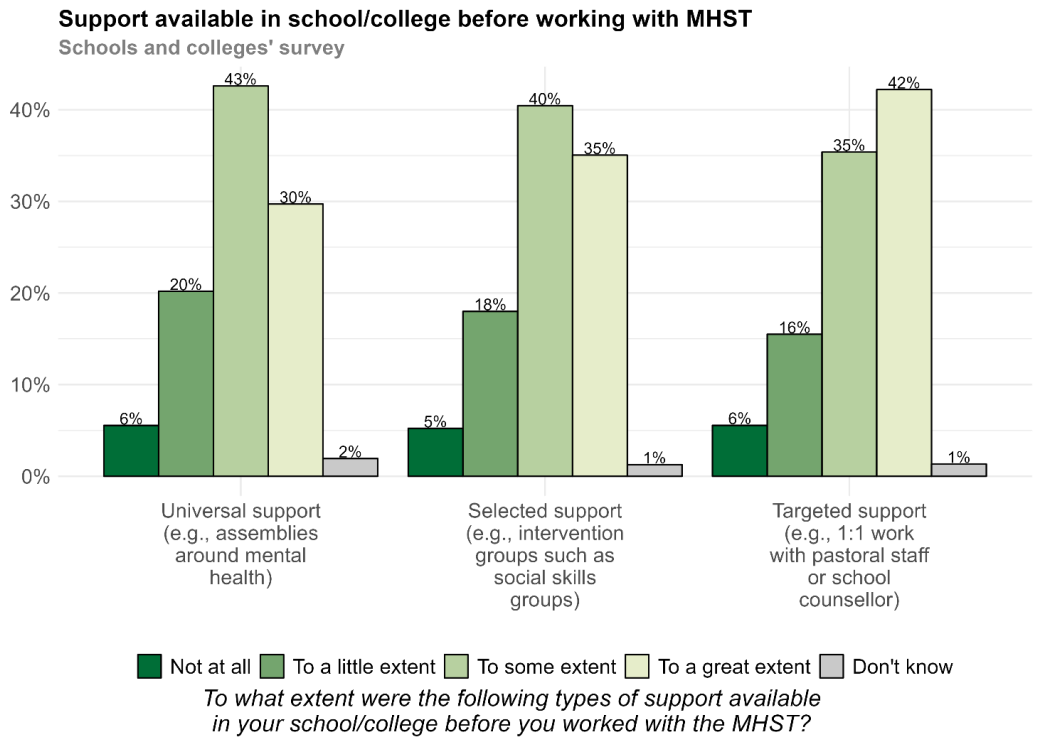


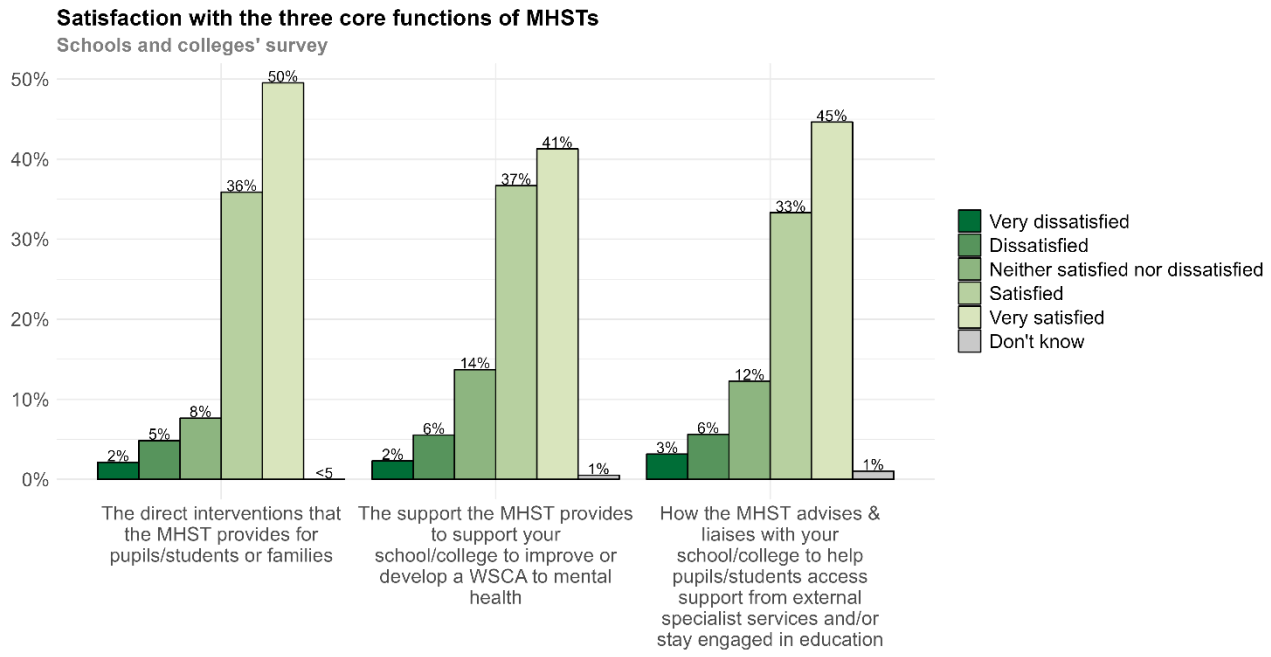
Figure 2. Extent that universal, selected, and targeted support for children and young people's mental health were available before the school/college started working with the Mental Health Support Team (MHST)

4.2 Delivery of the MHST service

Nearly all respondents (92%) in schools and colleges somewhat or strongly agreed that they were clear on the aims and objectives of the MHST programme, and 74% somewhat or strongly agreed that they were clear on the reasons for changes to the MHST offer.

We asked respondents about the delivery of MHSTs' three core functions. The vast majority said that the functions were being delivered well. Among respondents in schools and colleges, 86% were satisfied or very satisfied with the direct interventions that the MHST provided for pupils/students or families (function one), 78% were satisfied or very satisfied with the support that the MHST provided to improve or develop the whole-school/college approach (function two), and 78% were satisfied or very satisfied with how the MHST advised and liaised with the school/college to help pupils/students access support from external specialist services (function three) (**Figure 3**). Respondents who were overall dissatisfied with each core function were not clustered within particular MHST groups.

Just over two-thirds (68%) were satisfied or very satisfied with the delivery of all three core functions, while 3% were dissatisfied or very dissatisfied with all three. Respondents who were overall dissatisfied with all three core functions were not clustered within particular MHST groups.



To what extent are you satisfied or dissatisfied with...?

Figure 3. Satisfaction with the delivery of the Mental Health Support Teams' (MHSTs') three core functions from staff in schools and colleges

Note: WSCA = whole-school/college approach

Among respondents in MHSTs, views about the core functions were also generally positive: 96% said that the direct interventions with children and young people and their parents/carers were being delivered well or very well, and 82% said the same about how the MHST supported the schools and colleges to introduce or develop their whole-school/college approach to mental health and wellbeing. We asked about the third function in two parts to capture the dual activities that constitute this function: 79% said that giving timely advice to schools and colleges' staff was being delivered well or very well and 71% said the same for how the MHST liaised with external specialist services. Notably, 70% of respondents in MHSTs thought that the direct interventions with children and young people or parents/carers were being delivered *very* well, compared to 24 – 38% who thought this about the other functions (**Figure 4**). Respondents who thought that the core functions were being delivered somewhat or very poorly were not clustered within particular MHST groups.

Just over half of respondents (57%) said that all three core functions were being delivered somewhat or very well, and very few (<5 respondents) said that all three were being delivered somewhat or very poorly.

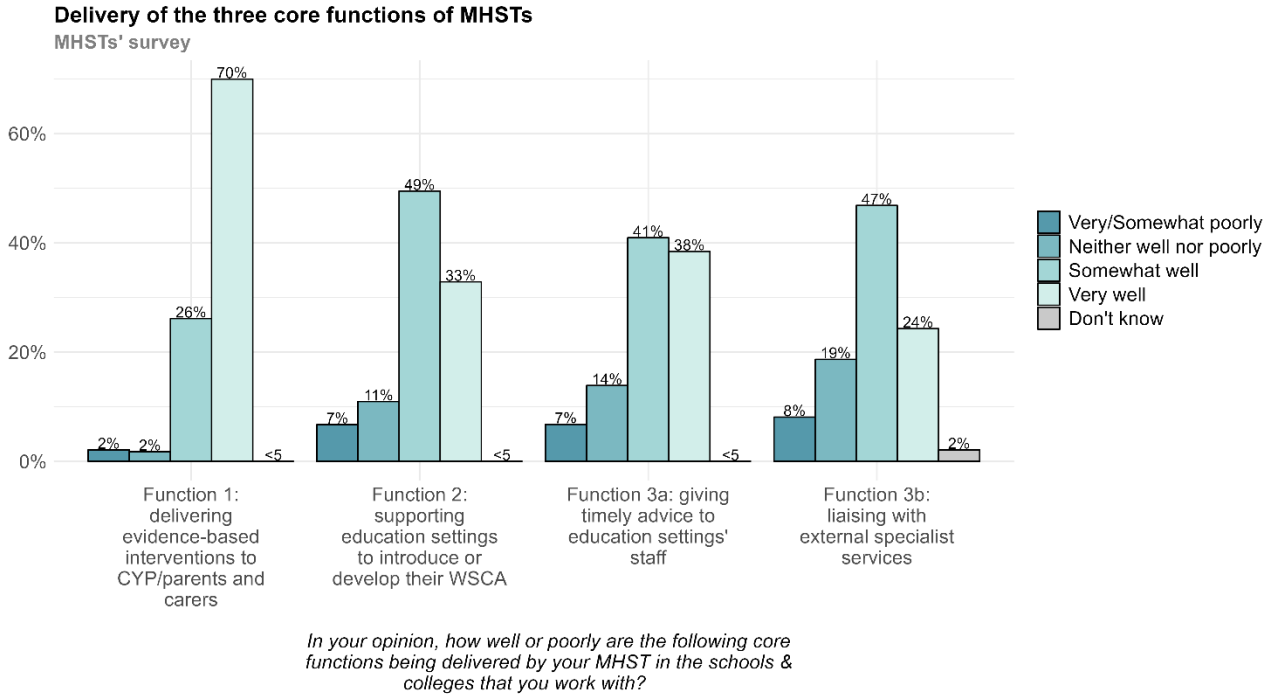


Figure 4. Views of Mental Health Support Team (MHST) respondents about the delivery of the three core functions in their MHST

Note: Function three was split into two parts to cover the two different activities that constitute this function.
CYP = children and young people; WSCA = whole-school/college approach

4.2.1 Direct interventions

Nearly all respondents in schools and colleges overall agreed that they were clear on the support their MHST provided in terms of direct interventions for individual children and young people (35% somewhat agreed, 57% strongly agreed). Five per cent overall disagreed (2% somewhat disagree, 3% strongly disagreed).

Respondents in MHSTs reported that the referral and assessment process of children and young people for direct interventions were being delivered well (**Figure 5**). Notably, 66% said that assessments of children and young people were being delivered very well. A slightly higher proportion of respondents said that the referral process and the triage of referrals were working somewhat or very *poorly* compared to the allocation of accepted referrals to a practitioner and the assessment; 12% for the referral process and the triage of the referrals and 11% for triage of referrals, compared to 5% and 4% for the allocation of accepted referrals and the assessment, respectively (**Figure 5**). Sixty-six per cent thought all four processes were being delivered somewhat or very well, and 2% thought all four processes were being delivered somewhat or very poorly.

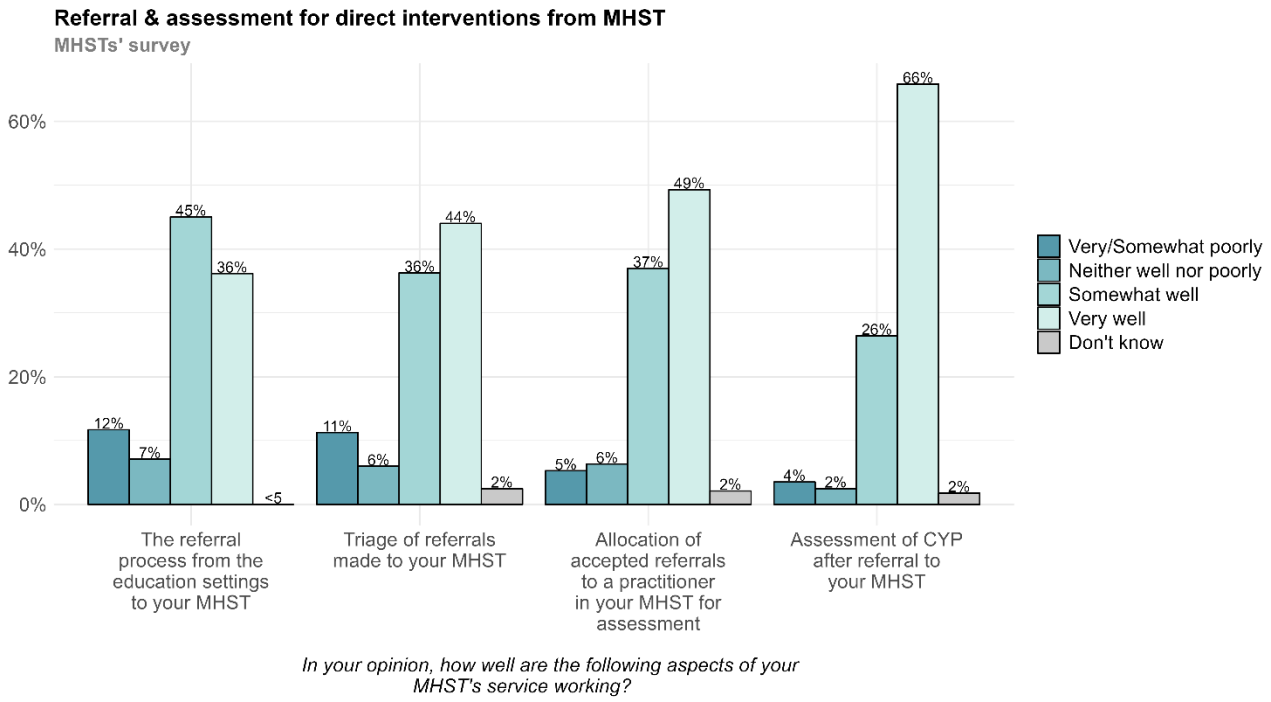


Figure 5. Views of Mental Health Support Team (MHST) respondents about the referral and assessment process of children and young people (CYP) for direct interventions

4.2.2 Whole-school/college approaches to mental health and wellbeing

Eighty-eight per cent of respondents in schools and colleges overall agreed that they were clear on the support that their MHST provides to implement or improve their whole-school/college approach to mental health (39% somewhat agreed, 49% strongly agreed), and 7% overall disagreed (3% somewhat disagreed, 4% strongly disagreed). We also asked whether they were clear on how the MHST service fitted into their whole-school/college approach – 87% overall agreed and 4% overall disagreed (**Figure 6**). We asked a similar question to the MHSTs and 86% were clear to at least some extent on how their team could support schools to introduce or develop their whole-school/college (44% were clear to a great extent, 42% were clear to some extent; **Figure 6**).

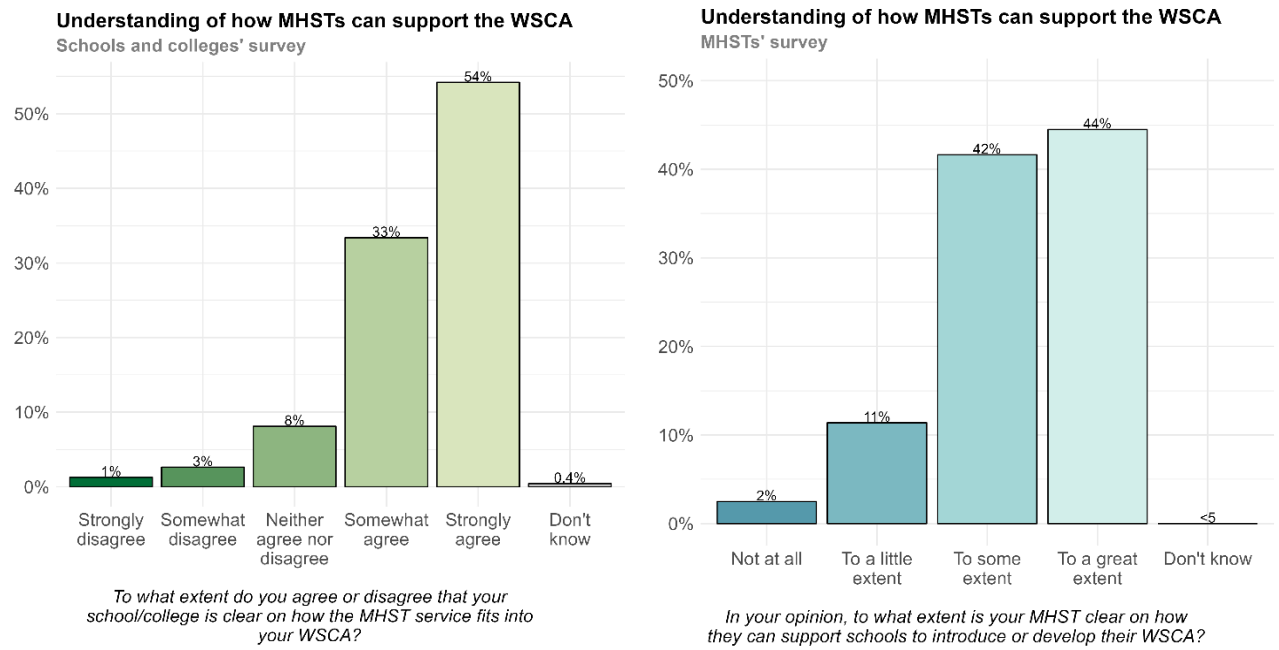


Figure 6. Views of respondents in schools and colleges (left) and Mental Health Support Teams (MHSTs; right) about clarity on how the MHST can support schools and colleges with their whole-school/college approach (WSCA) to mental health and wellbeing

We asked about the whole-school/college activities the MHSTs contributed to regularly, using the eight whole-school/college approach activities from Public Health England shown in **Figure 7** (Public Health England and Department for Education 2021). The two most frequently selected activities were 'targeted support' (91%) and 'working with parents and carers' (84%), and the two least frequently selected were 'curriculum teaching and learning' (36%) and 'leadership and management' (22%).

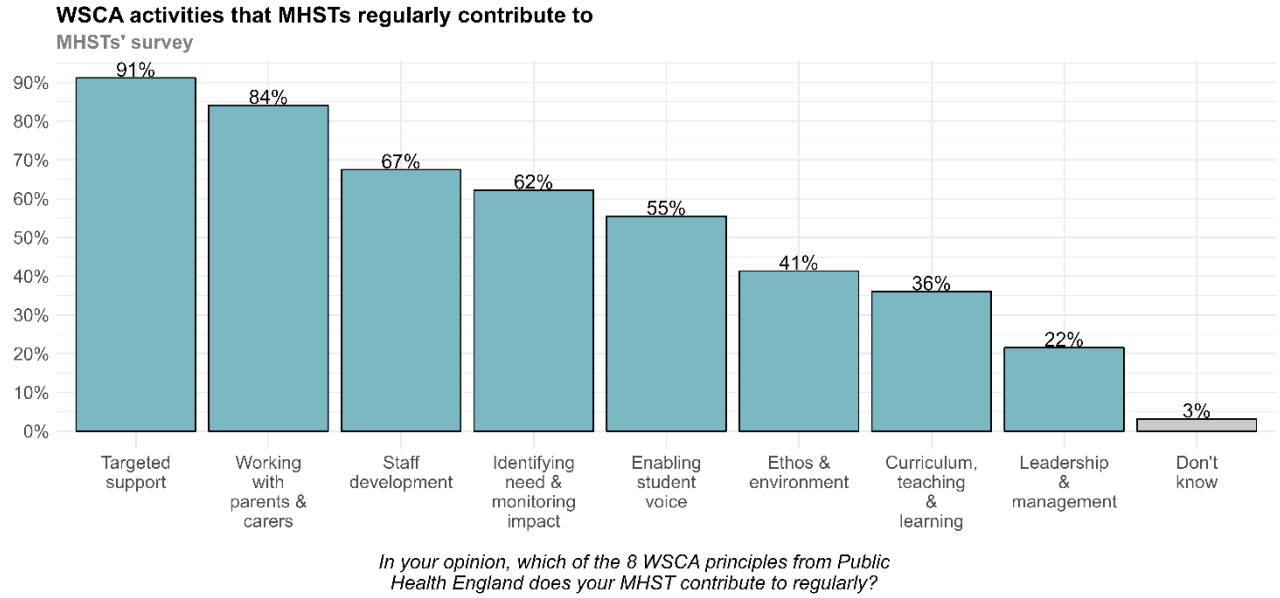


Figure 7. Frequency of whole-school/college activities (WSCA) that Mental Health Support Teams (MHSTs) regularly contribute to

Note: Fewer than five respondents selected 'My MHST does not contribute to the whole-school/college approach'.

4.2.3 Time MHSTs spent in schools and colleges

We asked respondents in schools and colleges whether their MHST provided interventions to children and young people and parents/carers only during term-time or in the school holidays as well. One quarter said that their MHST provided interventions during term-time only, 19% said that the interventions continued in the school holidays, 34% said that some interventions are provided in the school holidays if required, and 22% did not know (**Table 4**).

We asked how much time the MHST spent in their setting every week (**Table 4**). The most common answer was 'It varies week-to-week' (28%). Just under half (42%) said their MHST spends at least three hours a week in their setting.

Table 4. Time that Mental Health Support Teams (MHSTs) spend in schools and colleges (schools and colleges' survey; n = 1,189)

Survey question about time MHST spends in school/college	n = 1,189
Direct interventions in term-time/school holidays	
Term-time only	302 (25%)
Some direct interventions in holidays if required	404 (34%)
Direct interventions continue in holidays as usual	225 (19%)
Don't know	256 (22%)
Time MHST spends in school/college every week	
Up to one hour per week	128 (11%)
Up to two hours per week	133 (11%)
Up to three hours per week	175 (15%)
Up to one day per week	200 (17%)
Up to two days per week	81 (7%)
More than two days per week	38 (3%)
It varies week-to-week	326 (28%)
Don't know	98 (8%)

We asked respondents in MHSTs about how their team balanced its time across the three core functions (**Table 5**). On average, the direct interventions with children and young people and parents /carers (function one) received just over half of the teams' time. The other two functions received 20% each. Thirteen per cent of respondents in MHSTs said that their team dedicated 75% or more of its time to direct interventions and fewer than five respondents said that their MHST spent 75% or more of its time supporting whole-school/college approaches to mental health and wellbeing (function two).

Table 5. Time that Mental Health Support Teams (MHSTs) allocate across the three core functions (MHSTs' survey; n = 303)

Core function	Median % (Q1, Q3)	Mean % (SD)	Min, max %
Function 1: delivering evidence-based direct interventions to children and young people or parents/carers	55 (45, 70)	55 (16)	0, 95
Function 2: supporting schools and colleges to introduce or develop their whole-school/college approach to mental health and wellbeing	20 (15, 30)	23 (12)	0, 100
Function 3a: giving timely advice to school and college staff	10 (10, 20)	13 (7)	0, 30
Function 3b: liaising with external specialist services	10 (5, 10)	8 (5)	0, 30

Note: Q1 and Q3 = quartile 1 and 3, SD = standard deviation; MHST = Mental Health Support Team

4.3 Scope and equity of direct interventions from MHSTs

4.3.1 Scope of mental health needs that MHSTs support

The majority (90%) of respondents in schools and colleges said that they overall agreed that they were clear on the scope of mental health needs that the MHST can support and who that includes (39% agreed, 51% strongly agreed). A small proportion (7%) somewhat or strongly disagreed.

We asked respondents in MHSTs how often they accepted referrals for children and young people whose needs fall outside the original scope of 'mild to moderate' low mood, generalised and social anxiety, and common behavioural problems. Very few (<5 respondents) said that their MHST did not receive referrals for mental health problems that are outside 'mild to moderate' in severity, or outside

low mood, generalised and social anxiety, and common behavioural problems. **Figure 8** shows that 77% said that their MHST accepted referrals for children and young people whose needs fall outside 'mild to moderate' at least some of the time. Likewise, 75% said that their MHST accepted referrals for children and young people whose needs fall outside low mood, anxiety and common behavioural problems at least some of the time.

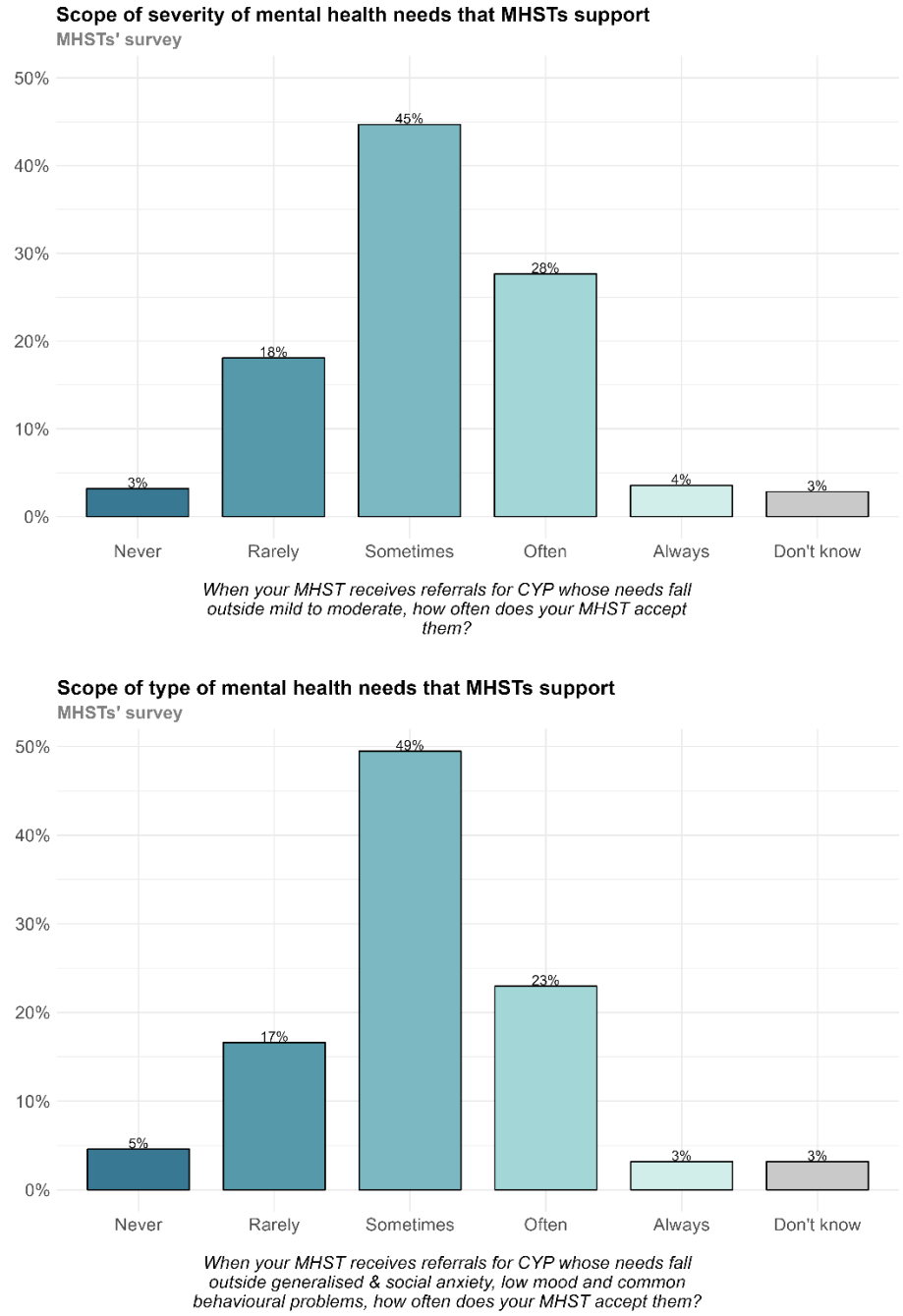
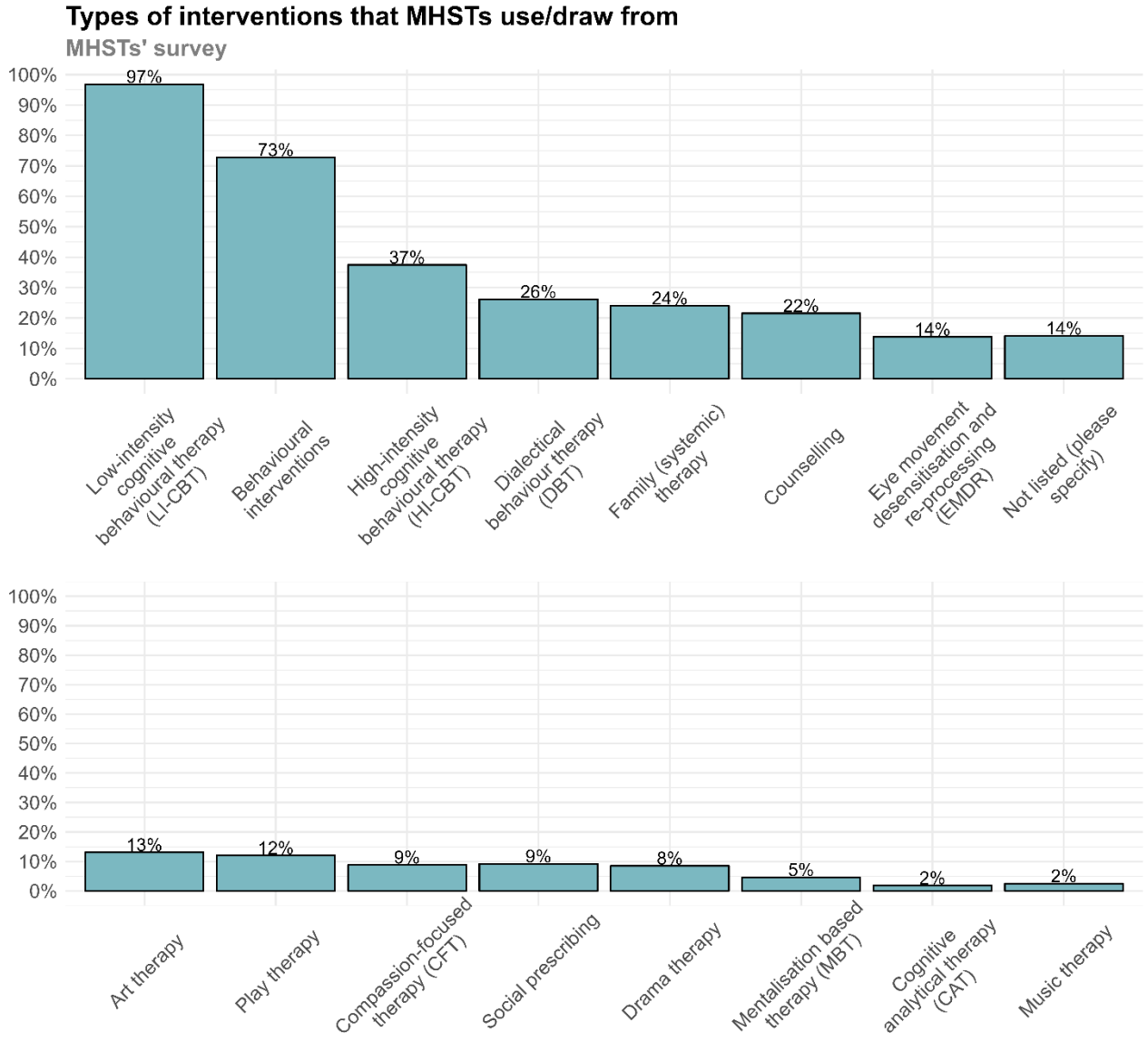


Figure 8. Views of Mental Health Support Team (MHST) respondents about how often their team accepted referrals outside their formal scope of 'mild to moderate (top), and outside low mood, generalised and social anxiety, and common behavioural problems (bottom)

4.3.1.1 Types of interventions delivered by MHSTs

We asked respondents in MHSTs about which types of interventions they used or drew from with children and young people and parents/carers. All intervention types listed were selected by at least five respondents, with the exception of schema therapy and animal-assisted therapy (**Figure 9**). The most frequently selected was low-intensity CBT (97%), followed by behavioural interventions (73%). The most frequently mentioned interventions that were not listed were solution-focused approaches and acceptance and commitment therapy (ACT).



Out of the list below, which approaches does your MHST use or draw from in their interventions with CYP/parents & carers?

Figure 9. % of respondents in Mental Health Support Teams (MHSTs) who selected different types of interventions when asked which interventions they used/drew from in their MHST's direct interventions with children and young people (CYP) and parents/carers

Note: None of the respondents selected 'Animal-assisted therapy' or 'Schema therapy'.

4.3.2 Equity of access to direct interventions from MHSTs

We asked about the extent to which access to direct interventions delivered by MHSTs was equitable across all groups of children and young people, either within their school/college (for respondents in schools and colleges) or within the schools and colleges that their MHST worked with (for respondents in MHSTs). We did not define the term 'equitable' so respondents will have their own interpretation of what this means. **Figure 10** shows that 75% of respondents in schools and colleges thought that access was equitable at least to some extent, and 86% in MHSTs thought the same.

We asked respondents in schools and colleges whether their MHST supported children and young people who were not attending school, and 25% said yes, 37% said no, and 38% did not know.

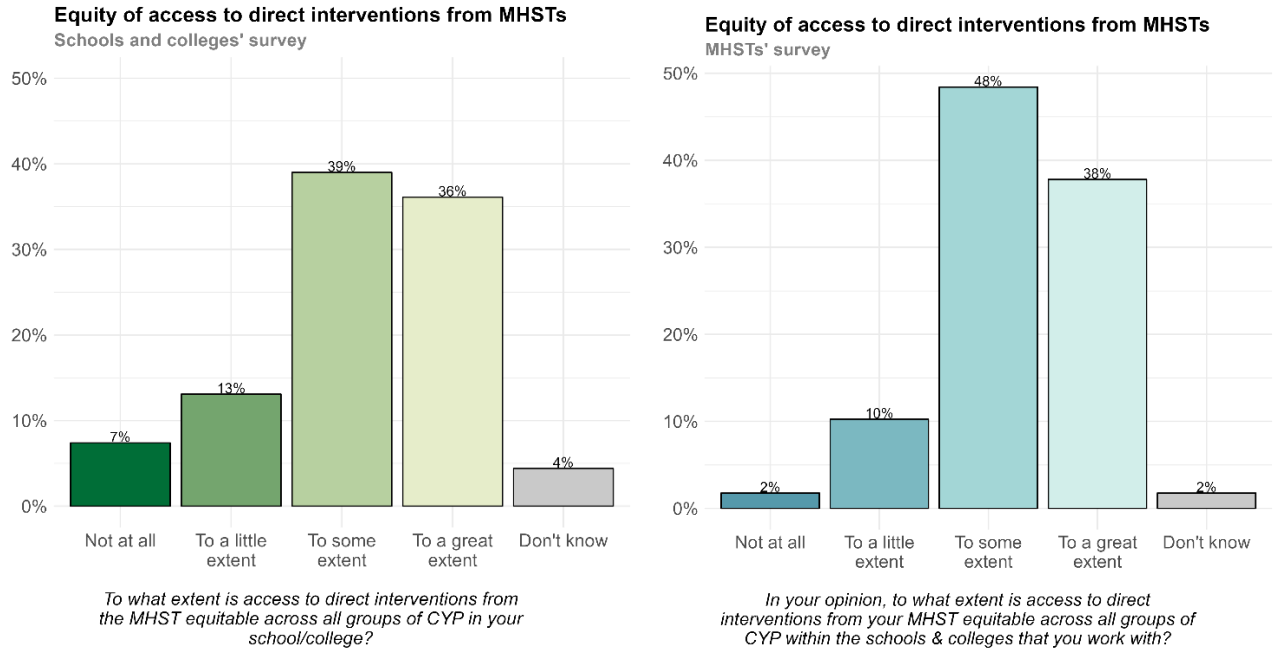


Figure 10. Views of respondents in schools and colleges (left) and in Mental Health Support Teams (MHSTs; right) about the extent to which access to direct interventions from the MHST was equitable across all groups of children and young people (CYP)

4.3.3 Suitability of direct interventions from MHSTs

We asked respondents whether there were any groups of children and young people for whom the direct interventions were less suitable. There was a discrepancy between the answers of the two groups: 30% of respondents in schools and colleges said yes (i.e., that there *were* groups for whom the interventions were less suitable), compared to 57% of respondents in MHSTs who said this. In both groups of respondents, around 20% said they did not know, and the remaining respondents said no (50% in schools and colleges and 21% in MHSTs).

Respondents in MHSTs who answered 'yes' (i.e., who thought there *were* some groups of children and young people for whom the interventions were less suitable) were statistically significantly more likely to report that their MHST accepted referrals outside the 'mild to moderate' scope, compared to those who thought there were no such groups (**Supplementary Table 6**), but were not more likely to report that their MHST accepted referrals outside low mood, generalised and social anxiety and common behavioural problems (**Supplementary Table 7**).

We received a range of answers to our request to specify which groups the interventions were less suitable for, but some groups were mentioned more frequently than others. Among 356 respondents in schools and colleges, the most frequently mentioned groups were younger children, (n = 61, 17%) of which 79% were seven years old or below, those with SEND (n = 52, 15%), and those with complex needs/greater severity mental health issues or need a higher tier service (n = 51, 14%). See **Supplementary Table 8** for all groups of children and young people that respondents thought the direct interventions were less suitable for (and were mentioned by at least five respondents). Many respondents reported that certain groups were unable to *access* support from the MHST in their comment, rather than the suitability of the interventions once the child/young person had been referred to the MHST. These are also shown in **Supplementary Table 8**. It may be the case that respondents used inability to access direct support from the MHST as a synonym for the MHST lacking appropriate interventions for these groups.

Among 161 respondents in MHSTs, the most frequently mentioned groups were neurodivergent children and young people (n = 79, 49%), those with SEND (n = 25, 16%), and those who had experienced trauma (n = 24, 14%), those with complex needs/greater severity mental health issues or who need a higher tier service (n = 22, 14%). See **Supplementary Table 9** for all groups of children and young people who respondents thought the direct interventions were less suitable for (and were mentioned by at least five respondents).

4.4 Workforce

4.4.1 Senior mental health leads in schools and colleges

The majority of senior mental health leads (or equivalent roles) in the schools and colleges' survey said that they felt they had the necessary skills and knowledge to fulfil their role to at least some extent – 47% said to some extent, and 50% said to a great extent. Very few (2.5%) said they had the necessary skills and knowledge to a little extent or not at all.

4.4.2 Education Mental Health Practitioners (EMHPs) in MHSTs

4.4.2.1 EMHP workload

The EMHPs who responded to the MHSTs' survey reported a range in the average number of children and young people they delivered interventions to, and the number of schools and colleges that they worked with (**Table 6**).

Table 6. Average number of children and young people (CYP) that Education Mental Health Practitioners' (EMHPs') delivered interventions to and average number of schools and colleges that they worked with (MHSTs' survey)

	% of EMHPs	% of EMHPs
Average number of…	**CYP that EMHPs delivered interventions to**	**Schools and colleges that EMHPs worked with**
0 – 3	<5	15%
4 – 7	16%	51%
8 – 11	25%	16%
12 – 15	39%	5%
16 – 19	14%	<5
20 – 35	6%	6%
More than 35	<5	<5
Don't know	<5	<5

4.4.2.2 EMHP training

We asked respondents in MHSTs for their views on the training that EMHPs received during their training year (including the university course and the in-service placement/experiences). **Figure 11** shows that respondents thought that the training equipped them for delivering direct interventions with children and young people and parents/carers more than the other two functions; 90% said that the training equipped them for the direct interventions to at least some extent, 63% said this for supporting schools and colleges with their whole-school/college approach, 52% said this for giving advice to education staff, and 34% said this for liaising with external specialist services.

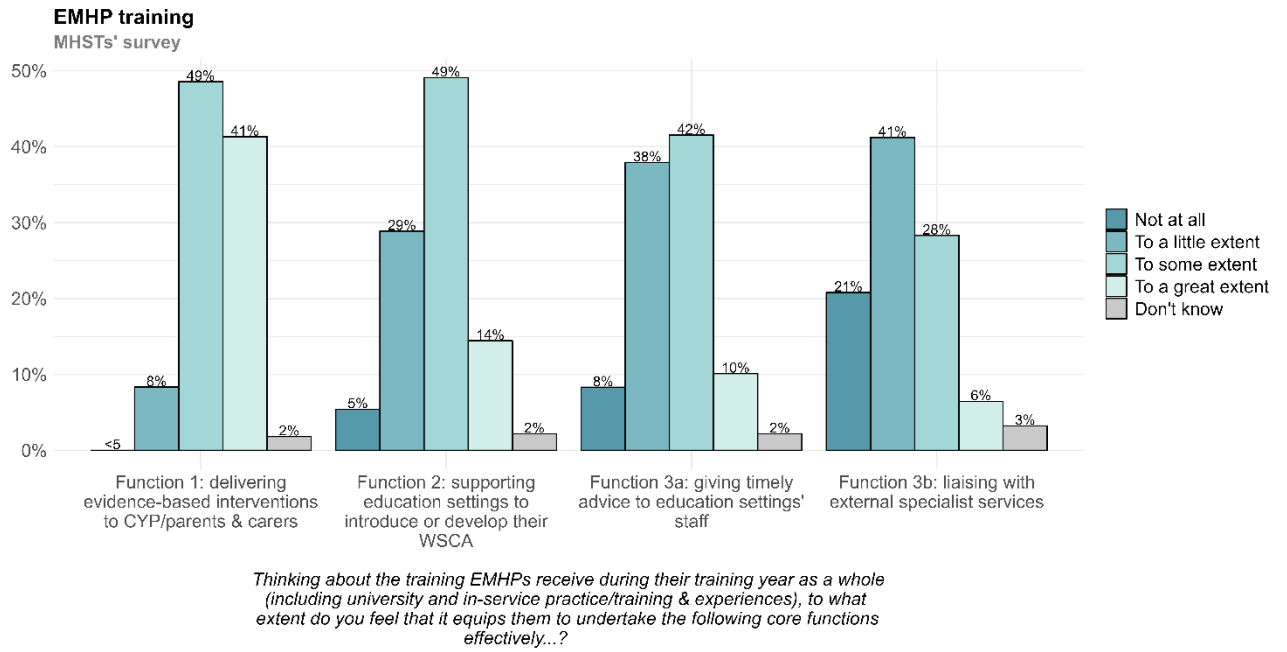


Figure 11. Views of Mental Health Support Team (MHST) respondents about how well the Education Mental Health Practitioner (EMHP) training equipped the EMHPs for the three core functions

Note: function three was split into two parts to cover the two different activities that constitute this function. CYP = children and young people; WSCA = whole-school/college approach

4.4.2.3 EMHP job satisfaction

The majority of EMHPs (including assistant and senior EMHPs) were satisfied in their role: 52% were moderately satisfied and 30% were very satisfied. A small minority (n = 9, 9%) were moderately or very dissatisfied. When these nine individuals were asked to give their reasons for this, they were presented with a list and asked to select which reasons, if any, applied to them. They were also given an opportunity to write their own reasons in a free-text box. The reasons and their respective frequencies are presented in **Table 7**.

Table 7. Reasons given by Education Mental Health Practitioners (EMHPs) for dissatisfaction with role (n = 9)

Reason given for feeling dissatisfied in EMHP role	n
Lack of opportunities for progression	8
Salary/pay	7
Admin/paperwork too high	6
Workload too high	5
Lack of opportunities for training and development	5
Role has not met my expectations/is not what I thought I was going into	<5
Working pattern	<5

Not listed (please specify): uncertainty about role; poor management; bullying

Note: EMHPs could select more than one answer.
MHST = Mental Health Support Team

4.4.3 Recruitment and turnover of MHST staff

We asked respondents in MHSTs about whether staff recruitment and turnover had been a challenge for any roles in their team. **Figure 12** shows that >70% reported that recruiting and retaining EMHPs had been a challenge. Recruiting supervising practitioners was reported as a challenge by 38%.

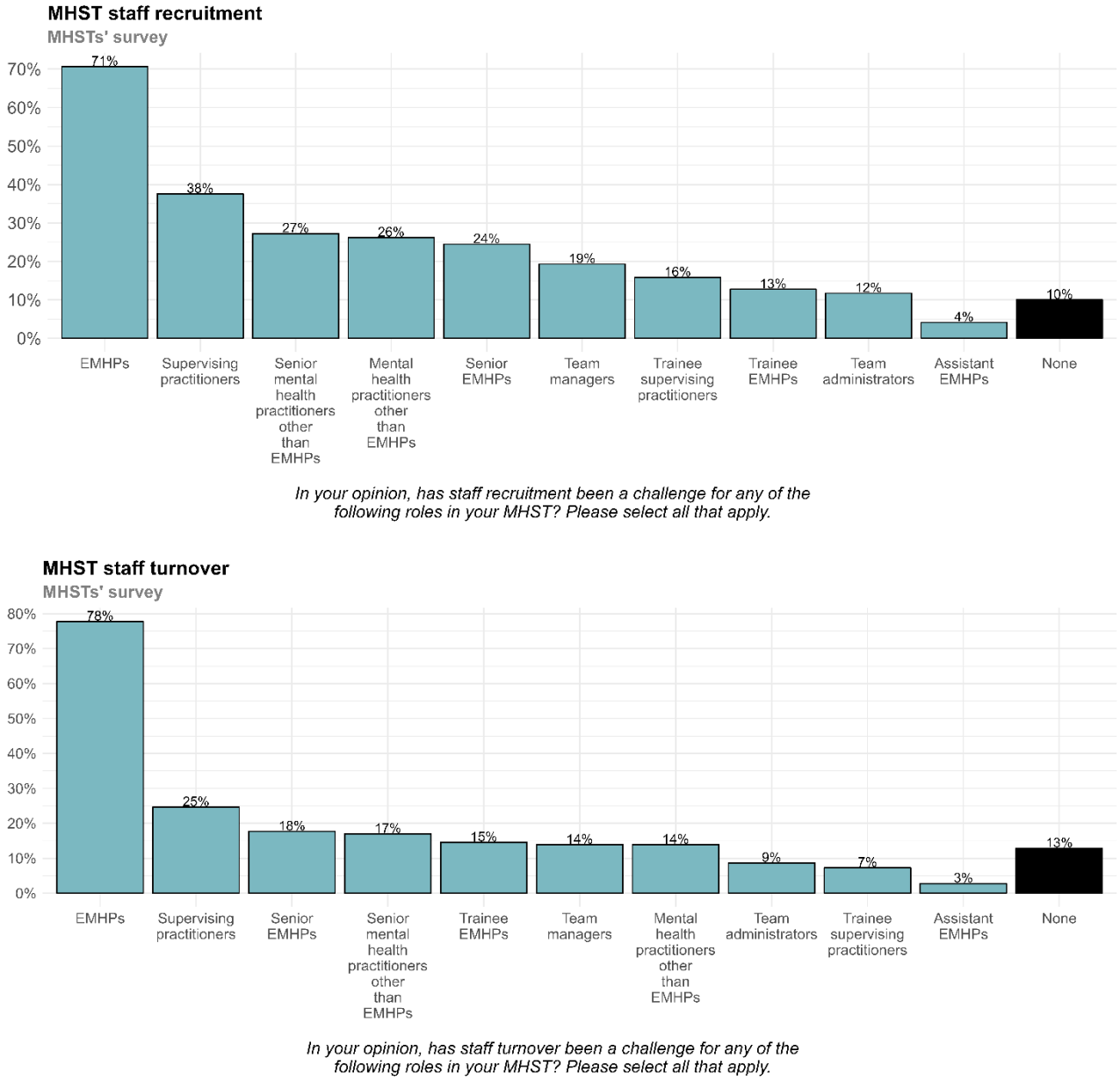


Figure 12. Views of respondents in Mental Health Support Teams (MHSTs) about which roles had been a challenge to recruit (top) and retain (bottom) in their team

4.5 Supervision of EMHPs

We asked EMHPs in the MHSTs' survey to report how much caseload supervision and clinical skills supervision they received every month (**Table 8**). The MHST Operating Manual (March 2022) from NHS England suggests that qualified EMHPs should receive a minimum of one-hour individual case

management supervision every fortnight (or 2 x 30 minutes per week). Group clinical skills supervision should be fortnightly for the first 6-months post-qualification (continuing from the training year). Thereafter, clinical skills supervision should be delivered in groups of four, with 30 minutes per EMHP in the group (i.e., two hours of clinical skills supervision for four individuals) every month, and not exceeding two hours. Clinical skills supervision can be offered more regularly if required. Therefore, as a minimum, EMHPs should receive two hours of 1:1 case management and 30 minutes of clinical skills supervision per month.

In the MHSTs' survey, none of the EMHPs said they did not receive any case management supervision, and fewer than five said they did not receive any group clinical skills supervision. Most commonly, the EMHPs received up to 2 hours (47%), followed by up to 4 hours (30%) of 1:1 caseload supervision per month. We found the same for group clinical skills supervision, with 48% receiving up to 2 hours and 19% receiving up to 4 hours per month.

Table 8. Amount of 1:1 caseload and group clinical skills supervision received by Education Mental Health Practitioners (EMHPs) every month

	n (%) of EMHPs	n (%) of EMHPs
Monthly amount of…	**1:1 caseload supervision**	**Group clinical skills supervision**
None	0 (0%)	<5
Up to 1 hour	7 (9%)	8 (10%)
Up to 2 hours	38 (47%)	38 (48%)
Up to 3 hours	7 (9%)	6 (8%)
Up to 4 hours	24 (30%)	15 (19%)
More than 4 hours	5 (6%)	9 (11%)
Don't know	0 (0%)	0 (0%)

Note: Answers are from EMHPs only, not assistant or senior EMHPs, since the guidance on the amount of 1:1 caseload and group clinical skills supervision relates to EMHPs post-qualification only.

We then asked those in EMHP roles for their views on the supervision that they had received (**Figure 13**). Eighty-four per cent found their 1:1 caseload supervision useful to at least some extent, and 83% found their group clinical skills supervision useful to some extent. A notable finding was that 73% felt supported by their supervisor(s) to a great extent, while just over half (55%) thought that their supervisor(s) had adequate skills and knowledge to supervise them effectively to a great extent.

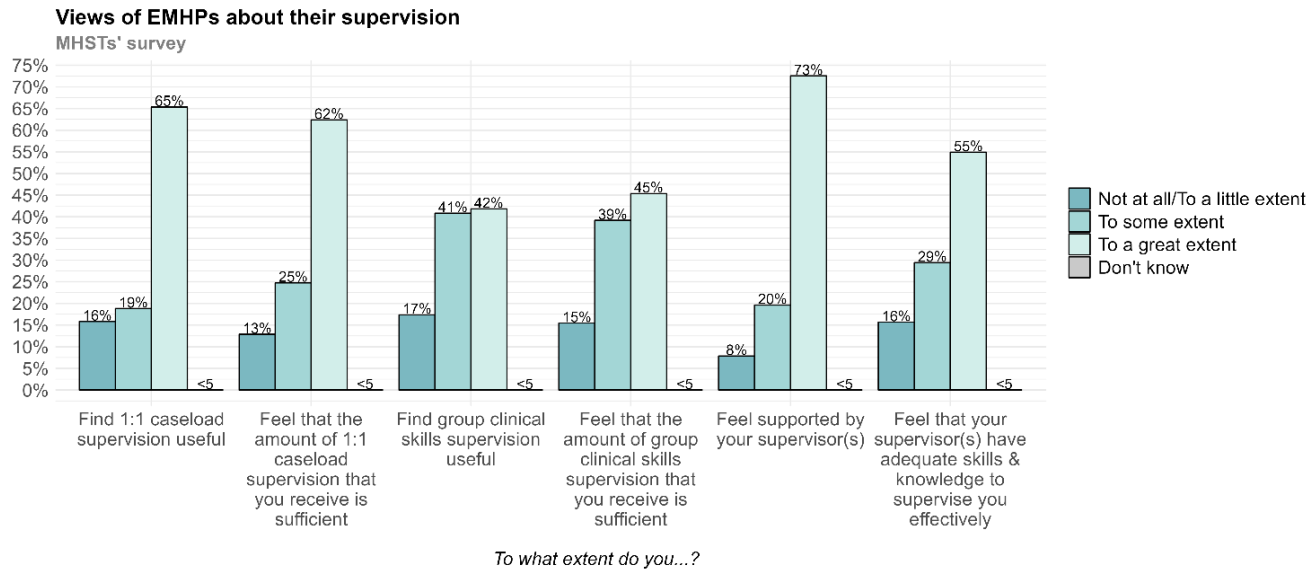


Figure 13. Views of Education Mental Health Practitioners (EMHPs) about the supervision they had received

4.6 Relationship between MHSTs and schools/colleges

The majority of respondents (82%) in schools and colleges were overall satisfied with how their setting and their MHST worked together to shape the MHST's support offer (47% were very satisfied and 35% were satisfied). A small minority (8%) were dissatisfied or very dissatisfied.

4.6.1 Opportunities for MHSTs to integrate with schools and colleges

We asked respondents in schools and colleges how often the MHST staff had opportunities to integrate with senior leadership and other education staff, the senior mental health lead or equivalent, and the wellbeing governor or equivalent. **Figure 14** shows that 58% of respondents in schools and colleges said that MHST staff had regular opportunities to meet with the senior mental health lead or equivalent role. Of the remaining respondents, the majority said that they have opportunities to meet when needed. It was less common for MHST staff to have regular opportunities to meet with senior leadership staff and non-senior leadership staff compared to the senior mental health lead or equivalent role, although most had opportunities when needed. Opportunities to meet with the

wellbeing governor or equivalent were less common; nearly half reported that their MHST did not get opportunities to meet the person in this role.

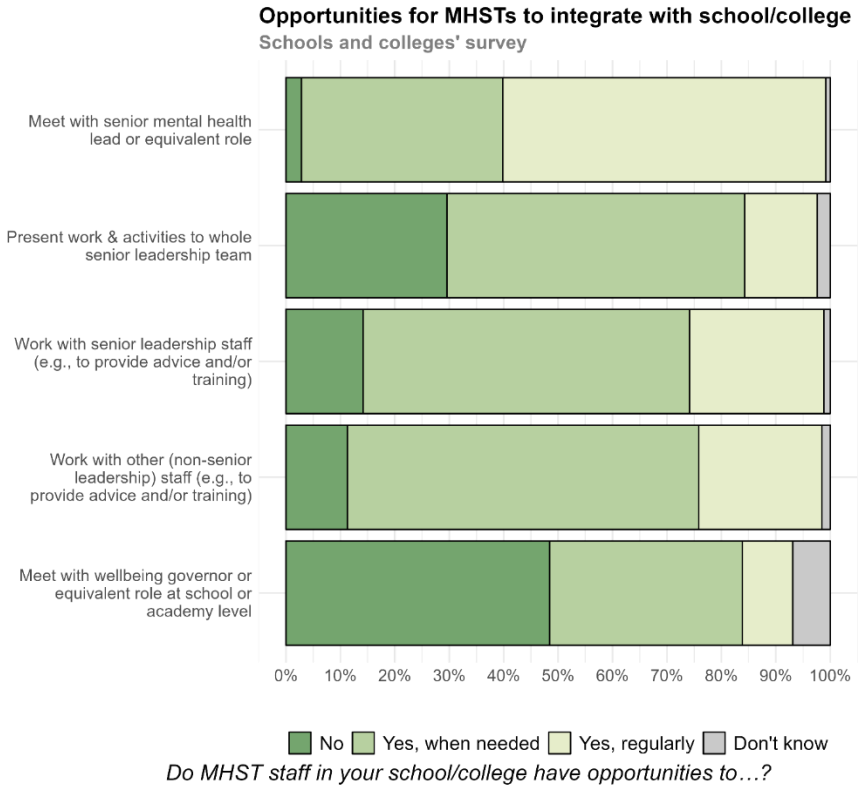


Figure 14. Views of respondents in schools and colleges about how often their Mental Health Support Team (MHST) gets opportunities to work with various members of staff/staff groups in the school/college

The pattern of MHSTs having more regular opportunities to meet with the senior mental health lead than senior leadership and other staff was mirrored by the answers given by respondents in MHSTs. Notably, 67% said their MHST worked very closely with the senior mental health lead compared to 39% for senior leadership staff and 37% for teaching and support staff (**Figure 15**).

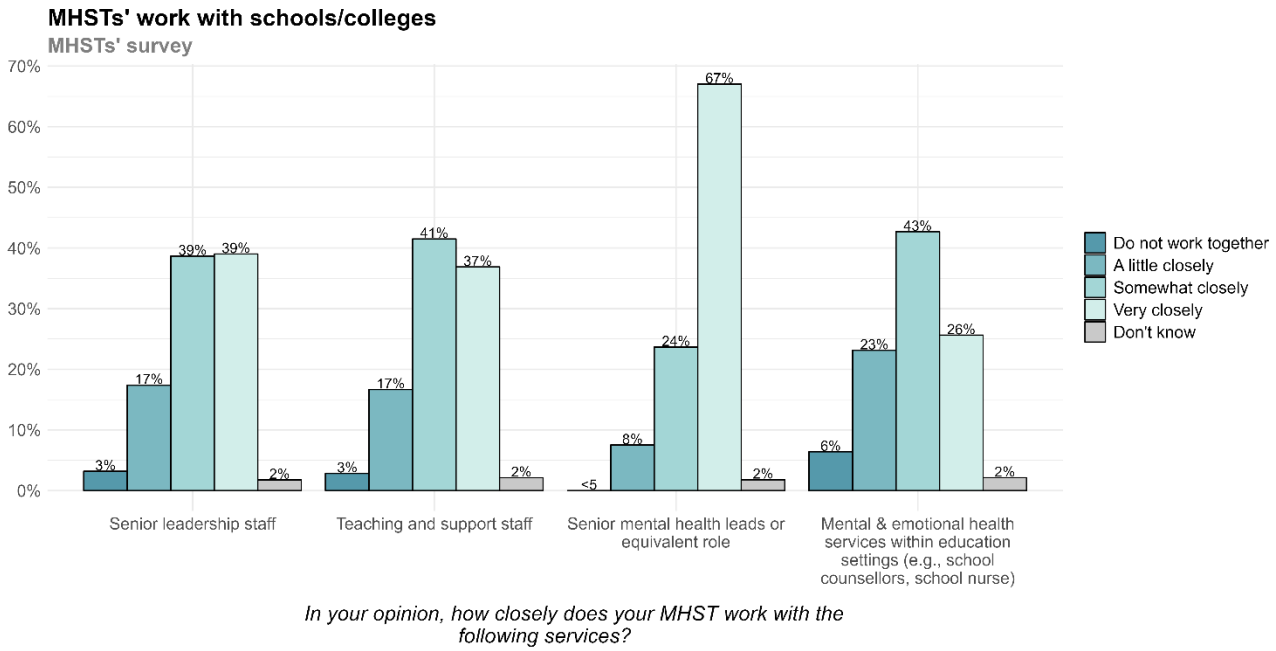


Figure 15. Views of Mental Health Support Team (MHST) respondents about how closely their MHST worked with staff members/staff groups within schools and colleges

4.6.2 Schools and colleges' engagement with and commitment to MHSTs

We asked respondents in schools and colleges about their settings' engagement and commitment to the MHST service. Eighty-two per cent agreed that their setting had dedicated sufficient time and resources to work effectively with the MHST and 9% overall disagreed with this. Ninety-two per cent overall agreed that they had senior leaders who were committed to making full use of the MHST offer **(Figure 16)**.

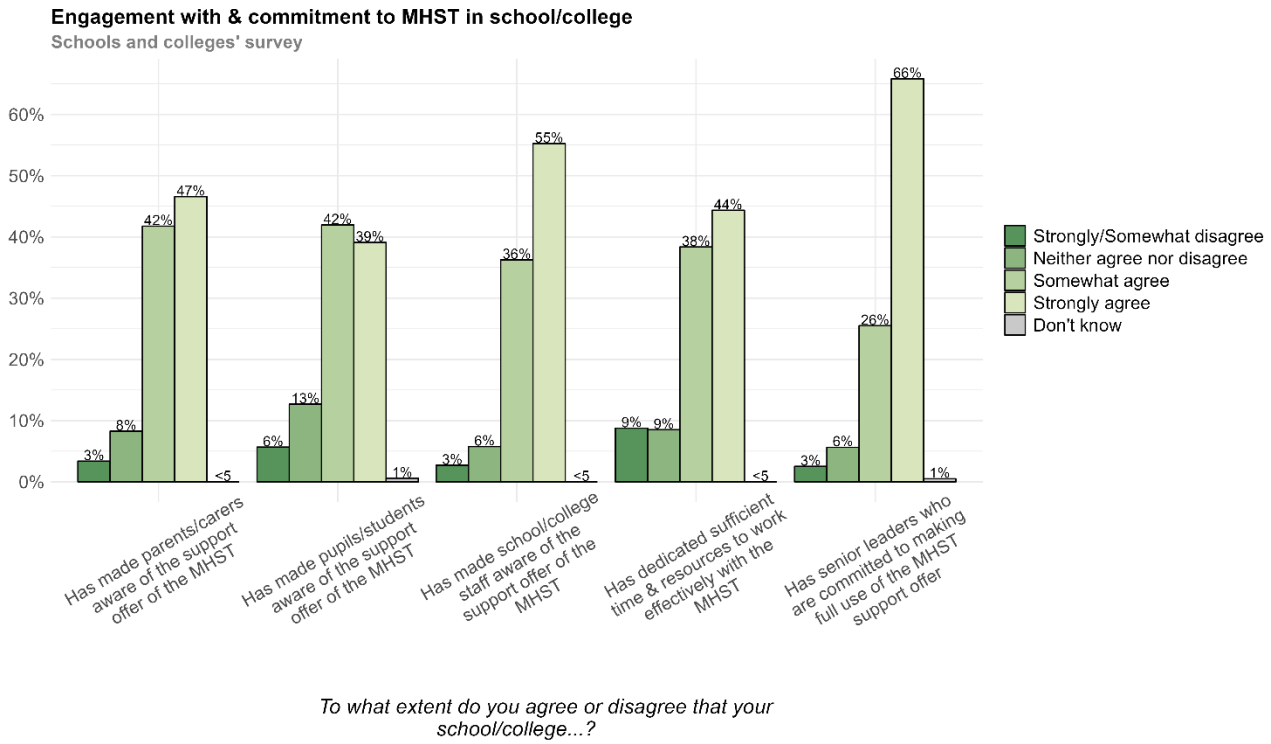


Figure 16. Views of respondents in schools and colleges about their settings' engagement with and commitment to the support offer from the Mental Health Support Teams (MHSTs)

4.7 Involvement in MHSTs' approach and services

4.7.1 Involvement of children and young people and parents/carers

We asked respondents whether they had involved children and young people in designing their MHST's approach and services. Among respondents in schools and colleges, 49% overall agreed that their setting had provided opportunities for children and young people to get involved (28% somewhat agreed, 21% strongly agreed) and 22% overall disagreed (14% somewhat disagreed, and 8% strongly disagreed).

Among respondents in MHSTs, 53% said that children and young people had been involved to a great extent, 40% said to some extent, 33% said to a little extent, and 11% said that children and young people had not been involved. We asked a second question about the involvement of families and

caregivers; only 9% said they had been involved to a great extent, 34% said to some extent, 37% said to a little extent, and 17% said they had not been involved.

4.7.1.1 Co-producing the whole-school/college approach with children and young people

We asked whether schools and colleges had involved children and young people in co-producing their whole-school/college approach to mental health and wellbeing (**Figure 17**). Forty-seven per cent had involved children and young people at least to some extent. Of those who answered 'to a little', 'to some', or 'to a great extent', 59% said their setting had included children and young people with additional needs and learning difficulties in the co-production.

We asked those who said children and young people had not been involved at all (n = 215) whether they had made plans to involve children and young people in co-production. Very few (<5 respondents) said they had made plans to a great extent, 16% had made plans to some extent, 34% had made plans to a little extent, and 44% had not made plans. Of those who answered 'to a little', 'to some', or 'to a great extent', 52% said they had planned to include children and young people with additional needs and learning difficulties in the co-production.

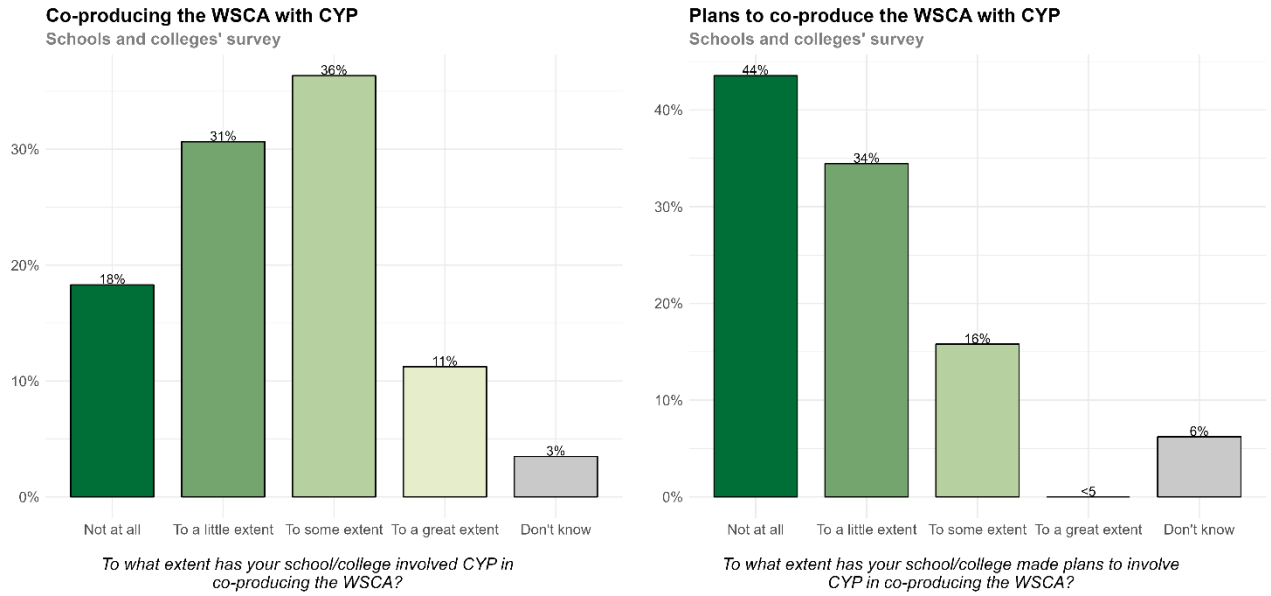


Figure 17. Views of respondents in schools and colleges about whether their settings' whole-school/college approach (WSCA) to mental health and wellbeing was co-produced with children and young people (CYP)

Note: The 215 respondents who had not involved children and young people in co-producing the whole-school/college approach were asked the follow-up question (right) about whether they had made plans to involve children and young people in co-producing the whole-school/college approach.

4.7.2 MHSTs' work with external services

Figure 18 shows responses from those in MHSTs about how closely their team worked with external services. MHSTs worked most closely with CAMHS, with 80% saying that their MHST worked at least somewhat closely with them. Two per cent said that their MHST did not work with CAMHS. These were not clustered in particular MHST groups. We tested whether respondents who said their MHST did not work with CAMHS were from a team that dedicated less time to direct interventions (function one) compared to those who did work with CAMHS but there was no difference found (**Supplementary Table 10**). The service that MHSTs worked least closely with (based on the frequency who selected 'Do not work together') was educational psychology teams (22%), followed by public health services (19%).

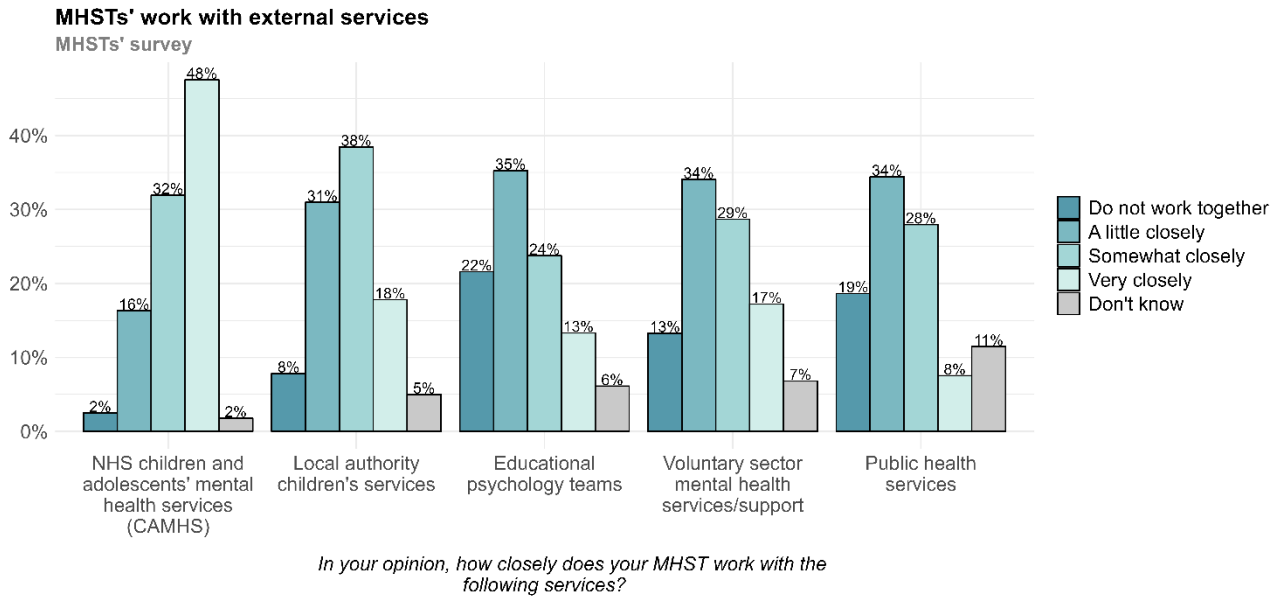


Figure 18. Views of the Mental Health Support Team (MHST) respondents about how closely their MHST works with other services

4.8 Feedback on MHSTs

The majority of respondents in schools and colleges overall agreed (85%) that their MHST was responsive to feedback from their setting, while only 4% overall disagreed (**Figure 19**). The majority (86 - 87%) of respondents from MHSTs said that clear mechanisms for children and young people, and parents and carers, to provide feedback on their MHST had been implemented to at least some extent. Thirteen per cent said that these mechanisms had been implemented to a little extent or not at all.

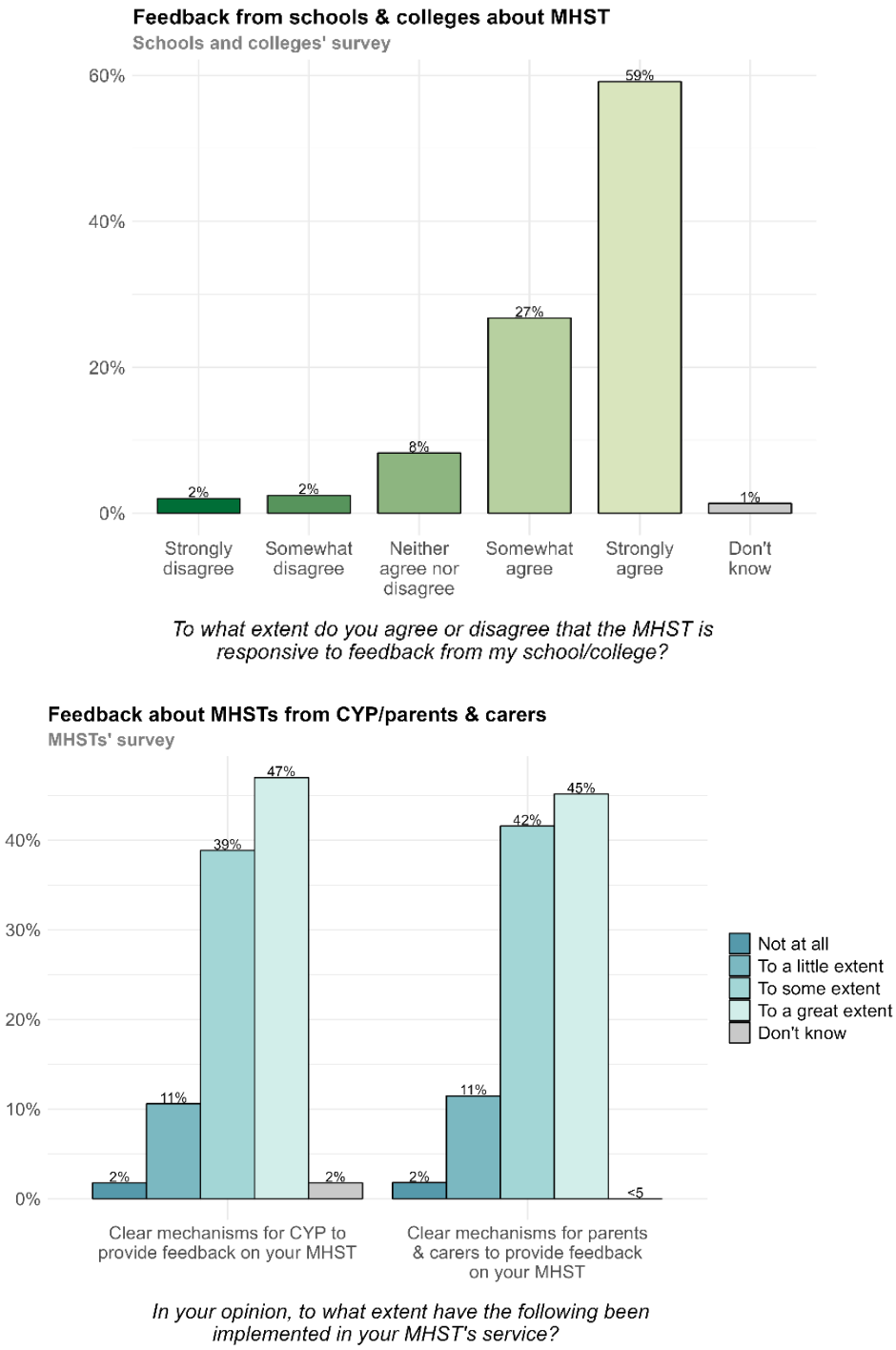


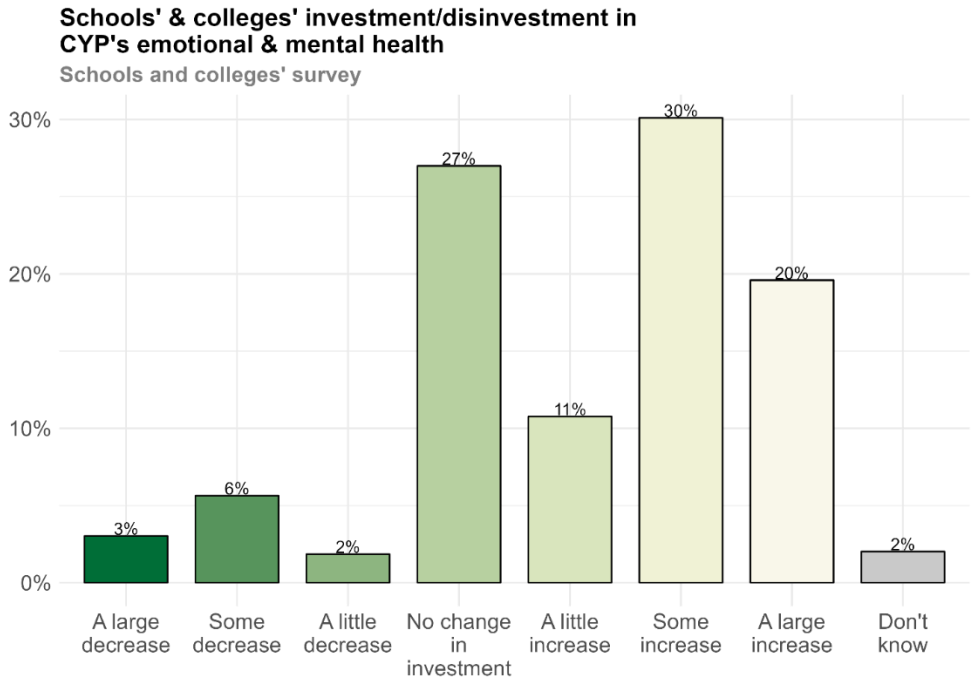
Figure 19. Views of respondents in schools and colleges (top) and Mental Health Support Team (MHSTs; bottom) about feedback on the MHST

Note: CYP = children and young people

4.9 Resources for, and investment in, children and young people's mental health and wellbeing

Figure 20 shows that the majority of schools and colleges have increased investment in their own resources and services for children and young people's mental health since working with an MHST (61% reported an increase). A small proportion (11%) reported decreased investment, and 27% reported no change.

Forty-three per cent of respondents in MHSTs thought that schools and colleges had sufficient resources to at least some extent, although only 3% thought they had sufficient resources to a great extent. Around three quarters (79%) thought that their MHST had sufficient capacity to deliver their core functions effectively to at least some extent (**Figure 20**).



Since working with a MHST, has your school/college increased or decreased investment in its own resources & services for CYP's emotional & mental health?

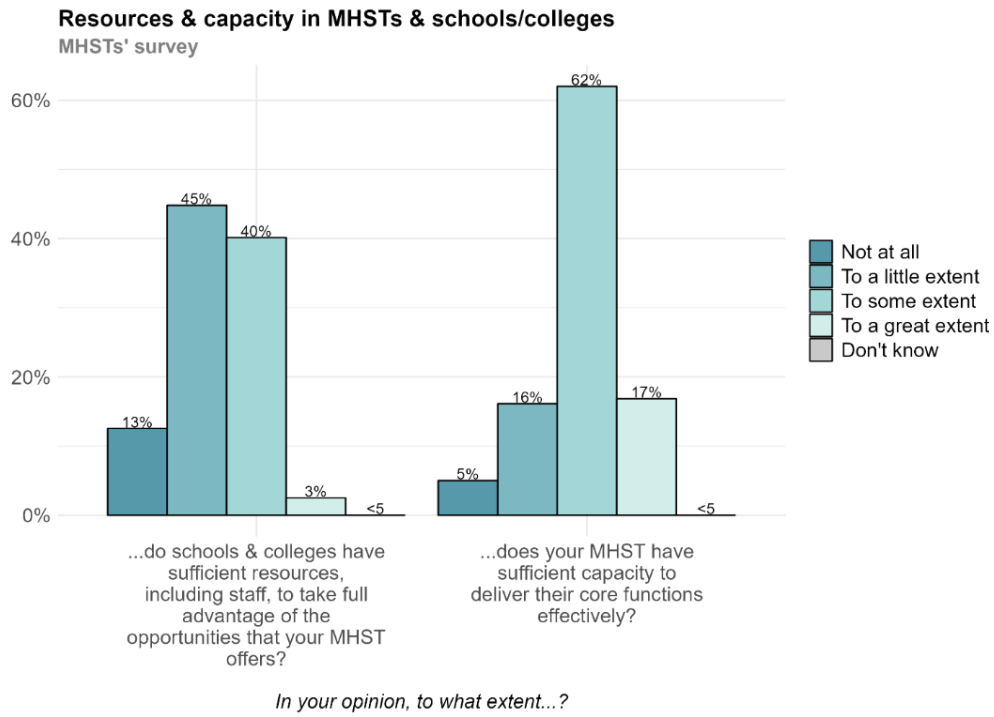


Figure 20. Views of respondents in schools and colleges about investment in children and young people's (CYP's) emotional and mental health since working with a Mental Health Support Team (MHST; top) and views of respondents in MHSTs about resources and capacity for the programme (bottom)

4.10 Perceived impact of MHSTs

We asked respondents in schools and colleges about possible impacts from working with an MHST. **Figure 21** shows that there were high levels of agreement about many of the impacts. Eighty-six per cent overall agreed that the MHST had provided better mental health and wellbeing support than would otherwise have been available. Notably, 57% *strongly* agreed with this statement. Additionally, 79% overall agreed that working with the MHST had improved their whole-school/college approach, and 75% overall agreed that working with the MHST had improved the settings' understanding of when and how to access external support for mental health

Some of the impacts received relatively lower levels of agreement; 65% overall agreed that working with the MHST had strengthened senior leadership's buy-in to promoting mental health and wellbeing, and 66% overall agreed that there were stronger links and more joint working between all partners including education, health, voluntary sector, public health and social care since working with an MHST.

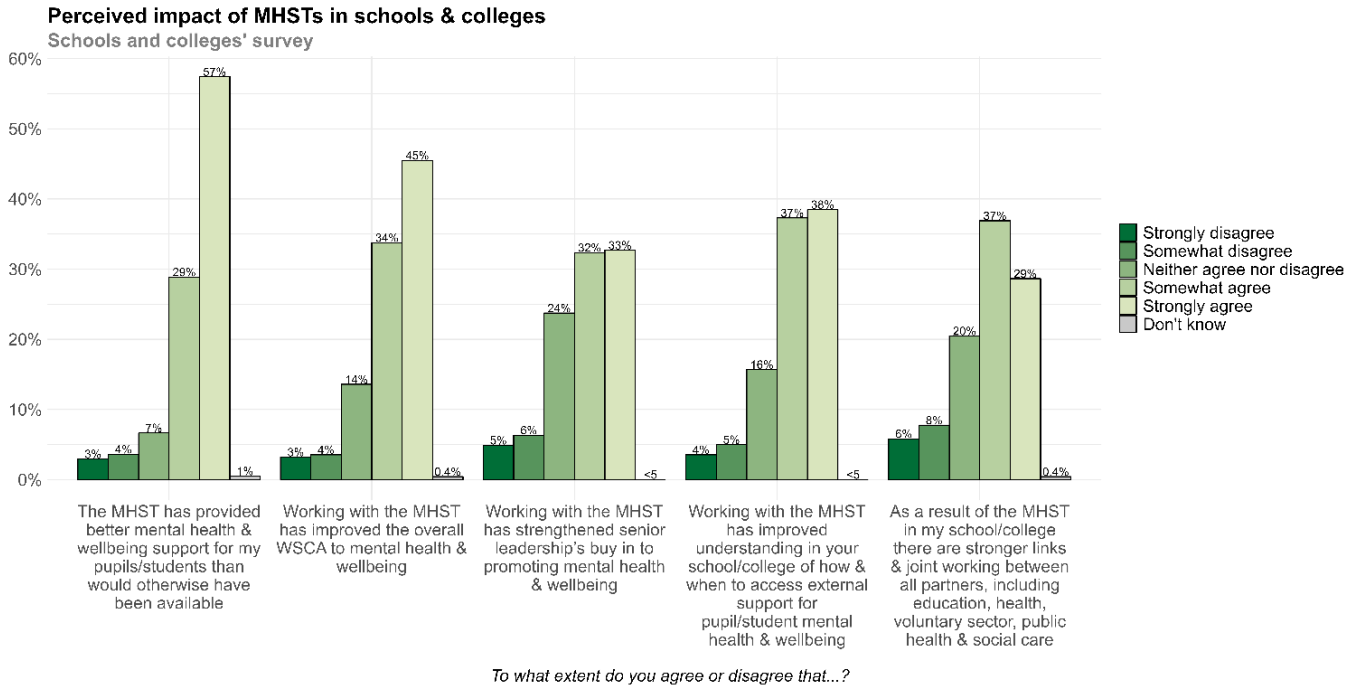


Figure 21. Views of respondents in schools and colleges about impacts of working with a Mental Health Support Team (MHST)

Note: WSCA = whole-school/college approach

The picture was more mixed for the impact of MHSTs on school attendance (**Figure 22**). Forty-seven per cent overall agreed that the direct interventions from the MHST had improved attendance in their setting, and 36% neither agreed nor disagreed. Similarly, 42% agreed that the support the MHST provided in terms of the whole-school/college approach had improved attendance and 39% neither agreed nor disagreed.

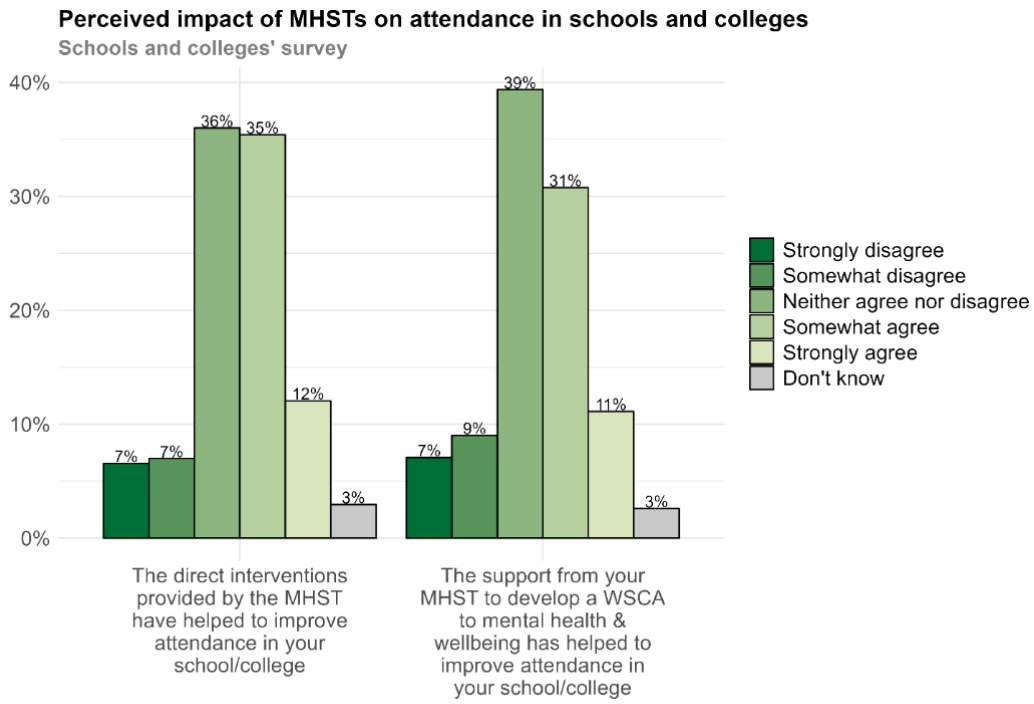


Figure 22. Views of respondents in schools and colleges about impacts on attendance of working with a Mental Health Support Team (MHST)

Note: WSCA = whole-school/college approach

5 Discussion

Key findings

1. There was high satisfaction among staff in schools and colleges and individuals delivering the MHST service, about the work of the MHSTs, both in terms of providing direct support to children and young people, and supporting whole-school/college approaches to mental health and wellbeing.

2. We found considerable variation in how MHSTs operate. This raises questions about which models work best and in what circumstances, which will be explored in the upcoming case study work.

3. The interventions provided by the MHSTs were reported to be making a difference to children and young people. However, a sizeable proportion of respondents said that the interventions were not suitable for all. Groups underserved include neurodivergent children and young people, those with SEND, children aged seven or below, and those who have experienced trauma.

4. Although MHSTs were designed to provide interventions to children and young people with 'mild to moderate' mental health needs, most respondents in MHSTs said that their team accepted referrals outside of this scope at least some of the time, often more frequently.

5. Recruiting and retaining EMHPs were reported as challenges for MHSTs. This has persisted from the inception of the programme.

The overall picture from the two surveys was positive with high levels of satisfaction with MHSTs' work across the three core functions. The findings show that MHSTs are perceived to be making a difference in schools and colleges, by providing better mental health and wellbeing support than would have otherwise been available and supporting whole-school/college approaches to mental health and wellbeing.

Generally, the findings about the role that MHSTs play in supporting whole-school/college approaches to mental health and wellbeing (function two) are promising, with schools and colleges being largely clear on how MHSTs fit into their work on this. A finding from the early evaluation of the Trailblazer

MHSTs was that function two might be deprioritised as MHSTs responded to increases in demand for support for 1:1 and group interventions, especially with the growing prevalence of mental ill health among children and young people following the COVID-19 pandemic. The MHSTs' survey suggests that MHSTs spend approximately 50% of their time, on average, providing direct support to children and young people or their parents and carers, with whole-school/college activities and giving advice to education staff and liaising with external specialist services receiving around 20% of their time each. This division of time has persisted since the Trailblazers and suggests that whole-school/college activities are still supported by MHSTs and the risk of deprioritisation has not materialised (Ellins et al. 2023). When we asked about which whole-school/college activities MHSTs contribute to, the most frequently selected were 'targeted support' and 'working with parents and carers', which are the two activities that most closely align with MHSTs' direct support function. This suggests that there are opportunities for MHSTs to become involved in other, school-wide activities outside of 1:1 or group interventions. Relatedly, it was notable that 34% of respondents in MHSTs thought that the EMHPs' training did not equip them for supporting whole-school/college approaches, or that it only equipped them to a little extent. This contrasts to the more positive views on training in direct interventions. This suggests that EMHP training could benefit from a greater focus on how they can work with schools and colleges in terms of whole-school activities, so that they feel more confident and capable when undertaking this aspect of their role

The two surveys show that there is substantial variation in how MHSTs work with schools and colleges and deliver their core functions, including how much time they spend in each setting; whether they offer direct support all year round or in term-time only; how closely they work with external services (e.g., CAMHS); the number of schools and colleges the EMHPs work with and how many children and young people they provide interventions to; the scope of mental health needs they support and the types of interventions they use and draw from. The surveys highlight that some MHSTs are sticking to the original scope of 'mild to moderate' low mood, anxiety and common behavioural problems, while others offer support to children with more severe and complex mental health issues, although the extent to which they do this varies between teams. This variation will be a key topic of interest for exploration in the detailed case study work which is coming next in the national evaluation. We note that, in the most recent publication from the Department for Education about the coverage of MHSTs, they describe function one as "delivering direct interventions for children and young people with mental health issues" and have dropped the reference to "mild to moderate" (Department for Education 2025). This may reflect a recognition that MHSTs are increasingly required to provide support to children with needs that fall outside of this scope. We will explore how MHSTs can and do use the flexibility in their service model to address unmet needs, and examine what factors influence their decisions about, for example, their service scope and which interventions to offer. We are also interested in understanding whether the skills and expertise of the team members, including managers, EMHPs, and other practitioners, influence flexibility in scope.

The two surveys raise many issues that echo findings from the early evaluation, suggesting that there are some longstanding challenges for the programme. These include challenges recruiting and retaining EMHPs; the suitability of the interventions offered by the MHST for certain groups (such as younger children, children and young people with SEND and/or who are neurodivergent, and those with complex mental health needs) (Ellins et al. 2023). The surveys also raise questions about whether schools and colleges have adequate resources to make the most of the MHST support offer,

and whether the programme has facilitated closer collaboration between education settings, external mental health services, and local organisations (e.g., charities and local authorities) to improve children and young people's mental wellbeing. These issues will be explored in more detail in the in-depth research and the economic evaluation.

5.1 Next steps

The survey findings show that staff in MHSTs and schools and colleges are generally positive about what MHSTs are offering. Building on this, research with children and young people who have received an intervention from case study MHSTs will provide insights into their experiences of being supported by the MHST service, as well as outcomes for the children and young people and their parents/carers. Additionally, the survey findings point to several areas that will be explored in-depth through interviews with MHST and education staff in six purposively selected case study sites, and have informed the development of the materials for this research, such as the topic guides for the interviews. For example, while most schools and colleges reported that the MHST had opportunities to integrate within the setting, a small proportion lacked this. The case study research will explore how MHSTs build relationships and work collaboratively with staff in schools and colleges, including with the senior mental health lead and other education staff. Additionally, the MHSTs' survey asked about the referral processes from schools and colleges to the MHST which the majority surveyed agreed were working well. The case study research will explore how these work in practice. We will also investigate other types of referrals (e.g., from primary care or other mental health services) and how they are managed by the MHSTs. The evaluation will report its full findings in 2026.

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