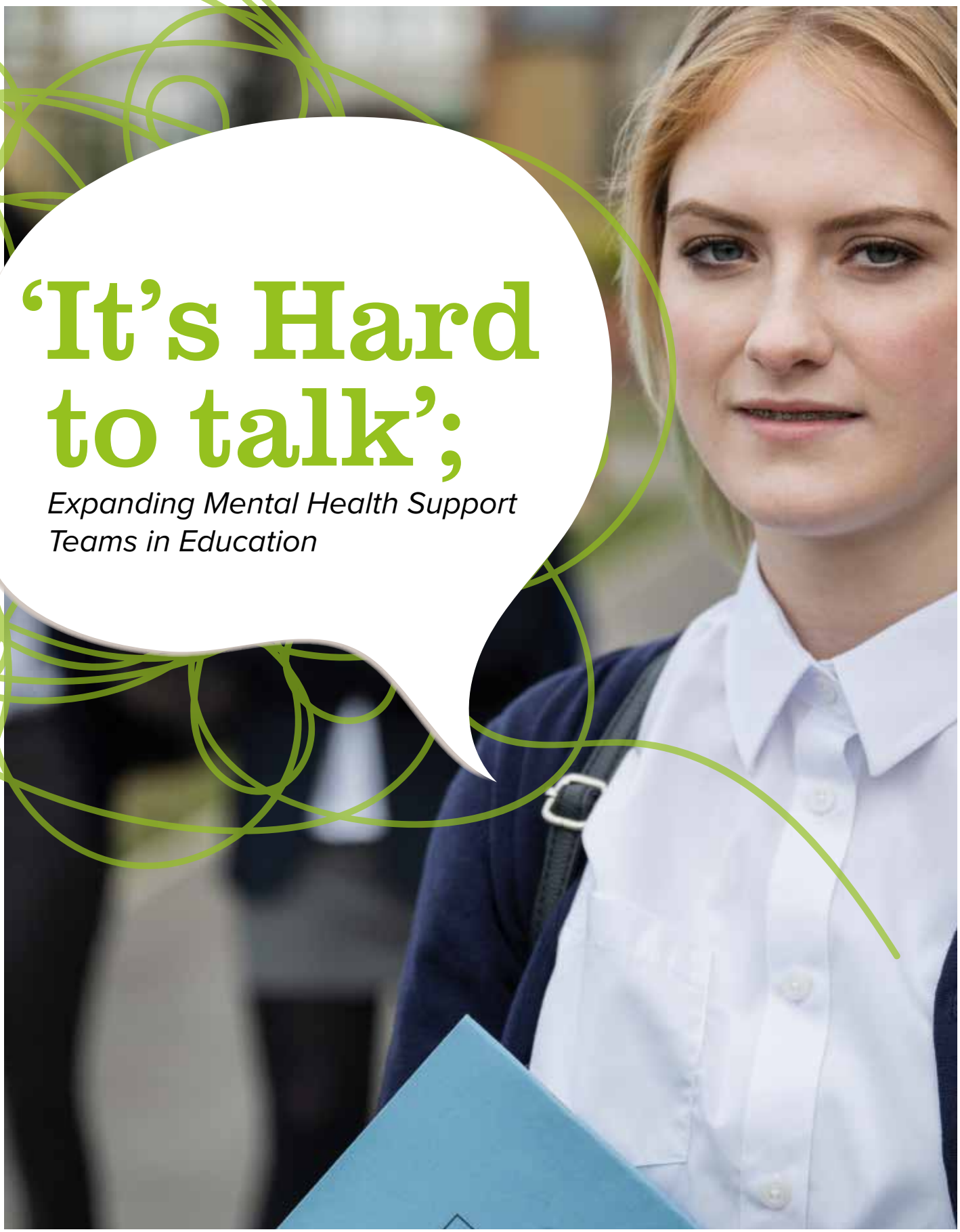


‘It’s Hard to talk’;

Expanding Mental Health Support Teams in Education

December 2022

Believe in children

Barnardo’s

About Barnardo's

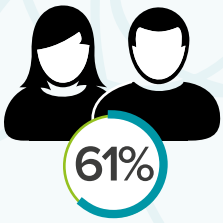
Barnardo's is the UK's largest national children's charity. In 2021/22, we reached 357,272 children, young people, parents and carers through our 791 services and partnerships across the UK. Our goal is to achieve better outcomes for more children. To achieve this, we work with partners to build stronger families, safer childhoods and positive futures.

Contents

Executive summary

Approximately one in six children and young people between the ages of 6-16 have a diagnosable mental health condition[1]. This rises to one in four for young people aged 17-19[2]. 50% of mental health issues are established by the age of fourteen[3], with long term health, social and economic impacts across the life course[4]. The crisis in children and young people's mental health, threatens the prospects of a generation.

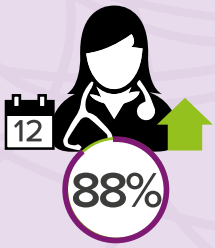
In August 2022, Barnardo's commissioned a YouGov poll of children and young people and parents.



of parents of children with a mental health condition believed it was negatively affecting their performance at school[5].

of children and young people reported feeling sad or anxious at least once a month[6].

In our September 2022 survey,



of practitioners
have seen an increase in the number of children and young people experiencing mental health issues in the last 12 months[7].

Pressure has been steadily increasing on services over the last decade, with a

134% increase in referrals and an

80% increase in emergency presentations as children and young people reach crisis point[8].

Effective, early intervention for children and young people experiencing mental health issues is patchy and delivered by different services. Education providers are responding to the increasing needs of their students and playing an increasing role in supporting children and young people's mental health.

Mental Health Support Teams (MHSTs) work across an average of 10-20 schools and provide individual support, help to develop and implement a whole school approach to mental health and support families and teaching staff. MHSTs are an effective prevention and early intervention service providing 1-2-1 and group-based support. Furthermore, they work with external partners to identify and refer children and young people to community, Children and Adolescent Mental Health Sevices (CAMHS) and other local services.

As well as providing an effective mental health service for children and young people, MHSTs also provide savings to the state. Analysis of Barnardo's MHST services finds that

for every £1 spent on MHSTs,

there is a return of **£1.90**

Our YouGov poll and September 2022 practitioners survey revealed:

73% of parents believe there should be **more funding made available for mental health support in schools**[9].

76% of children and young people would like **more mental health support in schools**[10].

72% of practitioners believe that mental health support team **expansion would make a positive difference for children and young people**[11].

MHSTs face several challenges in establishing themselves, integrating into the wider education, health and community systems, collection and use of data and providing support for the most commonly underserved groups. This report explores these challenges and makes key recommendations.

Recommendations

Recommendation one:

The government should commit to funding and delivering an accelerated roll out of Mental Health Support Teams in all schools and colleges in England to ensure access for all children and young people.

The current limited roll out of MHSTs does not guarantee new services beyond 2024. Current targets for 35% of children and young people to have access to MHST support builds in inequality in access, both geographically, and within local areas depending on how decisions on which schools and colleges should receive MHSTs are made. Addressing this inequality and providing a consistent early intervention service for mild to moderate mental health conditions, requires every school and college to have access to an MHST.

Recommendation two:

The Government should carry out and publish a full cost-benefit analysis of MHSTs.

Barnardo's delivers 12 MHSTs across the country. Based on data collected from 1-2-1 interventions, we have undertaken a cost-benefit analysis. However, this analysis is based on data that represents only one third of an MHST's work and is based on a small sample. To understand the full benefit of MHSTs, a full analysis should be undertaken.

Recommendation three:

Every Integrated Care Board (ICB) should have a duty to create a children and young people's plan, reviewing the contribution of all services including MHSTs, as well as the level of unmet need. This should contribute to Integrated Care Systems (ICS) strategy formation.

For MHSTs to fully integrate with health and community services, children's mental health services should play a more prominent role within ICS structures.

Recommendation four:

Create and issue national guidance on the data collection and reporting mechanisms required for MHSTs. Invest in the data infrastructure and systems capabilities to support data collection and best practice sharing. Outcomes data should be published as part of the NHS mental health dashboard.

There should be national direction and investment on data collection, ensuring services can effectively evaluate their services, innovate effectively and share information with other services.

Recommendation five:

Create effective tools and frameworks for analysing and evaluating whole school approach interventions for mental health and wellbeing to accurately reflect and evaluate the full range of MHST work.

When services are unable to evaluate and report on a whole school approach, their work isn't fully reflected in service evaluation, innovation is stymied, and services are not incentivised to carry out whole school approaches.

Recommendation six:

Create an expanded MHST+ service model, offering a qualified counsellor as part of every MHST.

Cognitive Behavioural Therapy (CBT) as an individual therapy does not work for all children and young people, particularly the youngest, and most complex. In this case, counselling services provide flexible alternatives that are evidence based and the National Institute for Health and Care Excellence (NICE) recommended. Counsellors have the potential to fill the 'missing middle' service for children and young people who have a moderate mental health need that cannot be met by CBT services but who are not acute enough for CAMHS intervention.

Recommendation seven:
Commission research into alternative interventions for children and young people's mental health and wellbeing to be delivered in schools.

Many MHSTs are partnering with community and health organisations and innovating to meet local need. Understanding best practice and undertaking research to formalise best approaches will improve outcomes for all, with a particular focus on underserved groups.

Recommendation eight:
Provide a clear career progression framework for Educational Mental Health Practitioners (EMHP), including senior EMHP roles, opportunities for career development and progression within MHSTs.

EMHPs are leaving the profession early to pursue more senior roles due to a lack of career progression opportunities. Increasing opportunities within MHSTs will improve retention, make the EMHP role more attractive and provide greater support for children and young people.

Recommendation nine:
Include the Educational Mental Health Practitioner role in future NHS workforce plans and strategies, including 5-, 10- and 15-year plans announced in the 2022 Autumn Statement.

EMHP posts are often attached to university places and there is a limited recruitment pool, leading to long-term staff absences. Long-term planning for EMHP staffing should be considered as part of wider workforce planning.

Introduction

Approximately one in six children and young people in England between the ages of 6-16 have a diagnosable mental health condition, equating to around 1.3 million[12]. This rises to one in four young people aged between 17 and 19[13]. The increasing prevalence of mental ill health poses a public health issue, resulting in long term health, social and economic impact[14].

Approaches to children's mental health and wellbeing rely on both preventing exposure to negative factors and promoting the positive. This begins with family approaches at the point of conception, through the crucial first 1001 days and beyond[15]. Multiple, intersecting factors affect the mental health and wellbeing of children and young people including:

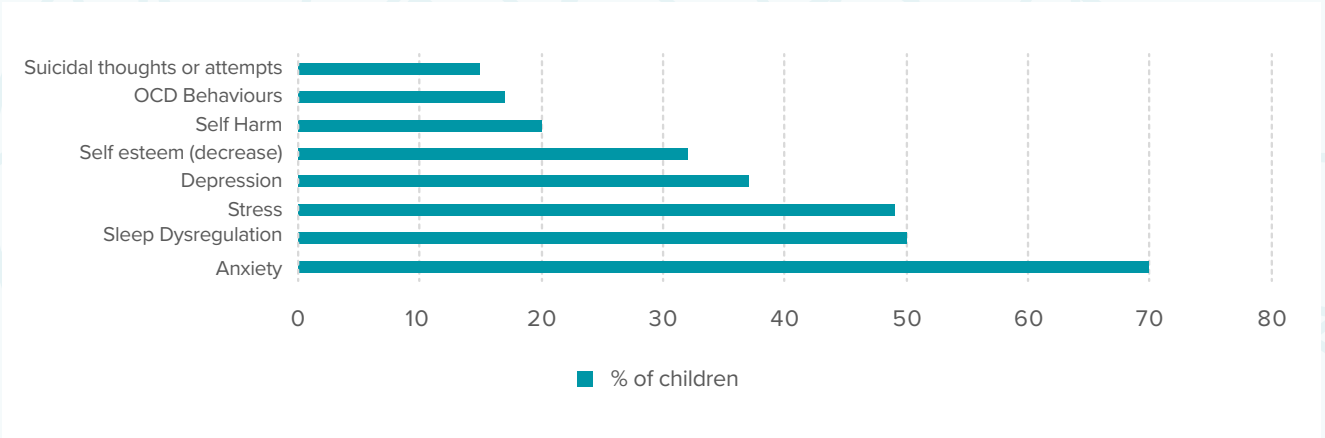
- Exposure to Adverse Childhood Events (ACEs) and experience of trauma
- Periods of change and transition within home life, education and beyond
- Experience of pressure for example because of caring responsibilities or schooling[16].

The Covid-19 pandemic has to a varying extent, impacted on all children and young people, creating additional trauma, change, and pressures through disruption to schooling, periods of social isolation, increasing financial pressures on families, experience of bereavement and ongoing uncertainty. As society adapts to live alongside the Covid-19 virus, children and young people must adapt again, returning to school, attempting to catch up academically and socially alongside a cost-of-living crisis expected to last well into 2023[17].

Given the context, it is unsurprising that children and young people, and the practitioners supporting them are consistently reporting mental health and wellbeing as a widespread and significant concern. Survey evidence from sources including the office of the Children's Commissioner[18] and Barnardo's[19] confirms mental health and wellbeing is a priority for action for practitioners and children and young people.

Barnardo's practitioners surveyed as part of the report "Covid-19 In Our Own Words" reported an increase in symptoms associated with mental health conditions and a decrease in child self-esteem during the pandemic[20].

Figure 1. Change in reported mental health and wellbeing of children and young people



A follow up survey of Barnardo's practitioners in July 2022 revealed that the situation for children and young people is worsening. 88% of practitioners reported an increase in mental health and wellbeing issues in children and young people over the last 12 months[21].

The crisis in children and young people's mental health threatens the prospects of a generation. In a YouGov poll commissioned by Barnardo's in August 2022, 61% of parents said mental health issues affected their children's attainment at school. 41% noted a drop in concentration and focus on schoolwork. Children and young people with mental health issues are less likely to feel safe at school or to enjoy their learning[22]. For children experiencing issues with their mental health, accessing the right support in right place at the right time can be a challenge[23].

'My mental health in the past has affected my schoolwork, there are certain lessons where I'd be great at it, and then I'd have a bad mental health day and not as much is done. It can affect what I do and the quality.'

Barnardo's Service User

'It affects my work. I feel sick and I can't concentrate.'

Barnardo's Service User

Waiting lists and gaps in support

Long-term disparities in physical and mental health spending mean that less than 15% of Integrated Care System (formally Clinical Commissioning Group CCG) spending for health is spent on mental health, learning disability and dementia[24]. Within this spending, significant gaps remain between adult and children and young people's funding. On average children and young people's mental health receives only around 1% of all health and care funding[25].

This disparity in provision for mental health has broadly been recognised and the UK Government has taken some steps to address it. The mental health investment standard requires a commitment that any increase in local health funding is proportionally spent on mental health and wellbeing (for example, a 5% budget increase leads to a 5% increase in mental health spending). As Integrated Care Systems (ICSs) are established and formalised, they will be required to continue this standard[26]. However, there is clearly a long way to go to level the playing field in children and young people's mental health investment.

Furthermore, mental health and wellbeing also relies on investment in public health to promote prevention and early intervention. In 2021, the Health Foundation and Association of Directors of Public Health (ADPH) revealed a real terms reduction in public health budgets of 24% since 2015/16. These reductions fell disproportionately on areas of deprivation, where poor health outcomes are more common[27].

Reversing this trend looks increasingly difficult as the cost-of-living crisis worsens and government seeks to limit public spending. Recent announcements within the 2022 Autumn Statement include funding increases for education and health. However, it is uncertain how these funds will be allocated, particularly given rising inflation and energy prices affecting spending power for schools and NHS organisations[28].

The gap in funding for children and young people's mental health is coupled with a significant and sustained increase in demand for services. Specialist services are often the only provision for children and young people. With a lack of alternative services, specialist services are under intense pressure. Referrals to children and adolescent mental health services (CAMHS) are increasing, up 134% in 2020/21 compared to pre-pandemic levels, and emergency care presentations are up 80%[29]. This increase in demand has led to an increase in the number of children receiving treatment but services haven't kept up with the pace of referral. This results in only around one in four children with a mental health need being seen by services each year. In addition, children and

young people are waiting longer to receive support and average waiting times contain high levels of local variability, with some children and young people waiting up to two years to be seen[30].

An Education Policy Institute report published in 2018[31] found that CAMHS teams vary in their eligibility and threshold criteria, professional mix, models of service delivery and commissioning arrangements. The lack of a consistent CAMHS offer results in local variations in the type of referral services can accept and the support that can be provided. The threshold children and young people must meet in order to access specialist services for treatment is high. For children and young people rejected by CAMHS, there is often limited follow up and a lack of alternative services, resulting in children and young people's mental health deteriorating without monitoring or much needed support.

Reasons for rejecting referrals vary, but demonstrate the barriers to access for specialist support for children and young people and the complexity of the mental health system which families are navigating;

- Services declining self-harm referrals without a concurrent mental health condition
- Services requiring that children and young people have engaged with an early intervention service before CAMHS (difficult when children and young people don't meet early intervention referral criteria due to acute illness)
- Rejecting children and young people who need support with family issues
- Declining referrals related to life events (for example abuse, bereavement or parental divorce)
- Services rejecting referrals where the mental health issue is only prevalent in one area of life (for example, school or home)[32].

The reality for many children is that they must be in crisis before support is offered. More than a quarter are rejected from waiting lists, before receiving any treatment[33].

Furthermore, a 2022 National Institute for Health Research (NIHR) review identified a growing trend in antidepressant prescriptions in young people who haven't received talking therapy or specialist treatment. This is against clinical guidelines and the research suggests that GPs are resorting to antidepressants due to long waiting lists or lack of treatment options[34].

Patchy provision of early support, long waiting lists and high thresholds for CAMHS intervention are leading to missed opportunities to intervene early, identify the most at risk and provide appropriate and timely interventions.

Lack of service integration

The long-term gap in funding and focus on severe illness has led to a postcode lottery in service provision for children and young people[35]. In many instances education providers have recognised the impact of mental health and wellbeing on school attendance, attainment and overall welfare and have increased their role in service provision to fill some of the current gaps[36].

While the increased role of education providers in supporting mental health and wellbeing is welcome, the result is often overstretched teaching staff who lack the skills and confidence to identify and refer. As well as a system that can be confusing and difficult for children and young people and their families to navigate. Services can work in siloes, with varying providers offering differing levels integration and communication[37]. The landscape for children's mental health and wellbeing involves a combination of primary care providers, schools, and colleges, CAMHS, secondary and inpatient care as well as community and voluntary sector support (for example family hubs).

The formation of Integrated Care Systems (ICSs), as a result of the Health and Care Act (2022) presents an opportunity to integrate services and to give parity of esteem to physical and mental health and to service providers, providing a more effective, place-based service offer[38].

Furthermore, reform to the Mental Health Act[39], a review of the NHS Long Term Plan and the formation of a Long-Term Plan for Mental Health and Wellbeing[41] have the potential to address long standing inequality in access, experience, and outcomes and to prioritise children and young people's health at a national level.

There is further potential to place health inequalities at the heart of policy making through the Health Disparities White Paper. Addressing health inequality is at the heart of an ICSs function[42] and the white paper could provide guidance and leadership as well promote integrated working across government. Ministers described their ambition to break the link between people's background and their prospects for a healthy life[43], however, publication of the paper has not been confirmed and its future is uncertain.

Integrated working at a national level is becoming increasingly common. Policy makers in health and education are increasingly working together, recognising the joint, integrated role that health and education play in the lives of children and young people. Education providers can be equal partners with health and fully integrated into pathways for referral and support in order to fill the gaps in provision and provide seamless, high-quality services for children and young people and their families[44].

The need for this level of integration is increasingly acknowledged by organisations responsible for issuing guidance and undertaking service evaluation. The National Institute for Health and Care Excellence's (NICE) guidance regarding social, emotional, and mental wellbeing in primary and secondary education recommends education providers work together with the local ICS to agree opportunities for joint referral pathways and practises[45].

What do children and young people think of the mental health support available in schools and colleges?

Children and young people's voices are central to Barnardo's policy approach, and we are committed to lived experience led policy making. To ensure children and young people were represented in the report's development and conclusions, Barnardo's conducted several interviews and focus groups. Children and young people between the ages of 11 and 18 described their experiences of mental health support in schools, what works well for them and what works less well, including within MHSTs. Participants reported a wide variety in the amount of support, type of provision and in who was responsible for delivery. Children and young people received support from school chaplains, counsellors, teachers, and senior school leaders. Many also discussed peer-led initiatives.

Children and young people stressed the importance of having a member of staff who is purely responsible for mental health and pastoral care within schools and colleges. They also identified a lack of a whole school approach and difficulties accessing mental health support through their teachers. Some were conflicted about approaching teaching staff for help when they are also responsible for discipline.

'In my school if you want to access mental health support you have to go to your head of year. But they are also the person who disciplines you and they don't have a lot of time. It's very hard to go and talk to somebody about mental health when they read you the riot act three days ago.'

Barnardo's Service User

'Teachers aren't always used to dealing with mental health and having a useful conversation with students. It's more shouting at them for doing something wrong.'

Barnardo's Service User

'There is an issue with how teachers deal with it when you have a mental health problem, which is a lot of the time in a disciplinary way. Especially if they don't have much time. When I take days off school for my mental health, which you know, has sometimes been the only option. I think I haven't got anything out of this. All I've got is told off. And I haven't been given support or anything like that.'

Barnardo's Service User

Others recognised that teachers lack the time, resource and training to build relationships and identify the right support.

'Some teachers say you need eight hours of sleep, but you need to do your homework straight away.'

Barnardo's Service User

'Some areas of school are really good at knowing that they can be part of the problem, and others just think it's all about getting schoolwork done.'

Barnardo's Service User

Children and young people further identified a lack of support at key times in their lives, particularly in transition periods as they are expected to take on more academic pressure and become increasingly independent. Children and young people discussed the increased anxiety and pressure they faced during transitions, and how school or college often contributed.

'The amount of homework and use of detention... Sometimes school pressures add to the problem and schools don't realise.'

Barnardo's Service User

'There is no age limit on mental health. In sixth form, we are kind of just given the message of deal with it yourself, you know. I'd argue that we're probably at one of the most important moments of our life and having no support can just make it feel ten times more isolating.'

Barnardo's Service User

For those who were able to access support, there were concerns about waiting times, the type of support on offer and the short duration of support.

'At my school there is a waiting list of around three months to see a learning mentor. However, you also aren't guaranteed one so it's waiting to be assessed and the decisions made by school leadership.'

Barnardo's Service User

'Sometimes you will have designated sessions, a certain time and place every week. That might be a 5-10-minute session or half an hour up to an hour. Since I got to year ten, it's changed and been 'come to me when you need me' when I have free lessons. That's because my mentor is support for year 7s, 8s and 11s.'

Barnardo's Service User

'People look at everyone's mental health like it's the same, but for some people; gay or lesbian or trans kids, people don't think about their specific mental health issues.'

Barnardo's Service User

There was widespread agreement between children and young people that their needs are not taken seriously and there is a lack of parity between physical and mental health.

'The education system isn't designed for the modern day; it doesn't teach students how to live. It's not designed for mental health and wellbeing. It is clearly a system designed for achieving A stars.'

Barnardo's Service User

'And I just think, take us seriously. It's not hormones. It's not overreacting. This is just how we feel, and help would be nice.'

Barnardo's Service User

Despite these issues, participants had examples of good practice within their schools and colleges, particularly highlighting the value of co-production when designing interventions.

'In our school a really good thing that they do is they have a lot of student involvement in mental health. And I think that that's really good because, you know, sometimes schools do need to be told this isn't working.'

Barnardo's Service User

'On our website we have a mental health area, pointing you to sites you can visit. We have notes at school, a book you can take with information for getting help with mental health.'

Barnardo's Service User

Mental Health Support Teams (MHSTs)

Schools and college's role in protecting and promoting mental health and wellbeing has evolved over several years. Education providers play a vital role in mental health literacy through the curriculum, through identification of at-risk children and young people, through early intervention and access to specialist support[46]. Teachers are the most common first point of contact and source of support for children and young people experiencing mental health issues. Their role in the lives of their students goes beyond that of educator and frequently into public health professional[47] .

The Government has recognised the important role schools can play and have developed various policies which have sought to provide improved mental health support in schools and colleges for children, young people and families. In 2008, a government study 'Me and My School' began, evaluating Targeted Mental Health in Schools (TAMHS). Services are now well established in many local authorities, taking a systemic approach to mental health, with parents, school staff and local health agencies. Services aim to create a sustainable, positive impact on mental health, attainment, bullying, attendance, and exclusions[48].

Steps have also been taken by various administrations to develop and embed a whole school approach to mental health among education providers. A whole school approach makes mental health 'everybody's business' with a shared culture and positive focus on wellbeing across governors, school leaders and staff body, external services, pupils and parents/carers[49]. Several publications have considered the barriers and facilitators to a whole school approach, including 'Mental Health and Behaviour in Schools'[50]. In 2014, the Government established the Children and Young People's Mental Health Taskforce to identify local and national measures which would provide opportunities to intervene earlier and more effectively for children, young people and their families[51].

The Taskforce also discussed the future of the mental health workforce for children and young people, particularly within education. Included in the report's extensive recommendations was mental health training for all staff in contact with children and young people and the development of a workforce strategy to increase capacity, fill skills gaps and diversify the workforce to ensure its fit for the future[52]. Reports have also considered the specific role of professionals, including school nurses[53], therapists, and counsellors in embedding whole school approaches, supporting school staff to refer and respond to potential mental health issues in children and young people and in providing direct support[54]. The government paper "Counselling in Schools; A Blueprint for the Future" provided advice to schools on installing counselling services and stated it was a strong expectation that counselling be available to all pupils[55].

Despite these efforts, numbers of school nurses have dropped considerably over the past decade[56], as have the number of schools in England with access to a counsellor, from 62% to less than half[57].

In response, Mental Health Support Teams were first announced in the 2017 Green Paper 'Transforming Children and Young People's Mental Health Provision' co-produced by the Department for Health and Social Care and the Department for Education[58].

Each MHST serves an average of 8,000 children across 10-20 schools and further education settings. They work together with mental health leads and wider school staff to:

- Deliver evidence-based interventions for mild to moderate mental health issues
- Support or develop a whole school approach to mental health alongside school mental health leads
- Give timely advice to school and college staff regarding referrals and keeping children and young people within education[59].

MHSTs therefore have the potential to provide solutions to many of the issues children and young people currently face in accessing mental health support. They are positioned to identify at-risk children and young people,

provide early intervention, and fill the current gap in provision between self-management and a CAMHS referral. Services also play a key role in identifying children and young people in crisis and referring onwards for appropriate interventions in a timely manner. This positioning allows MHSTs to build strong relationships and bridge gaps between health services and education. Well integrated services ensure a smoother pathway to support and continuity for children and young people.

The services provided by MHSTs include 1:2:1 support, group interventions, parenting support, curriculum support through psychoeducation (learning about mental health and wellbeing) and whole school approaches. MHSTs present an opportunity to be flexible in meeting the needs of school staff, children and young people and their families. In practice, this allows MHSTs and school or college leaders to shape support to fit each setting. MHSTs must also consider the role of co-production, designing and evaluating services with the teachers, families, children and young people they serve. This helps to address inequality in access, experience, and outcomes for underserved groups. Much of this work is performed by Education Mental Health Practitioners (EMHPs), an additional role within the mental health workforce focused solely on the mental health and wellbeing of children and young people[60].

Children and young people supported by Barnardo's were positive about the development of MHSTs in offering mental health professionals in schools and colleges and supporting teachers to recognise and support students.

'I think they are a brilliant idea. Senior leadership and teachers need be involved and see the incentive.'

Barnardo's Service User

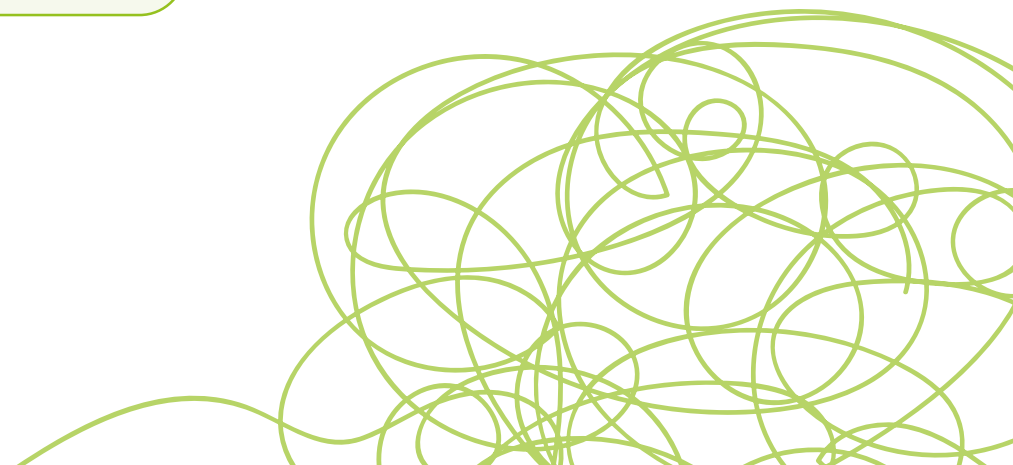
'They provide a safe space that helps you relax... There are support groups, people who take you out of lessons and safe spaces to talk about your worries." '

Barnardo's Service User

The government plans to ensure that 35% of schools have access to an MHST by 2023[61]. However, we estimate this timetable leaves around 6.5 million children without access in the medium term. The lack of universal access to MHSTs embeds a postcode lottery in support and therefore results in inequality of access, experience, and outcome of mental health services for children and young people.

Furthermore, for the implementation for MHSTs to be successful, policy makers must evaluate existing MHSTs, to better understand how they are working for children and young people and how effectively they fit into the wider landscape of support and local need. This requires a robust evaluation of MHSTs and learning from the application of models across different areas to support best practice and continued investment.

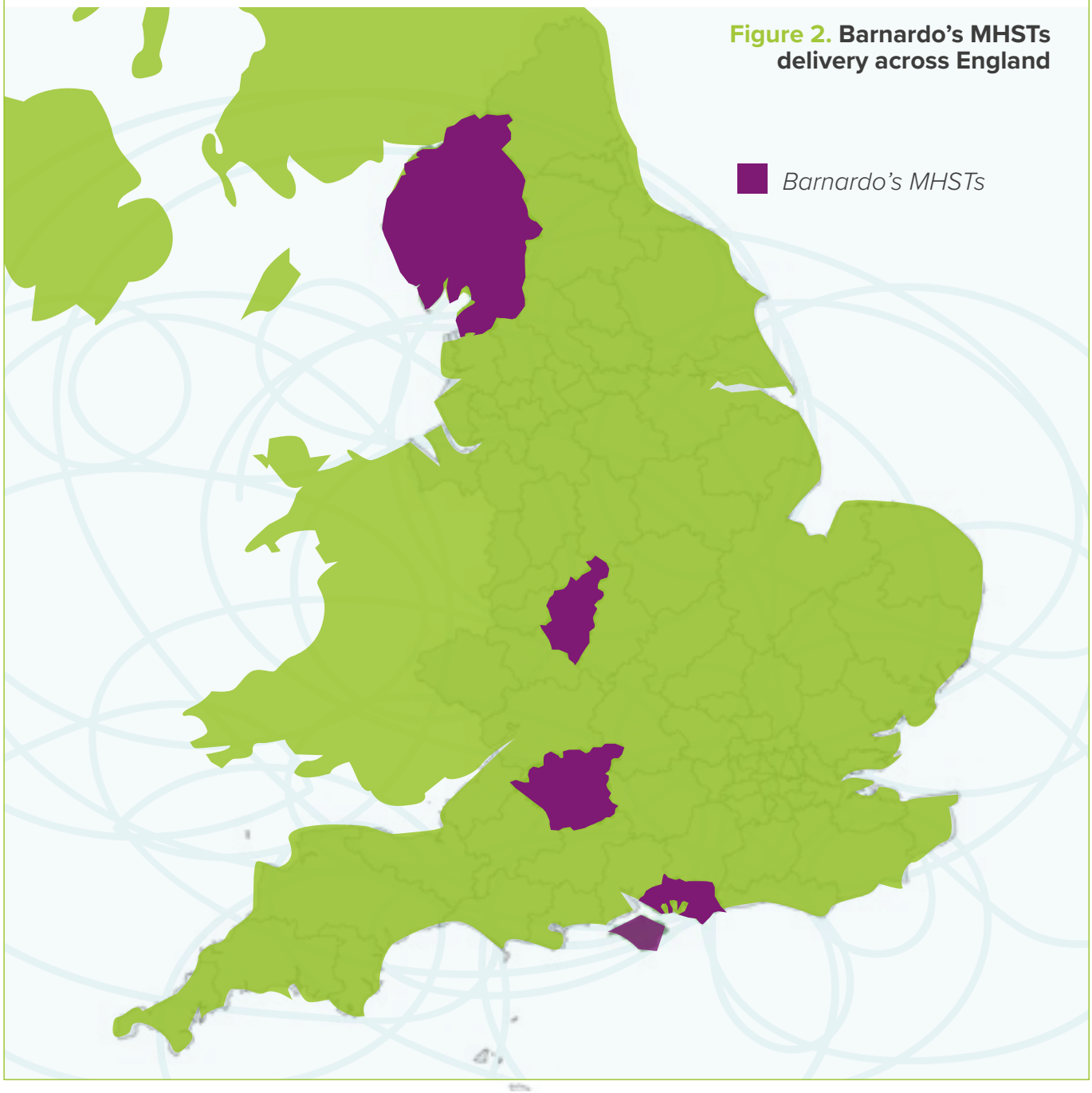
Children and young people say they need more support at schools, but policy and funding has not yet gone far enough to address this. Barnardo's polling by YouGov[62] revealed that 76% of 12–18-year-olds believe that they would benefit from mental health services in school but only 34% currently have access to specialist school-based support. In addition, 73% of parents believe that more money should be made available for mental health support schools[63]. Mental health professionals agree, 72% of Barnardo's practitioners think that increasing the roll out of mental health support in schools would have a positive impact[64].



Delivery of MHSTs

Barnardo's delivers 12 MHSTs across England and have been involved in the delivery of MHSTs since the first wave of commissioning in 2018/19. Barnardo's Swindon MHST was part of the Trailblazer roll out and we have since become the lead delivery partner to Birmingham and Solihull, Morecambe Bay and North Cumbria Clinical Commissioning Groups (CCGs) and are part of a delivery collaborative on the Isle of Wight. Furthermore, Barnardo's delivers a wide range of services to support children and young people's mental health within and beyond education settings across the UK, providing examples of potential development for MHSTs through implementation of scalable, evidence-based best practice.

Figure 2. Barnardo's MHSTs delivery across England



A whole school approach to mental health and wellbeing

A whole school approach to mental health and wellbeing addresses many potential barriers to delivering better mental health support in schools and facilitates the success of MHSTs through promoting a culture of wellbeing fostered at a leadership level. A whole school approach promotes an outward facing presence for education providers, strengthening community and health relationships and facilitating integration. There is emphasis on training and development for staff, embedding mental health and wellbeing in the curriculum and providing flexible interventions co-designed with children and young people[65].

NICE, the Department for Education (DfE), Barnardo's and other voluntary and social enterprise sector organisations including the Children and Young People's Mental Health Coalition (CYPMHC), medical professionals and the Children's Commissioner all support a whole school approach to mental health.

Figure 3. A whole school approach to mental health

Methodology

Barnardo's conducted desk research, reviewing research and grey literature to inform this report.

We gathered information and data from Barnardo's MHST services regarding referral data and outcomes to inform our analysis of MHST's cost benefit and overall effectiveness.

We conducted interviews and focus groups with 18 practitioners and commissioners in areas with MHSTs in situ, eight children and young people between the ages of 11 and 18 and two school teachers between September and November 2022. Participants contributions were subject to thematic analysis to inform our conclusions and recommendations.

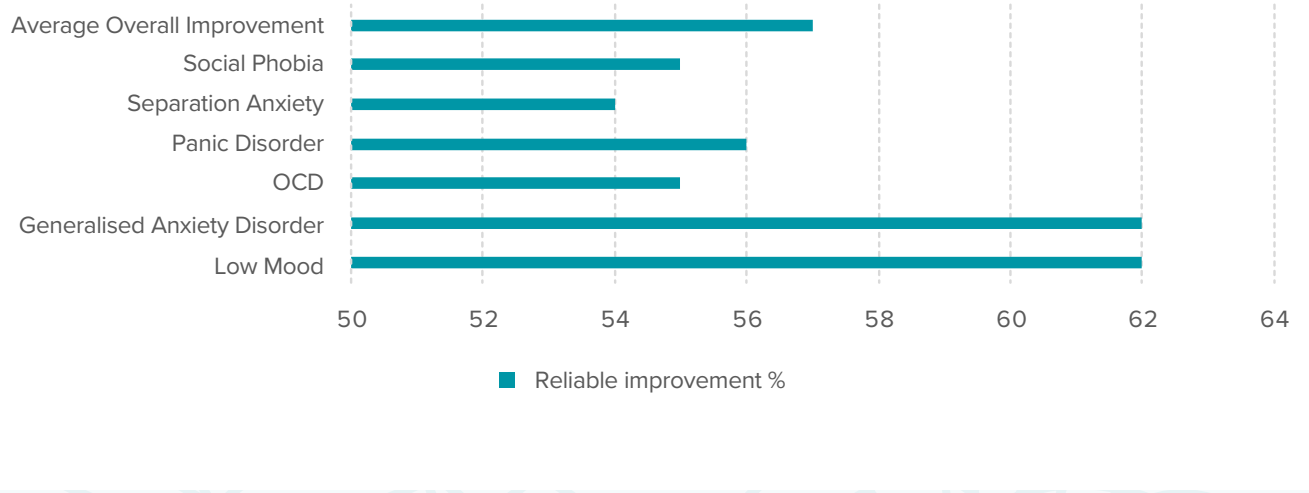
This work was further supported by YouGov polling of 745 children and young people and 4208 parents in August 2022.

How effective are MHSTs?

Barnardo's gathered a variety of qualitative and quantitative evidence to assess the effectiveness of MHSTs against the Government's aims for services.

1. Delivering evidence-based interventions for mild to moderate mental health conditions

MHSTs offer a short course of low intensity cognitive behavioural therapy (CBT) as a standard offer for mild to moderate mental health conditions. The interventions offered by MHSTs are improving outcomes for children and young people with mild to moderate mental health conditions, without which need may escalate. Barnardo's evaluated the outcomes data for 1145 children receiving 1-2-1 interventions across two areas of the country (Morecambe Bay and Swindon) and found sustainable benefits for a range of conditions and symptoms. The data revealed **an average improvement of 57% across a range of symptoms including low mood and anxiety.**



2. Supporting schools to introduce a whole school approach to mental health and wellbeing

Barnardo's MHSTs have effectively worked with schools, health, and community organisations to implement a whole school approach to mental health and promote a culture of wellbeing. Practitioners reported multiple examples of best practice, targeting underserved and protected groups who may not otherwise engage with school-based interventions.

Whole school approach offers have been tailored to local need and have included auditing and developing a holistic teaching offer, developing resources, school-based workshops, peer mentoring, mental health first aid and community facing partnerships. The resulting positive impact on school and college environments has led to both cultural change and development of school/college policies that promote wellbeing.

Gosport MHST- Coping and Resilience Education (CARE) Programme

The CARE programme consists of a three-week course comprised of three sessions of one hour for children from a year group identified to be struggling with emotional resilience and coping mechanisms. A total of 25 children were identified as eligible for the course and seen in two groups.

The programme aimed to:

- Develop a child's understanding of emotions and how to communicate and express themselves emotionally
- Develop and enhance a child's emotional resilience by providing techniques and strategies to help them cope with emotions including sadness, anxiety and anger
- Improve confidence in children asking for help if they are struggling emotionally and to educate children in and where to access support it necessary.

Evaluation

Children were individually assessed using the emotion thermometer, asking them to rate their feelings on a scale of 0-10 before and after each session. 0 represents feeling calm, happy and relaxed. 10 represents feelings of anger, upset or worry.

Results

Children reported feeling calmer and happier at the end of each intervention compared to the start (average improvement 1.86 points). Children reported feeling calmer and happier overall.

'The children with the highest emotional needs seemed to gain the most and were more confident talking about their emotions in a safe space.'

Class Teacher

3. Providing timely advice and referrals to ensure children and young people receive the right support and stay in education

MHSTs reported close partnership working with external bodies to ensure a smooth pathway for children and young people, both stepping up with increased support needs, or receiving step down services. Services reported working with children and young people and families to refer to community services including early support and family hubs. They worked with specialist services including autism, sleep clinics and social prescribers. MHSTs also ensured referrals to Children and Adolescent Mental Health Services (CAMHS) and emergency services were appropriate. Staff worked with other mental health services to assess, triage and follow up referrals in partnership.

Swindon Town Football Club and Swindon Project Me

The Swindon Town Football Club Community Foundation and Swindon Project Me (MHST) is an example of an effective partnership between education and the community to improve children's mental health and wellbeing.

The project provides several opportunities for children and young people to engage including mentoring programmes, outreach for socially isolated children, holiday clubs and a scholarship programme for those identified as particularly talented.

A Barnardo's practitioner described the benefits of the holiday club for building discipline and teamwork, and the knock-on impact on attendance for one child in particular.

'He is in primary school and really struggling with attendance, being regularly excluded. He was on a path to enter specialist provision for behaviour difficulties, but he displayed this talent. The holiday club suited him so well, his teacher took him in because his family couldn't get him there. At football he learnt about discipline and about teamwork. It has improved his attendance, and as a result, he has been offered a place on the scholarship programme.'

Barnardo's Practitioner

Where MHSTs are in place, they provide vital support for children and young people. They provide holistic and wide-ranging support in wellbeing and early intervention. They partner with other organisations to prevent siloed working and ensure that no children and young people fall through the cracks. Commissioners and Barnardo's practitioners are proud of MHSTs and reported their positive impact on children and young people's mental health and wellbeing.

'It's one of the most important things we've ever done. Getting the MHST's in for emotional wellbeing of children.'

Service Commissioner

'We are seeing such positive results within the early intervention remit. It's one of those stories that is amazing, and you know that it's a fantastic job.'

Barnardo's Practitioner

'Headteachers all sing the praises of MHSTs, how they are designed and working.'

Barnardo's Practitioner

Teachers also praised the work of MHSTs, and the value of having a service in school, working alongside staff and recognising their role in supporting children and young people.

'For us and our teachers, MHSTs are accessible, and it feels as though there is no wait time compared to other services. We also hear back so we know when a child's had their assessment and what is happening next. We don't always get that elsewhere.'

Headteacher

'The difference in the children, and in their parents has been amazing. They work with the parents too, reduce the anxiety in the parents and it changes everything for the child.'

Primary School Teacher

Do MHSTs represent value for money?

Barnardo's have carried out a cost benefit analysis of Mental Health Support Teams (MHSTs) based on analysis of outcomes data for 1-2-1 CBT interventions from our MHST service in Swindon between April 2019 and July 2021.

Data used in the analysis was derived from two outcomes measurements, The Outcomes Rating Scale (based on progress towards children and young people's goals) and the Child Outcome Rating Scale (children's self-reported symptoms). A successful intervention was recorded if children and young people made a reliable improvement in their condition. Costs and benefits were based on health care savings and the indirect benefit of improved school attendance and educational attainment.

We found that for every £1 invested in services, there is a return of £1.90 to the state.

These benefits are a likely underestimate. The analysis was based on 1-2-1 intervention outcomes, only a portion of the work that MHSTs carry out. It was not possible to include whole school approaches in the analysis due to difficulties capturing outcome data. Furthermore, data collection took place throughout the Covid-19 pandemic, and during the establishing phase of the MHST when staff were still in training.

The analysis also suggests that the cost to the state of failing to roll-out MHSTs to 6.5 million children and young people is an estimated £1.8 billion. We also estimate that each MHST provides a potential saving of £2 million to the state. A full government-led cost-benefit analysis of MHSTs would help to underpin this analysis.

MHSTs therefore, are a cost-effective service that improves mental health and wellbeing outcomes for children and young people. Pilot projects and initial roll out have been successful and the case for expansion is clear. Every school and college should have access to an MHST service. The current lack of commitment to sustainable long-term funding for existing teams and to future expansion creates inequalities in provision affecting children and young people, their families and teaching staff as well as the success of existing MHSTs.

What are the lessons from the current MHST roll-out?

MHSTs work, but the pace of roll-out builds in inequality

The phased roll-out of MHSTs, covering variable numbers of schools and colleges across an Integrated Care System (ICS) has led to inconsistencies in the support available within local areas and across England. Whilst prioritising areas of deprivation has increased provision in these areas, it has led to patchy service provision in localities and across England as whole. As MHST roll-out often means teams are unable to support all education settings in an area, commissioners found it difficult to know whether to prioritise installing MHSTs in primary schools, secondary schools, or colleges and children and young people find the gaps in support challenging as they move between education settings. This was particularly pronounced for young people who without early identification and support in college, end up attempting to navigate the adult mental health system for support.

'There's a real like tension for me because the primary offer would be about prevention, which is really important. But the high school offer is about dealing with the issues and stopping things getting worse.'

ICS MHST Service Commissioner

'We have a mental health support team, for the high school but not for sixth form. I think we need them in sixth form as well, less of a presence, but knowing that they are there and being able to reach out. It would be good to have them throughout so you can get that attachment and build that bond of trust. Also, for new people to the area, they can build the relationship, or it can feel quite isolating.'

Barnardo's Service User

'There is no age limit on mental health. In sixth form, we are kind of just given the message of deal with it yourself, you know. I'd argue that we're probably at one of the most important moments of our life and having no support can just make it feel ten times more isolating.'

Barnardo's Service User

Access to MHSTs also varies between localities within an ICS with some areas experiencing full coverage in schools and colleges, and some, less than half. Children and young people outside of MHST service provision, may face additional barriers to accessing wellbeing support, receiving an early diagnosis and participating in interventions compared with their peers locally. Some Barnardo's MHSTs reported attempting to work to fill these gaps by providing services to additional schools or supporting children and young people through education from an initial referral.

'I'm keenly aware of the issue of health inequality and actually the rollout of the MHSTs creates health inequality right from the go.'

Barnardo's Practitioner

'MHSTs are a platinum service. Really you can't replicate that by putting a bit of training in or a bit of group support.'

Service Commissioner

'That is something that we feel so keenly, there's a minority of schools that don't get a service. So, we try to offer out and offer something to everyone.'

Barnardo's Practitioner

'If I could put MHST in every school, they would be there now. I wouldn't hesitate.'

Service Commissioner

Without expansion of MHSTs to all schools and colleges, children and young people will continue to experience disjointed pathways to support and a postcode lottery for provision in early intervention services for mild to moderate mental health issues. Additional pressure will be placed on existing MHSTs to provide services for schools and colleges outside of their area.

CBT is an effective therapy, but does not work for all children and young people

The current offer for individual therapy within an MHST, is a baseline of cognitive behavioural therapy (CBT). While CBT is evidence-based and effective, it is not an appropriate intervention for all children and young people. Birmingham University's evaluation[68] of the first wave of MHSTs identified groups for whom Cognitive Behavioural Therapy (CBT) is less likely to be effective and who therefore may be underserved by the MHST offer including younger children, children with a minority ethnic background and those with special educational needs. This analysis was supported by Educational Mental Health Practitioners and Barnardo's teams during interviews.

Practitioners identified the complexity of children and young people's support needs as a factor affecting how effective CBT can be. The initial targeted roll-out of MHSTs, aimed at areas of deprivation was cited as a positive in principle, but in practice resulted in many referrals being unsuitable for MHSTs under the current model. This led to friction between the MHST model and the reality of practitioners' experience.

'We are set up to work predominantly with the schools in areas of the highest level of deprivation, but at the same time we are supposed to work with early intervention and our practitioners are not trained to work with the added complexity that those areas often bring with them so there is quite a discrepancy in the way the model is set up.'

Barnardo's MHST Practitioner

'For some children with systemic and complex needs, CBT doesn't touch the sides.'

NHS MHST Practitioner

Practitioners in established MHSTs often reported that the current service model is too rigid to meet local need. Services response to this was varied. Some felt unable to expand their offer and were concerned about the impact on children and young people.

'The model is very rigid. Often what children need is counselling, and not CBT. We also wanted to provide art therapy, but, though management would listen, it's not part of the model.'

NHS MHST Practitioner

'We need a whole family approach, for some of the children and young people, we are never going to get engagement without it.'

Primary School Teacher

'CBT doesn't work for everyone. They might not meet the threshold. They might have special educational needs. We have expanded our offer so there's something out there for everyone.'

Barnardo's MHST practitioner

'With (support at school), you get 6 to 8 eight hours. Then it's OK, there's nothing more that we can do for you. There's the door.'

Barnardo's Service User

Local approaches have therefore been developed to meet the needs of children and young people for whom CBT is inappropriate or ineffective. MHSTs have recognised the importance of working with families, particularly when supporting younger children, for whom CBT is not appropriate. Practitioners reported providing interventions through parents, provision of seminars and workshops for parents and informal drop ins. They emphasised the importance of a whole family approach to mental health alongside a whole school approach. Together, they provide an environment that promotes wellbeing and supports recovery.

'We work in a lot of primary schools and the work we do there is through the parents, so you need that relationship. It's a whole family approach too.'

MHST Practitioner

'Sometimes the parents we need to speak to may be anxious, or have had a bad experience in school, so we need the MHST to help us think outside the box and engage. We are on the school gate and doing coffee mornings, just to drop in for a chat, to meet the EMHP and get things going'

Headteacher

Practitioners reported wide scale innovation in developing individual and whole school approaches to target those underserved by CBT but also described difficulties in reporting and evaluating these approaches. In supporting MHSTs to provide effective early intervention for all children and young people, the Government should consider commissioning research into some of the existing models used by MHSTs to identify best practice. Furthermore, therapies in addition to CBT require their own framework for measuring and reporting outcomes, to ensure their value can be accurately presented alongside CBT. This would allow local innovation to benefit children and young people nationally[69].

Services need to be supported by data

MHST staff and service managers consistently reported challenges in data collection, reporting and service evaluation. At present, multiple data sets are collected by MHSTs, determined by commissioners and NHS England. Managers and practitioners reported frequent changes to the type of data MHSTs are asked to collect, store and report. This results in widespread confusion about what data should be collected, and variation in the type and quality. Some MHST services reported difficulties in collecting referral data, evaluating outcomes, and working with other services data systems. In turn, services cannot always effectively understand if they are reaching underserved groups.

Practitioners described the need for consistent nationally led guidance on data collection and outcome reporting that can be shared across systems. They also acknowledged the difficulties of assessing 'what works' within their services, in identifying, evaluating and sharing best practice and in comparing services. Lack of data transparency was described as a barrier for children, young people and their families to understand what services were locally available to them, and which may be most appropriate.

MHST managers discussed how they submitted various data sets without any feedback or publication that could support service evaluation and improvement.

'Data systems can't be commissioned because NHSE isn't clear on what data it wants to collect.'

MHST Manager

'We get asked for different data every time, sometimes with very little warning. I have to go back through and retrospectively try and find something. We can never be ready.'

MHST Manager

Multiple MHST services described the benefits of joint working and shared data systems to allow for a seamless referral pathway for children and young people experiencing poor mental health. Referrals can be triaged and allocated between services, and in complex or uncertain cases, a single, integrated multidisciplinary team meeting to allocate support ensures that the right service is accessed, and children and young people don't fall through the gaps in provision.

'We only have one referral form, and it all comes into a single point of access. This reduces confusion and helps us make sure people are where they need to be from the very beginning. We screen referrals every day, so there's a maximum wait of 24 hours before we've given them an outcome.... They don't know which service they are seeing, only that they are getting the help they need.'

Barnardo's MHST practitioner

'We are based in schools and want to be a school service first. But if we can pass on a referral, or someone can pick up the phone and ask us a question and we have all of the information, that helps people know they have made the right decision to refer, and that we are the right service to respond.'

NHS MHST practitioner

Managers and practitioners also described difficulties accurately reporting the full extent of their activities. Managers face challenges in identifying what constitutes an intervention when in many cases MHSTs provide non-clinical intervention and signposting. They also described barriers in gaining consent for recording these activities. It was therefore difficult for some managers to measure waiting times, to report on number of interventions delivered and to measure and report on outcomes, particularly of whole school approach interventions.

Though NHS England guidance on recording measures including waiting times is expected to be issued for MHSTs, practitioners still face uncertainty about what data should be collected and what the outcome measures should be for

group and whole school approaches. Without a formal data collection and recording mechanism for the whole school approach, there can be a mistaken emphasis placed on individual support compared to the prevention or wellbeing role of MHSTs.

'What they didn't think about was how they're going to collect the data for the whole school approach. We see a lot of children through one-to-one sessions, that's not an issue, but we are seeing more young people through other ways.'

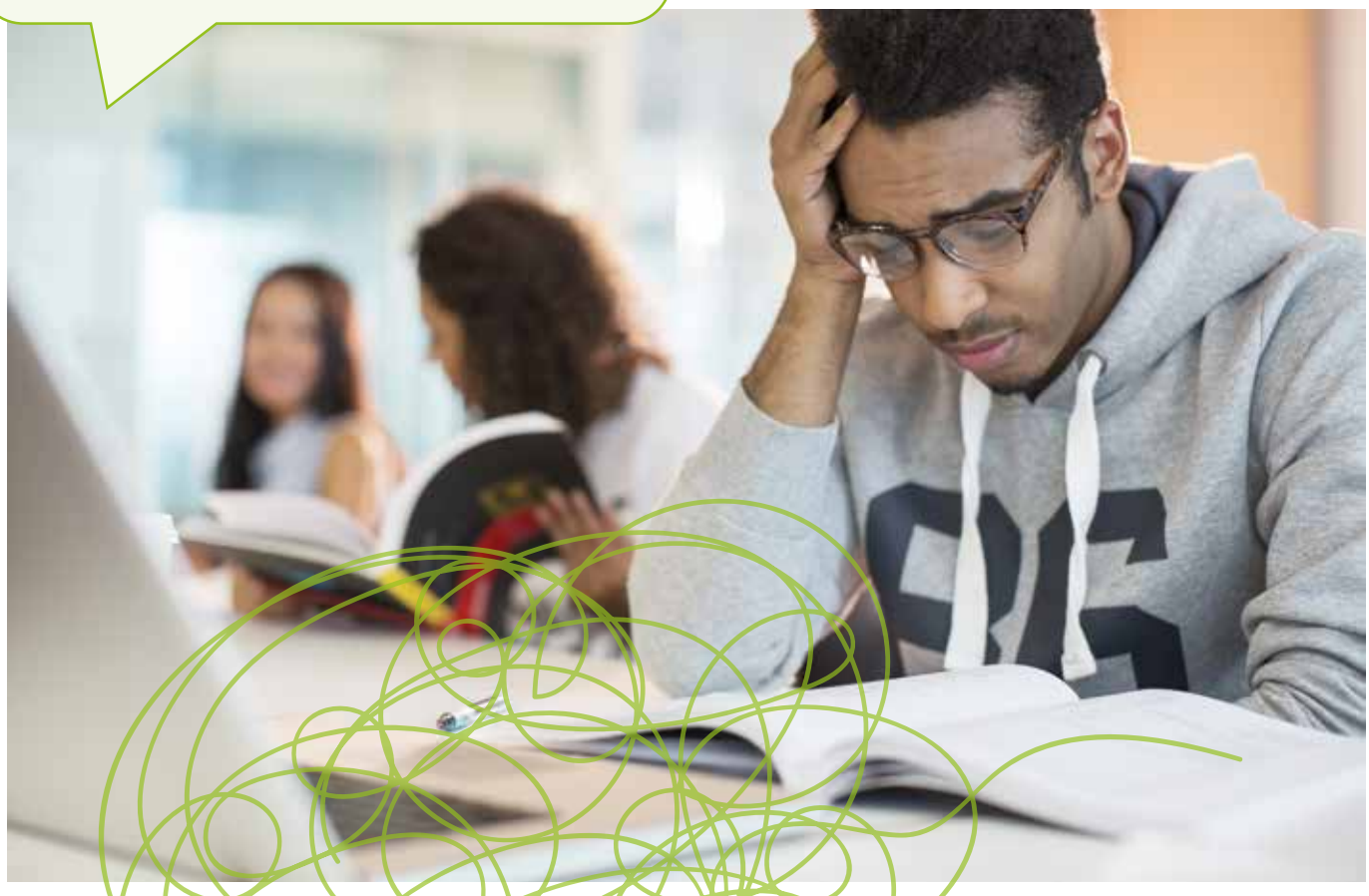
Barnardo's MHST practitioner

'Across the region it's been difficult in terms of what we report back on and our data. There are three different aspects of work in terms of whole school approach, staff support and consultations and the one-to-one offer. But there's a lot of focus in terms of reporting on the amount of one-to-one intervention. But that's a third of what we're supposed to be offering.'

Barnardo's MHST practitioner

These discrepancies result in difficulty understanding how effective services are at reaching and producing reliable improvement for all children and young people across an MHST's area, particularly the most at risk and underserved whose participation in MHSTs services cannot be properly monitored and evaluated. Furthermore, it makes reporting on the impact and outcome of whole school approach interventions challenging. MHSTs may therefore find it difficult to evaluate their services and respond to demand and any areas of unmet need. It also makes it difficult to understand interventions that represent best practice and are most effective.

Establishing clear data collection and reporting frameworks, integrated with other services to ensure a smooth pathway for support, would improve access and outcomes for children and young people, while reflecting an MHSTs impact accurately and laying the ground for innovation to meet local need and respond to emerging issues.



MHSTs are most successful when they work in partnership and are well integrated

One of the Government's expectations for MHSTs, is to act as a bridge between education, community, and health care providers, reducing siloes in working and improving care pathways for children and young people and their families. This bridge building acts to integrate services, improve pathways and democratise access for all children, young people and families to mental health services[71].

In practice, for MHSTs to integrate effectively, they must be able to build close working relationships across sectors and between children's and family mental health services to ensure that children and young people, potentially with a range of complex needs, are correctly identified, referred, triaged, signposted and treated.

Relationship building relies on structures being in place that facilitate partnership working, and a positive local culture regarding children and young people's mental health. The Health and Care Act 2022 mandates the creation of Integrated Care Systems (ICSs) and aims to shift the culture of the health service away from competition and towards collaboration. This cultural shift has the potential to improve the integration of MHSTs and facilitate their aims. Success relies on Integrated Care Boards (ICB) within ICSs prioritising children and young people in the development of their strategies and in planning of services. Barnardo's recommends that this takes place through each ICB producing a children and young people's plan, reviewing the contribution of all services including MHSTs, as well as the level of unmet need. These plans should contribute to ICS strategy development and MHSTs should be included as a delivery partner, specifically named and included in Department of Health and Social Care guidance regarding services to consult in the formation of strategic plans[72].

Furthermore, ICSs should take a pathway approach to mental health and wellbeing provision for children and young people and families, collaborating on integrated systems that create a single point of access and joint decisions regarding triage and treatment. This approach also allows for children and young people to step up or down the service pathway according to level of need, facilitating a smooth transition for those requiring escalation or a safe, supported step down.

Practitioners reported the benefits of collaborative working in establishing successful MHSTs, ensuring they are well positioned to provide mild to moderate mental health support, and in referring children and young people to other services where appropriate.

'We've worked really hard. It's an ongoing negotiation and discussion to build those relationships and to get ourselves into a position where we are seen as one of the three big providers of mental health services in the area.'

Barnardo's Practitioner

'The idea is that when a child needs help, you complete one referral and then at that single point of access meeting that's where the decisions are made about where that young person can go.'

Barnardo's Practitioner

'We've made ourselves an integral part of the single point of access. So that a meeting happens twice a week with TABS (targeted mental health services for CYP) and CAMHS. In practice, if a referral were to come into us from a school that we're not participating in then we'll make sure that they're picked up by another team or service and vice versa. If teams get referrals that should be for us, then we can pick those up as well.'

Barnardo's Practitioner

Many Barnardo's MHSTs therefore, are able to integrate effectively and act as a bridging service for education, health and community.

'CAMHS came through school and through my Mum, I was on the waiting list and then spoke to school about it, had a referral from my mentor who put it in so I could be seen sooner.'

Barnardo's Service User

However, practitioners reported that in some areas, particularly where MHST coverage is low, local culture is not collaborative and the role of the service is poorly understood, partnership working was difficult, and friction developed between services. The result is continued siloed working, duplication of effort and children and young people who are more likely to fall through the cracks.

'I don't think people have got that information or knowledge about which schools we're in. There's a lot of ambiguity. And I think if it was a uniform service across the county, we would be more integrated because people would know that, yes, MHSTs are part of the system, whereas at the moment, I don't feel like we're part of the system.'

Barnardo's Practitioner

In areas where MHSTs are well established and coverage is high, practitioners reported a system wide focus on children and young people's mental health, a wider range of services available in schools and the community, and greater integration and collaboration.

'We have around 80% coverage, so we find integration easier. If you have something like 35% to 40% coverage with MHSTs it's very, very difficult, I think to become integrated in the way we are because they're so very far away from that 100% coverage.'

Barnardo's Practitioner

'The benefits of being in 80% of schools are paying off now. We have an 11 Week Wellbeing Group that young people from anywhere, any school can attend, and we've just rolled out digital wellbeing assemblies for primary schools that any school can request, and there's various other things like we do holiday clubs based on the five ways of wellbeing and anybody can access those as well. So we've tried to expand our offer and are looking at how to do that further to make sure children don't fall through the net.'

Barnardo's Practitioner

For MHSTs to be effective in their positioning as an early intervention service for mild to moderate mental health issues, services must be integrated within local ICSs and be able to collaborate with partners across sectors. True integration requires 100% MHST coverage in all schools and colleges, inclusion within ICS structures and a local culture of collaboration.

MHSTs best serve their local populations when they are empowered to innovate

MHST practitioners, managers and commissioners widely commented on the rigidity of the current staffing and intervention model. There was frequent frustration regarding the challenges this presented in terms of a service offer that met local need, and in the difficulties associated with innovation. Many Barnardo's MHSTs identified the benefits of community-facing, partnership working in improving service provision and reaching underserved groups. However, the ability to innovate was dependent on proving a case for service expansion and is not incentivised by the current model.

'Experienced services should have some flexibility in saying there is a gap in the provision. Bring forward a sensible proposal if we see there's a gap in provision that we can fill, have a go at it and feedback.'

Barnardo's MHST Practitioner

Practitioners recognised the importance of evidence-based intervention in guiding MHST work but recognised the limitations of the current service model in meeting the needs of the children and young people referred. Many practitioners and managers advocated for an expanded MHST service model, with the potential for local place-based flexibility and innovation guided by best practice and an overarching vision; effectively an MHST+ model.

MHST+ reflects an expanded basic service model with the ability to respond to local need, including through internal service expansion and partnership working. The basic MHST+ model should expand to include the addition of a trained school counsellor, increasing availability to every school and college, in line with Scotland, Wales and Northern Ireland. Fewer than half of schools and colleges in England provide an on-site counselling service, despite evidence that counselling support improves mental health and wellbeing[73].

Counsellors have the potential to fill the 'missing middle' service for children and young people who have a moderate mental health need that cannot be met by CBT services but who are not acute enough for CAMHS intervention. Embedding counsellors within an MHST model increases access to this service, allows MHSTs to meet a greater variety of need and establishes smoother support pathways for children and young people[74].

Figure 4. Levels of mental health support for children and young people

Isle of Wight MHST

Barnardo's works in partnership with the Isle of Wight NHS Trust and IOW Youth Trust to deliver children and young people's mental health services across the island.

The services are well integrated and take a pathway approach to providing support based on the needs of children and young people. Barnardo's MHST staff meet with Youth Trust counselling providers as well as CAMHS on a weekly basis to discuss referrals and ensure children and young people can access the right service at the right place and time. This partnership working also facilitates a step up or down in the amount of support required, reducing uncertainty and making sure no child or young person is lost in the system.

The partnership provides a clear pathway to support and fills the missing middle between MHSTs as an early intervention and preventative service and specialist CAMHS services through the inclusion of counselling.

Children and young people receive a single service and MHSTs maintain their independence and position as a schools-based intervention led by each schools' children, young people, families and teaching staff.

MHSTs currently face challenges in acting as a prevention and early intervention service, that the addition of counselling would help to resolve. Practitioners often reported receiving inappropriate referrals for children and young people unsuitable for the current MHST range of interventions. Practitioners suggested this was due to a lack of understanding regarding the remit of MHSTs, the limitations in the current model and overstretched CAMHS services resulting in greater acuity and complexity of young people's needs.

'It's really pushing the end of moderate; acuity has gone up. We know there are a lot of children on waiting lists and on waiting lists they get worse.'

Barnardo's MHST Practitioner

'Sometimes we feel that the level of need is too high for us, but they don't meet criteria for CAMHS, that that happens quite a bit. We want to help but there is also fidelity to the model and what the evidence says about how safe it is.'

NHS MHST Practitioner

Creation of an MHST+ model would reach more children and young people, expand the MHST offer and more effectively serve those for whom CBT is not appropriate but who still require support. Counselling offers multiple alternatives approaches to CBT that are more fluid, flexible and discussion based for children and young people who prefer this to the more rigid structure of CBT. Where CBT is active and focused on the here and now, counselling is reflective, with several possible models including family therapy and individual talking therapies[75].

'I think a counsellor in every school would be supportive for students. I'd like to be able to go to someone and say this is what's happening and what I've done about it, and they can help you get more support or help.'

Barnardo's Service User

'We have an MHST and a counsellor, I can talk to someone within an hour if I need to.'

Barnardo's Service User

Furthermore, school counselling services are cost effective. Pro Bono Economics analysis of Place2Be counselling services calculates that every £1 spent represents a return of £8 to the

state. This provides an average benefit of £8,700 per child. If a counsellor was employed in every school, in addition to the current MHST offer, this would represent a £751 million return annually .

Alongside counselling, MHSTs should have the option to innovate and target underserved groups with early intervention and prevention measures as well as work with partner services to fill the 'missing middle' for children and young people with moderate need. Practitioners described working with Improving Access to Psychological Therapies (IAPT) therapists as a possible compatible service.

At present, local innovation and best practice requires support from commissioners, additional local funding or flexible use of budgets. Lack of published comparative data means MHSTs find it difficult to assess how well their service is performing and identifying and sharing successful local innovation more of a challenge. Practitioners identified multiple examples of innovation where they had successfully built relationships with commissioners and other partners to meet local need. Practitioners also identified partner organisations providing specialist services including bereavement and suicide support. Barnardo's MHSTs created strong links with community organisations and other voluntary sector partners to provide group and 1-2-1 support for specific local issues or underserved groups.

It is essential to build flexibility into the MHST model through data collection and publication, and through an MHST+ model, so that success is not dependent on local arrangements.

To be most effective, an MHST+ model should also promote local innovation through partnership working to meet the needs of children and young people who remain underserved by the MHST model and do not fit the criteria for CAMHS. Children and young people interviewed by Barnardo's emphasised the importance of MHSTs acting as a bridge between education, health and community services. There was widespread agreement that MHSTs should be able to reach into communities and provide tailored local support to children and young people.

'Mental health support with community outreach is a brilliant idea... you can build up a rapport and have contact in different ways, not just at school, say through football or email.'

Barnardo's Service User

An MHST is only as good as its workforce

Commissioners and practitioners described the workforce as the key to MHST delivery. Children and young people also identified a lack of staff in both education and health care settings to support their mental health. Many raised concerns about the capacity of mental health services in general, and MHSTs to meet the demand.

'There isn't capacity to help everyone who comes forward. And often those who don't come forward need the most help.'

Barnardo's Service User

'For me (my mentor) doesn't have a lot of free time, but whenever she has the chance, she will speak to me. If she can convince someone (to cover) she can come and see me. It's based on her time, and how extreme my mental health is and whether I've asked if she can see me as soon as possible.'

Barnardo's Service User

MHST managers and commissioners reported considerable issues for MHSTs in becoming established and meeting children and young people's needs within the current staffing framework. Education Mental Health Practitioners spend the first 18 months of their careers undergoing training, and the associated responsibility dictates the offer an MHST can provide, and the number of students that practitioners can see.

'In reality, if you're starting out a new MHST, you have to accept that the first 18 months is bound by what the university wants. You're not going to be able to really mould your model and have it as you want it and until the majority of the EMHPs are qualified.'

Barnardo's Practitioner

Timeframes for establishing MHSTs were also affected by attrition during the training phase of an EMHPs career. Practitioners reported confusion regarding the positioning of the role, potentially due to similarities with the Children's Wellbeing Practitioner role. This led multiple MHSTs to lose EMHPs before or shortly after completing their university courses.

'People are starting the training and it's not always what they expected and then leaving the system. So we are constantly trying to get new places and new trainees.'

Barnardo's MHST Practitioner

'It's not as straight forward as just recruiting, they need a university place and wait for a new cohort, so you have to thoroughly interview, it's a long process.'

NHS MHST Practitioner

MHST teams also face attrition due to a lack of progression for EMHP staff. Opportunities for EMHPs within an MHST often rely on further postgraduate study, whereas CAMHS and other NHS roles may not require this commitment or expense. Practitioners reported staff leaving for equivalent or more senior roles throughout the NHS. Training places are tied to teams, and therefore there is an extremely limited pool of workers to replace those lost.

'We are supposed to have four EMHPs, currently there is only one. There is no pool to recruit from. We are implementing a senior EMHP role to help with attrition and provide line management and supervision responsibilities.'

NHS MHST Practitioner

Some MHSTs therefore find themselves in a spiral, whereby the service is unable to develop due to a constant expensive training cycle. Providing further flexibility to MHSTs to develop their staffing model would help to address attrition through the provision of training and career development for MHSTs. This flexibility must be supported by a career framework for EMHPs, maintaining their skills within MHSTs, facilitating the expansion of services to meet local need and providing opportunities for those EMHPs who wish to develop their skills.

'A lot of applicants were using the training as a steppingstone. Applicants want progression. It would be good if the MHST could offer that.'

Barnardo's MHST Practitioner

Recommendations

Recommendation one:
The Government should commit to funding and delivering a rapid roll out of MHSTs to ensure access for all children and young people.

Recommendation two:
The Government should carry out and publish a full cost-benefit analysis of MHSTs.

Recommendation three:
Every Integrated Care Board (ICB) should have a duty to create a children and young people's plan, reviewing the contribution of all services including MHSTs, as well as the level of unmet need. This should contribute to Integrated Care Systems (ICS) strategy formation.

Recommendation four:
Create and issue national guidance on the data collection and reporting mechanisms required for MHSTs. Invest in the data infrastructure and systems capabilities to support data collection and best practice sharing. Outcomes data should be published as part of the NHS mental health dashboard.

Recommendation five:
Create effective tools and frameworks for analysing and evaluating whole school approach interventions for mental health and wellbeing to accurately reflect and evaluate the full range of MHST work.

Recommendation six:
Create an expanded MHST+ service model, offering a qualified counsellor as part of every MHST.

Recommendation seven:
Commission research into alternative interventions for children and young people's mental health and wellbeing to be delivered in school.

Recommendation eight:
Provide a clear framework for Educational Mental Health Practitioners, adding senior EMHP roles, opportunities for career development and progression within MHSTs.

Recommendation nine:
Include the Educational Mental Health Practitioner role in future NHS workforce plans and strategies, including 5-, 10- and 15-year plans announced in the 2022 Autumn Statement.

Appendix:
Cost-benefit analysis of the Mental Health Support Team service

A. Summary

1. Barnardo's have conducted a cost savings analysis of Mental Health Support Teams (MHSTs) based on analysis of outcomes data from our MHST service in Swindon. The analysis finds that for every £1 invested in the programme, the benefit to the government and the wider economy is around £1.90 but this likely represents a significant underestimate given the assumptions and approach taken.
2. The rest of the appendix contains: an overview of selected service outcomes used in this analysis; an outline of the approach taken; details of the assumptions made; the results.

B. Outcomes from Swindon MHST

3. The children and young people supported by the Swindon MHST are assessed against a variety of different outcomes. For the 1:1 Cognitive Behavioural Therapy (CBT) service, service users are typically assessed against a scale, with progress monitored by comparing start and end scores. The data and analysis used in this assessment are based on two distinct practitioner outcome tools used by the MHST, namely Goals Based Outcomes (GBO) and the Outcome/Child Outcome Rating Scale (ORS & CORS).

GBOs are a way of evaluating progress towards a goal in clinical work with children and young people. It compares how far a child or young person feels they have moved towards reaching a goal they have set themselves at the start of an intervention, using a scale from zero to ten (where 'zero' means the goal is not met in any way, 'ten' means the goal is met completely and 'five' means they are half-way to reaching the goal). **Table 1** below shows a random selection of 10 goals set by Swindon MHST service users.

Table 1 – Example GBO goals

Goal	Targeted issue
To arrange a meetup with friends	Social anxiety
To play by myself in my room for 30 minutes in the evening, whilst mum is downstairs	Separation anxiety
To talk to people I trust about my worries or to put my worry in a worry box at home or at school	Generalised anxiety; Worry
To spend an hour at home alone	Separation anxiety
To use my calming strategies when fear shows up	Generalised anxiety
To spend a night away from my parent	Separation anxiety
To go to the gym two times a week	Social anxiety; Physical wellbeing
To spend more time with my parents everyday (sitting downstairs with them, watching a movie, chatting to them)	Low mood
To meet my friends at the park after school or on the weekends twice a week	Low mood
To visit a shopping centre	Social anxiety

4. The Outcome Rating Scale (ORS) and Child Outcome Rating Scale (CORS) are measures used to monitor childrens', young peoples' and their families' or carers' feedback on therapeutic progress. Measuring overall wellbeing on a 40-point scale, these measures are made up of four equally weighted 10-point sub-scales, designed to assess areas of life functioning known to change following therapeutic intervention: personal or symptom distress; interpersonal well-being; social role; and relationships outside of home. The ORS is designed for adolescents and adults (aged 13+), while CORS is an adapted version of ORS developed for children aged 6–12.
5. Via both measures, we can identify the service users who have made what is known as a 'reliable improvement' and, within this group, those who made a 'reliable recovery'. A 'reliable improvement' is a metric used to determine whether significant change has occurred at an individual level, which is not a result of measurement error. A 'reliable recovery' explores reliable change for those within the clinical range at the start of treatment who then move to the normal range.
6. The GBO has a suggested reliable change index at 2.45 points (i.e. any change in GBO score of magnitude greater than 2.45 points is significant and cannot be attributed to measurement error). The equivalent reliable improvement score for ORS/CORS is 5 points. ORS/CORS also specify cut-off scores between the clinical population and the non-clinical population are different depending on the age of the client (ORS: 28; CORS: 32).

C. Approach

7. We hypothesised that investment in earlier intervention in children's mental health and wellbeing would lead to improvements in outcomes for children and families, and also generate savings to the state. While it is difficult to predict a service user's potential trajectory in the absence of intervention, by making some conservative assumptions we can estimate how much investment this service has saved the state.
8. The analysis uses a cost savings approach which has two main elements:
   i). Factual scenario: the cost of running the intensive family support part of the service.
   ii). Counterfactual scenario: calculating the fiscal, economic and social costs that would have been incurred in the absence of the service, which can be interpreted as cost savings.
9. In calculating the cost associated with working with these users we used the database produced by The Greater Manchester Combined Authority (GMCA) Research Team (formerly New Economy). The unit cost database brings together more than 600 cost estimates in a single place, most of which are derived from Government reports and 16 academic studies.
10. The database gives us the highest level of costs that are incurred by the state for a child or young person facing the highest level of risk for a particular outcome, such as poor mental health. Based on the descriptions of the costs in the database, we have matched these with the most relevant outcomes related to the service.
11. The outcomes we have deemed relevant to this intervention are primarily related to better wellbeing and/or mental health and the associated benefits to different relevant individuals. In addition, we have also chosen other, more indirect, outcomes which relate to better school attendance and entering and sustaining education/employment.
12. Looking at the average score improvement for each outcome for the children and young people the Swindon MHST worked with, we can then provide an estimate of the reduced costs to the state the service achieves. We can then compare the running cost of the service with these fiscal, economic, and social costs if families did not receive any intervention.

E. Assumptions

13. We have assumed that service users who register a 'reliable recovery' across either outcome tool incur the maximum *mental health* related cost saving as calculated by the Manchester cost database. While this is clearly definable for ORS/CORS, there is an absence of a clinical threshold for GBO. As such, we have assumed any improvement equal to two 'reliable improvements' (i.e. any improvement above or equal to 4.90 points) constitutes a 'reliable recovery'. For those who registered a reliable improvement but not a reliable recovery, the mental health-related cost savings have been prorated against the respective tool (i.e. an ORS/CORS improvement of 5 points would constitute 1/8th, or 5 over 40, of the respective cost saving).
14. For the indirect cost savings related to school attendance and education/employment attainment, we assume these are prorated to the full 10-point and 40-point scales, regardless of whether a reliable recovery was observed or not (so a GBO improvement of 5 would incur 50% of the total available cost savings). Furthermore, we do not assume all service users obtain these indirect cost savings. Instead, the proportion that do have been informed by a survey of Swindon MHST practitioners.
15. This survey included 14 Swindon MHST practitioners, who were asked specifically about these outcomes. From this, it was determined that **17%** of their respective case load had an issue with **school attendance/refusal** *and* had improved in this area because of the intervention. Similarly, the survey found that **28%** of service users had an issue with **educational engagement** and had also improved due to the intervention.
16. We have also assumed that a service user who received no intervention would stay at the same outcome risk they were assessed at when they entered the service. Though partly informed by research on similar mental health interventions, this assumption may be conservative as in reality without intervention many could end up at increased risk.
17. Regarding costs, we have estimated the cost of running the service using 2021 cost figures obtained from the Swindon MHST. **Table 2** below gives a breakdown of these, per service user.

Table 2 – Assumed costs

	Per user cost (GBO)	Per user cost (ORS/CORS)
Practitioner cost	£3,936	£3,405
Coordination cost	£844	£730
Total cost	**£4,780**	**£4,135**

E. Results

18. The data used for this analysis refer to 154 closed pair GBO cases and 178 closed pair ORS/CORS cases, both over the April 2019 to December 2021 period.
19. Of the 154 GBO service users, 103 made a 'reliable improvement' with the remaining 51 users either unchanged after the intervention (49) or registering a deterioration (2). Of those that improved, the average start and end scores were 2.4 and 8.1 respectively, thus constituting an average improvement of 5.7 points. As this is greater than the 4.90 threshold set out above, full mental health-related cost savings were attributed to all 103 individuals (**Table 3**).

Table 3 – GBO improvement outcomes

Outcome (beneficiary)	Number of users	Maximum cost saving per user
Improved mental health and wellbeing (NHS)	103	£4,671
Improved child wellbeing (individual)	103	£3,500
Improved family wellbeing (family)	103	£5,167
Reduced persistent truancy (NHS, police & individual)	17	£2,351
Enter & sustain employment, education or training (DWP/ HMT, DH, individual)	29	£19,153

20. For the indirect cost savings related to reduced truancy and sustained education/employment, the proportion of GBO users eligible for these were defined by the survey highlighted in the previous section.

21. For ORS/CORS, we can split the number of 'reliable improvements' into **three categories:**
    i) those who were **non-clinical before and after** the intervention;
    ii) those who were **clinical before the intervention and remained clinical,** despite improving, at the end of the intervention; and
    iii) those who were **clinical beforehand and recovered by the end of the intervention.**

22. Tables 4 & 5 show that there were 38 and 52 'reliable improvements' registered across the ORS and CORS outcome data. Across both, the bulk of these were recoveries (i.e. category iii), at 26 and 33 service users respectively. We assume this group incurs full mental health-related cost savings. All other cost savings are prorated.

Table 4 – ORS improvement outcomes

	Category 1: nonclinical before and after intervention		**Category 2:** clinical before and after intervention		**Category 3:** clinical before intervention and recovered after		**Maximum cost saving per user**
Outcome (beneficiary)	Number of users	Average improvement	Number of users	Average improvement	Number of users	Average improvement	
Improved mental health and wellbeing (NHS)	4	7.3	8	10.1	26	14.2	£4,671
Improved child wellbeing (individual)	4	7.3	8	10.1	26	14.2	£3,500
Improved wellbeing (family)	4	7.3	8	10.1	26	14.2	£5,167
Reduced persistent truancy *(NHS, police and individual)*	1	7.3	1	10.1	4	14.2	£2,351
Enter & sustain employment, education or training *(DWP/HMT, DH, individual)*	1	7.3	2	10.1	7	14.2	£19,153

Table 5 – CORS improvement outcomes

	Category 1: nonclinical before and after intervention		Category 2: clinical before and after intervention		Category 3: clinical before intervention and recovered after		Maximum cost saving per user
Outcome (beneficiary)	Number of users	Average improvement	Number of users	Average improvement	Number of users	Average improvement	
Improved mental health and wellbeing (NHS)	4	5.6	15	10.0	33	12.8	£4,671
Improved child wellbeing (individual)	4	5.6	15	10.0	33	12.8	£3,500
Improved wellbeing (family)	4	5.6	8	10.0	33	33	£5,167
Reduced persistent truancy *(NHS, police and individual)*	1	5.6	3	10.1	6	12.8	£2,351
Enter and sustain employment, education or training *(DWP/HMT, DH, individual)*	1	5.6	4	10.1	9	12.8	£19,153

23. Using the approach, data and assumptions outlined above, the results below were produced, and indicate that for every £1 spent on the MHST service delivers long-term benefits of around £1.90 (**Table 6**). However, we believe the benefits to the state and the wider economy could potentially be much larger. Firstly, the above analysis was conducted based only on the service's one-on-one CBT therapies, which represent one third of the MHST's overall offering. In addition to this, much of the data was gathered during the Covid-19 pandemic and when Swindon MHST practitioners were in training, potentially impacting referral rates and caseload numbers.

	(GBO)	(ORS/CORS)	
Cost per user supported	£4,780	£4,135	
Benefit per user	£11,083	£5,812	**Average**
Benefit-cost ratio (value for money)	**2.3**	**1.4**	**1.9**

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