HOUSE OF COMMONS

Education Committee and Health and Social Care Committee

Oral evidence: Children and Young People's Mental Health, HC 239

Tuesday 16 June 2026

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Watch the meeting

Education Committee members present: Helen Hayes (Chair); Darren Paffey; Rebecca Paul; Manuela Perteghella; Mark Sewards; Peter Swallow; Caroline Voaden.

Health and Social Care Committee members present: Layla Moran (Chair); Jen Craft; Josh Fenton-Glynn; Paulette Hamilton.

Questions 73-154

Witnesses

I: Professor Jo Ellins, Professor of Health Services Research, School of Social Policy and Society, University of Birmingham; Professor Nicholas Mays, Professor of Health Policy, Department of Health Services Research and Policy, London School of Hygiene and Tropical Medicine; and Dr Jessica Mundy, Research Fellow, Department of Health Services Research and Policy, London School of Hygiene and Tropical Medicine.

II: Claire Evans, Deputy Chief Executive Officer, Anna Freud; Morgan Flack, Policy Officer, National Association of Head Teachers; and Catherine Roche, Chief Executive Officer, Place2Be.

Examination of witnesses

Witnesses: Professor Jo Ellins, Professor Nicholas Mays and Dr Jessica Mundy.

Q73 **Chair:** Welcome to this morning's joint Select Committee oral evidence session in our joint inquiry between the Education Committee and the Health and Social Care Committee on children and young people's mental health and wellbeing. This is the second oral evidence session in this important inquiry. I invite our witnesses to introduce themselves to us, starting with Professor Ellins.

Professor Ellins: Hello, I am Jo Ellins. I am a Professor of Health Services Research at the University of Birmingham. I have over 25 years' experience of policy programme evaluations in the health field. Since 2002, I have led two evaluations with my colleague Professor Mays: the first was of the trailblazer mental health support teams, and the current evaluation is a full impact evaluation of the Green Paper programme.

Professor Mays: Hello, I am Nick Mays. I am a Professor of Health Policy at the London School of Hygiene and Tropical Medicine. I have over 40 years' experience of policy evaluation and analysis within Government. As Jo said, I have been co-leading evaluations of the mental health support teams in schools and colleges.

Dr Mundy: Hi, I am Jess Mundy. I am a research fellow at the London School of Hygiene and Tropical Medicine. My background is in mental health research, and I have a PhD from the Institute of Psychiatry at King's College London. For the last two and a half years, I have been working on the evaluation of mental health support teams with Nick and Jo.

Q74 **Chair:** Thank you very much. I will start with some questions on mental health support teams. Could you start by giving us an overview of how effective mental health support teams have been, in your view, in delivering their intended functions to date? What is the evidence that underpins your assessment? We will get into some of the detail a bit further down, so please be high-level in answering this first question.

Professor Mays: I will start and then generally direct traffic left and right. That gives me an opportunity to say that our impact evaluation is in progress. While we are delighted to be in front of this inquiry, we have some of our evidence and, as you saw in the written submission, other work is ongoing. Some of the quantitative effectiveness work looking at the linked data in the national pupil database and the mental health services data in the NHS is in progress, and we will be doing an economic appraisal of the programme.

As a bit of context, most of our evidence today comes from a series of surveys with those who work in MHSTs and those who relate to them in the relevant schools and colleges, and also from work in six carefully

selected and diverse case study sites with different kinds of MHSTs and different populations served. It is work in progress.

On effectiveness, Jess can elaborate more about what our survey suggests, but schools and colleges very much welcome the additional input from MHSTs in their work with individual children and young people, and also to the extent that they are able to do whole school work alongside and with schools. The programme design overall meets the broad expectations. There is very little criticism coming back to us from the frontline about the way that teams are working with groups of schools and so on. In that sense, it is a positive story.

There is a lot of diversity in how MHSTs organise themselves and how they work. We can give factual information about that, if you are interested. Overall, having EMHPs in schools is highly valued.

Dr Mundy: We did a survey in 2024 and 2026. Both surveys were of 1,000 schools that work with a mental health support team, and we are receiving very positive feedback about mental health support teams' work in the support that they provide in the whole school approach, and especially in the advice-giving function, sometimes called function 3. Schools value that advice and having a professional practitioner to go to and get feedback about things they are worried about with children's mental health.

On the whole school approach, mental health support teams are making a real contribution to helping schools plan by doing an audit with schools to understand what activities they might benefit from. Is it helpful to talk about the balance between the functions?

Chair: Yes.

Dr Mundy: What we have found through our work is that function 1, interventions, seem to be prioritised. This has been an enduring pattern from the trailblazer evaluation that Nick and Jo led. We found that most mental health support teams report that they spend 50% or more of their time delivering interventions to children or their parents and carers. Then 25% of time is spent on whole school approach activities and 25% is split between function 3. We are seeing a prioritisation of the first function.

Q75 **Chair:** We have had some evidence that indicates that due to the growing scale and severity of mental health need, mental health support teams are being asked, in practice, to pick up the provision of support for children and young people with moderate to severe needs rather than their intended mild to moderate need cohort. What are your thoughts on that from the evidence that you have?

Professor Ellins: That is absolutely true. We had a specific question in the current survey about how often you accept a referral for children with moderate to severe needs. Jess will correct me if I am wrong but only 4% of respondents said that they always accept those referrals, but the vast majority said that they do accept referrals from that group. The high-

level picture is that MHSTs are providing support to mild to moderate, but they are not fully stretching to cover the gap between what we might call early intervention and CAMHS. We are seeing it being done much more ad hoc.

The question then is, how are they making that decision within the group? It largely depends on what they can provide and the extent that they feel that the interventions and support that they can offer would be suitable and appropriate for that group. That explains why you are seeing some acceptance of referrals but not all. We will come to the skills of the workforce and the extent that they are being trained and are accredited to provide that support, but it creates a challenge for MHSTs.

MHSTs are facing something of a moral dilemma daily of, "Do we hold to that original mild to moderate remit, which is what our frontline workforce is trained for and where we feel we can have the greatest impact if we focus on that group? Or do we stretch to cover the others?" We know that that group, often referred to as the "missing middle", often does not access support elsewhere; there simply are not services for them. That creates a moral dilemma as to how to respond to that.

Chair: That is really helpful.

Q76 **Jen Craft:** This is mainly to Professor Mays and Professor Ellins. Your early evaluation has identified workforce shortages, professional registration and limited career progression as key challenges for mental health support team recruitment and retention. Is the Department currently doing enough to support the recruitment and retention of MHST staff?

Professor Ellins: Can we bring in Jess here for some survey findings? That will illustrate some points brilliantly and then we will come to Nick and me.

Dr Mundy: In 2024, we asked about the difficulty that mental health support teams have in recruiting and retaining different staff members. We asked across all the different roles in a mental health support team. Education mental health practitioners came out as the one where there is difficulty recruiting and then, once they are in post, difficulty keeping them after they finish their training. In the most recent survey that we did a few months ago, 63% of mental health support team respondents said that it had been difficult to fill vacant EMHP roles and this was having an impact on their ability to deliver the service, and 38% said that this difficulty recruiting had been impacting their service to a great extent. The workforce shortages are having a tangible impact.

Q77 **Jen Craft:** Do you have data as to why there is difficulty recruiting and retaining?

Dr Mundy: This has come up in our case study work and in a survey that was done by NHS England in 2022, which shed light on some of the reasons why. Are you asking about recruitment or retaining?

Jen Craft: It would be helpful if you could do both.

Dr Mundy: On retention, we found through our evaluation and case study work that there are very few opportunities for career progression in the education mental health practitioner role. A couple of years ago they brought in the senior wellbeing practitioner role, so after two years of being an education mental health practitioner, you can do part-time training for two years, where you take on supervision roles and more senior responsibilities. That is great, but after that there is little room for further progression. That is a key reason.

Another thing that we have heard is that the training that education mental health practitioners receive, although views were broadly positive, is very different from the reality of doing the job. The training does not prepare education mental health practitioners enough for the complexity of the cases and needs that they are supporting in delivering interventions. Working within schools, doing whole school approach activities and trying to not change the culture of a school but enable a school to develop a positive culture around mental health is a difficult ask of a single practitioner. We have heard from the surveys and the case study work that the training is very light on the whole school approach work.

Q78 **Jen Craft:** Is it that the role is too convoluted? Is doing the whole school approach, interventions and staff training in one role perhaps not ideal? Should it be more of a team-based approach?

Professor Ellins: That is a good question. We are seeing some specialisation or differentiation within teams. We are seeing teams where precisely what you have described is happening. Some of the work—for example, the whole school work—is being led by a different workforce, freeing up EMHPs to focus on interventions. That might make some sense for managing work and being able to deliver interventions to the maximum number of young people.

I want to emphasise that it comes through very strongly in this in-depth case study work that where MHSTs work really well is as a holistic model, where the different functions interact and support one another. To give you a couple of examples, we were told of things that had come out in intervention, in one-to-one support, that identified improvements that could then be made in the school environment to improve mental wellbeing for all children. Another example is where work in function 3, getting advice and seeking help, helped to work out what children were best then referred to MHST support.

There is something about the interconnectedness that seems to make the functions greater than the sum of their parts. There is a risk that if we fragment the workforce, we lose some of that added value.

Q79 **Jen Craft:** I am running over my allotted time but, very briefly, what kind of targeted interventions or further measures—I know we are not

looking for a silver bullet but if there were some real things that the Government could listen to—could be introduced to strengthen recruitment, improve retention, support longer-term career development and bolster the education mental health practitioner role?

Professor Ellins: Jess is spot on that there is a concern at the beginning that the EMHP might be a "stepping stone" role. We see elements of that. We see people coming into the EMHP role who want to progress on to other roles in the psychological workforce. The issue of career development is far more significant. MHSTs are losing EMHPs because they cannot grow and develop in the role in ways that they want to.

Coming back to the original question, we also have a misalignment between the scope of what the service is there for, what EMHPs are trained for and what they are professionally accredited to deliver. Until we get those three things aligned, we will have a situation where EMHPs are coming out of training having been told that they are to going to do one thing, into a workplace environment where they are told on day one that the work will look quite different. EMHPs have said they are told that on day one. We have some real challenges there and addressing that would be the fundamental thing for me.

Q80 **Caroline Voaden:** You have covered some of this in the previous answer, but I would like to talk about the progress that has been made towards national coverage of MHSTs by 2029-30. We know that 47% of primary school and 70% of secondary school pupils are covered, so there is much better coverage at the secondary level. Could you give us an idea of what the main barriers are to achieving coverage?

Professor Mays: As researchers, one group we have not been able to talk to very much is schools that are not involved in the programme, so I will caveat my answer there. There is obviously a question of to what extent the funding will be there for the long term. This may sound a little academic, but there is also the issue of what we mean by coverage. Do we mean geographic? Do we mean having a team in every area? Do we mean every school in each area that has a team being engaged? There will be teams that are working with some of the schools in an area, and they may be gradually accumulating additional schools if they have extra staff. We also know of schools that have dropped out.

One of the barriers and things that we need to understand more about in the final period of the roll-out is why some schools and colleges have not engaged in the programme or are not very actively engaged. As you were hinting, it is clear that in the final stages of the roll-out, to get to 100% coverage, however you define it, you need to be working with and bringing in schools and colleges that are either more specialist or have other reasons why they did not engage in the first place. There could be two ends of the spectrum. On one end, there could be schools and colleges that have an active and well-developed wellbeing mental health programme and have always prioritised that. On the other end, there

could be schools and colleges that are struggling to deal with external requirements and so on.

As evaluators of this particular programme, I do not believe that we have been able to look directly at that. But I suppose it is a simple mathematical thing to say that if the target is to get 100% coverage by 2030, it will be pretty heroic to get there in that time.

Q81 **Caroline Voaden:** You mentioned schools that have dropped out of the programme. Do you have any data on that and why they dropped out? Are you evaluating that?

Dr Mundy: We do not have any specific data, but through our work we have heard about situations where schools have not engaged with the mental health support team. The mental health support team has reached out and offered its service but it is not getting anything back. That could be because the school is under pressure in other areas and cannot prioritise this. We have found that the senior mental health lead role is crucial. The relationship that the mental health support team develops with that role is crucial to the success of the programme. If schools have not prioritised that role, there might be some difficulties in communication. Although it has been rare, there are some situations where the school has dropped out, but we do not have any data on the specific reasons why.

Professor Ellins: The point that Jess raises is crucial. A colleague in the team described it as, "This model is a collaboration, not a referral." This is not just an "IAPT in school" service where you have taken a clinical service and said, "We'll just deliver it in a school setting." It requires something active from the school across all three of those functions. For those schools that have not engaged or that have initially engaged and then disengaged, we need to be thinking about whether it is because of what is being asked of them. Is it not manageable in relation to other demands or do they not have a staff member who has the time to allocate? The time that a senior mental health lead or equivalent role can give seems to be the crucial ingredient to maximising what the school is getting from an MHST.

Q82 **Caroline Voaden**: It sounds quite concerning that there might be schools that just do not have the capacity to do that. Finally, do you think there are any particular groups, areas or settings that should be prioritised for these teams, either geographically or by age or any other group that you think should be a priority?

Professor Ellins: One group that has come out strongly throughout all of the research in the last six years is children with special educational needs, particularly children who are neurodivergent. We hear from MHSTs that a lot of the referrals that they are receiving are for children with mental health issues who also have special educational needs. We hear concerns from schools and MHSTs themselves that they do not always feel equipped to provide support to those groups effectively. That

might be partly an issue of having the training to work with those groups and partly what can they offer, what interventions they have and whether they are suitable.

If you look at the most recent Department for Education figures, we know that the roll-out in special schools and alternative provision is lower than in mainstream settings. If 100% coverage is defined by coverage of all schools, we know that there are a lot of schools in those categories in particular that MHSTs will have to start establishing working relationships with. That is one of the groups where the attention is crucial. We also know that that is a group where there is a huge overlap with persistent absence. The impacts of mental health on school engagement and learning is particularly strong for that group. I would want to see some focus there.

Q83 **Caroline Voaden:** Have you noticed any pattern between urban and rural areas?

Dr Mundy: A challenge that we have heard in rural areas especially is the distance that EMHPs have to travel between the schools. That can take up a lot of their time. That could potentially be one barrier. Something else I wanted to mention was that we have heard through our research that the uneven roll-out has made it a little difficult for mental health support teams to promote themselves and to promote their service in their area, because not all schools have access to the service. That has meant that they are a little hesitant about putting themselves out there because it could lead to schools asking if they can access that service, and it would have to be a no. Thinking about how mental health support teams are integrated with other children and young people's services for the 100% roll-out will be beneficial.

Q84 **Caroline Voaden:** I do not understand, why would it have to be a no in some cases?

Dr Mundy: The way that the roll-out works—and we are on wave 12 at the moment—is that each time new funding and new teams are created or expanded, they work with a new set of schools. They have a set of schools that they then work with and that gets bigger, but it is not all schools. None of the areas that we worked with is working with all schools in their catchment area.

Professor Mays: That is a capacity issue for the MHST. There is a rule of thumb of how many students could you possibly work with in how many schools. You could argue that it is a great investment, but it is quite thinly spread. I think Jess was saying there is an average of 17 schools and colleges per MHST.

Dr Mundy: In our survey research, we asked EMHPs how many schools they are working with, and the range was huge. Some people selected up to 35 schools. That was rare.

Q85 **Chair:** How many people in a mental health support team would be

covering those 17 or 35 schools?

Dr Mundy: We asked EMHPs, "How many schools does your mental health support team cover?" and the most common was four to seven, but the range was huge, so it went up to 35 schools.

Q86 **Chair:** How many staff are covering that number of schools? How many professionals cover that number of schools?

Dr Mundy: That is one.

Chair: Just one?

Dr Mundy: Yes, sorry. The question is about them personally—how many schools do they work with.

Q87 **Darren Paffey:** In your view, what role should the mental health support teams play to support children and young people while they are waiting to access more specialist services?

Professor Ellins: It is a good question. We know that a lot of mental health support teams are doing that already. That may be case by case rather than saying, "We wholly provide support to children on CAMHS waiting lists," for example.

It is almost about taking a step back with this question. For a child waiting for support from a specialist mental health service, it is thinking about what kind of interim support would be helpful and valued, and what are the risks around that, and then also thinking about whether the mental health support teams are the right service to provide that.

It comes back to the issue of professional training and registration. The educational mental health practitioners are registered and accredited only to provide support to children with mild to moderate mental health issues, for specific conditions. The vast majority of frontline delivery is provided by EMHPs. You have a bit of a mismatch here when thinking about CAMHS or children on developmental pathways in that they need support but they sit in a category that EMHPs have not been trained in and are not accredited to provide support to. We know that down on the ground, responses vary substantially between MHSTs as to whether that support is provided and who it is provided by. EMHPs are providing some of that support but that is outside the scope of their training and professional regulation at the moment.

Q88 **Darren Paffey:** We are seeing that the degree of integration between those services, and presumably the waiting times, vary hugely across different parts of the country. Is there any work going on to deal with or mitigate that in the meantime? Are decision-makers aware of those disparities and what is happening to the roles that you have just described, where they are being stretched beyond what they were designed for?

Professor Ellins: It is known. For me, there is a fundamental question. We talk about this group called the "missing middle", as I have mentioned, which sits between early intervention, that MHSTs were originally set up for, and what CAMHS support. We know that the policy position is that MHSTs can flex to move into that group and all are, to some extent. None is fully covering it. We do not understand the size and scale of what we are talking about here with that group. We need proper research to say how many children we are talking about.

One slightly rough and ready estimate from last year was the British Association for Counselling and Psychotherapy who suggested that group is at least 730,000 every year. They based that on how many referrals are made to CAMHS that are either closed without any contact or closed after one contact. That is probably a conservative assessment of how many children sit in that. We are talking about at least possibly 750,000.

We also need to understand the mental health issues and other issues that those children are experiencing so we can make a proper assessment as to whether MHSTs have the right training and sufficient resource to be able to address that. To ask them to flex to cover an unknown group that we do not understand the size, scale and nature of is not a long-term sustainable strategy for responding to mental health needs in children.

Q89 **Darren Paffey:** For clarity, your estimate is that between 750,000 and 1 million young people constitute the "missing middle"?

Professor Ellins: I do not have a figure, and that is the work that sorely needs to be done. As I said, if we assumed that we could assess that gap just on the basis of how many children are referred to CAMHS but those referrals are rejected, it would be 730,000 a year at the moment, but there will be children who are not being referred to CAMHS who sit in that group as well.

Q90 **Darren Paffey:** Very finally and quickly, are there any plans at the moment to conduct the research that you have just identified as a gap?

Professor Ellins: I am not aware of that.

Dr Mundy: No.

Q91 **Layla Moran:** I have so many questions. I promise I will not take too much time. If we can just zoom out for a moment, my questions will focus fundamentally on integrations, so early support hubs, Young Futures hubs and so on. We are doing this joint inquiry because it is spanning DHSC and the Department for Education but, as you know, Young Futures hubs are actually based in DCMS. In reality, how is this landscape governed? Where are the funding flows to decide what schools get a mental health support team versus what areas might have an early support hub versus what areas will have a Young Futures hub? From your perspective, as people who are navigating this space, can you help us to understand? If the idea is that all of these services are integrated across

three Government Departments, a laudable idea, where in reality does the governance and decision-making sit? Can anyone help me?

Professor Mays: Not really. This is one of the problems of undertaking a piece of research that was commissioned two and a half years ago, when some of the things you just mentioned did not exist and there was a different Government. The way that the commission was articulated as following the Green Paper programme, which at that time was dominated by the delivery and development of MHSTs, means that we are not looking at the local mental health and educational wellbeing support system, sadly. In a way, I cannot really tell you about that.

All we can say a little bit about is that the early support hubs and Young Futures hubs are not mentioned by the people we talked to. That is probably explicable because of their recency, relatively small numbers, where they are in the country and so on. NHS England would be able to explain how resources were allocated, how areas were chosen and then how schools and colleges were approached for each wave of the Green Paper programme. In the early waves, our understanding was that the priority should be given to schools and colleges serving more disadvantaged communities. What we saw was quite a broad range of different settings, populations and kinds of school, which perhaps for researchers was not a bad thing.

Q92 **Layla Moran:** Focusing on mental health support teams, as that is your expertise, there was a common pot between the two Departments. Is that where the money came from?

Professor Mays: No. MHST funding is NHS funding exclusively.

Q93 **Layla Moran:** It is just NHS funding?

Professor Mays: Yes.

Q94 **Layla Moran:** That was presumably flowed through the ICBs?

Professor Mays: That did not exist.

Q95 **Layla Moran:** That did not exist, but currently funding is flowing through the ICBs?

Professor Mays: Very recently.

Q96 **Layla Moran:** So it is the ICB that decides what teams get to grow and what teams do not, and so on?

Professor Mays: Yes, but their engagement and involvement in that, inevitably because of the amount of structural change in the NHS, is quite recent so we do not have much to add to all of this.

Q97 **Layla Moran:** This is what I am trying to get to. We have a lot of turmoil going on in this space currently. I appreciate your research is long standing and this is much more recent, but are you getting a sense of any impact on these teams as a result of the turmoil?

Professor Mays: No, because we are studying the teams that already exist. We should have made clear that our evaluation covers the trailblazers and up to wave 6, not because we are uninterested in what is happening with new teams beyond that but principally because we wanted to be able to look at outcomes, impacts and costs. At the time we were commissioned, our judgment was that if we went beyond wave 6, it would all be far too recent and it would not be possible to look at the impact on things like school attendance or mental health outcomes in out years, for example. We are looking principally at the MHSTs set up, up to wave 6, that are mature and in place. So far, as far as we are aware, they have not been defunded, relegated or altered by the system change around them.

Q98 **Layla Moran:** The key point is that when we talk about integration with early support hubs and so on, they just do not get mentioned. That is interesting in itself. Perhaps unsurprisingly, I went to visit one in Devon and the vast majority of young people there were there because they felt, in their words, that school had failed them. A lot of them were neurodivergent. One said they walked past it on the street and were able to go in, and it saved their life—that is what they told me. It was deeply moving, but also a suggestion that mental health support teams in schools are not the only answer. I am slightly concerned that they are not integrating, or at least from your perspective you have not seen any evidence of integration.

Professor Mays: I will make one comment generally about research in health and social care and the way it is commissioned. I am biting the hand that has fed me for four decades, but there is a tendency when a new programme is set up to say we must do an evaluation. We commission an evaluation of that programme and then say it has to look at effectiveness and cost. That means it has to be continued for several years. During that time, inevitably, Government and others produce new schemes and no one actually looks at the systemic impact. It is not easy methodologically, but it is possible.

Again, we are looking at the MHST bit of the terrain and we are aware that it is being impinged upon and to some extent supported by other things that are going on, but we are not able to look at those directly.

Q99 **Layla Moran:** Would system-level research be helpful?

Professor Mays: Yes, it would, particularly when we are changing that environment the whole time and adding new schemes in. There is a big risk when we think of mental health support teams, early support hubs, Young Futures hubs, that just the words will mean very little to parents and children and even to us as people working in the field. What is the difference? If you were asking me to give the exam answer, I am not sure I would be able to easily summarise that. It is quite complicated to have these different schemes that all presumably have a good rationale. This is just a plea for more systemic research and slightly less that is programme specific because your questions are difficult for us to answer.

Q100 **Paulette Hamilton:** Good morning. My questions will be based around what happens within education departments or sections relating to MHST teams. Some of the research I have read talked about the data provided by the Department for Education in 2017, which states only 18% of education settings nationally were offering CBT to pupils. A national evaluation was done in 2025 that showed that the most frequently selected intervention by MHST was low-intensity CBT. My first question to you is: what do you feel are the challenges that the MHST teams face in embedding the whole school approach to mental health? I want you to take on board that within this, you have people who are LGBT, who are from ethnic minorities where English is not their first language, and others who this just is not reaching at all at the moment.

Professor Ellins: I will focus on the whole school approach. To take a step back a minute, the original Green Paper intention was to improve early interventions and to improve mental wellbeing for all children. That was the right intention—prevention and intervention—and MHSTs have been designed with the three functions that span that. As we have talked about, those three functions and the integration between them is crucial. A point I will make, which I am sure others will make in their evidence, is that for some children, school is a great place to be. It is a very safe and positive place to be. For other children, it is not.

When we talk about whole school approaches, we might be talking about mental health awareness or literacy activities, and we know that MHSTs are doing a lot of that work. The fundamentally important things that we are talking about here are school policies, practices, interactions, relationships and environments. MHSTs can influence and help to motivate, encourage and influence that work, but they cannot do that work for a school. The work of improving a school culture or changing school practices has to be led and done by schools.

When we talk about embedding whole school approaches, we have to think about what schools bring to this. We are hearing from schools that they get value from MHSTs. They get support to do audits and assessments to understand where they are currently and what they might do around improvements. They get some literacy awareness activities for parents, children and sometimes staff. But when we think about changing the behaviour policy, that is for the school to do. It is again about the school's commitment and resourcing, and what the school brings. We know that schools lack time and that senior mental health leads struggle to allocate time to that role and to the work involved in that role.

We know that not all headteachers and SLTs see mental health as a core responsibility for schools or that they should be prioritising it. We know that there is a lot of turnover in the key roles. We have talked about turnover of EMHPs and senior mental health leads. We also know that the wider policy environment is not helping. An environment that encourages or asks schools to fine for non-attendance is not an approach that is well aligned to a mental health approach.

Q101 **Paulette Hamilton:** Let me stop you there, because I have heard a lot of negatives. Before I bring in the other two witnesses in, I will give you a little challenge. What would you tell me to say to schools that are under the cosh? They have all these different types of young people; they need this support and they are struggling to get it. Give me three things that you would suggest the school should do to help address all the challenges you have just laid out to me.

Professor Ellins: The first place I would start is their behaviour policy and approach. If a school really wants to be a mentally healthy environment for children to be and learn in, they need to think about how they tackle behaviour. If a school takes a punitive, reactive, sanctions-based approach, the risk is that if there is an underlying mental health condition, or if the child has, for example, neurodiversity that is not identified, it will be punishing a behaviour that, ultimately, we could be identifying and dealing with at source. Children talk about this in the research; they feel that injustice. That is where I would ask schools to start. To think about how they tackle behaviour and attendance would be the crucial ones.

Q102 **Paulette Hamilton:** Can I bring in Professor Mays; do you want to add anything to that?

Professor Mays: No. It is a very normative question, from my point of view; I am, sadly, taking a rather empirical approach to this. We are in midstream for some of our research on this, so I have nothing to add.

Dr Mundy: I just want to mention that from what we have heard from EMHPs about their work with the whole school approach, they broadly enjoy doing it—they want to do it and see a lot of value in what it brings to the school—but the need for direct interventions is so high in some schools that they prioritise delivering that direct support to the children, and the whole school approach can slightly slip off the radar. As Jo was saying, that is where the relationship with the school and the school's contribution and motivation to bring in whole school approaches are so crucial.

Again, the senior mental health lead role and that relationship is so important. We found that just over 30% of senior mental health leads who we surveyed do not have protected time for that role. That is even higher in primary schools, where nearly half of the senior mental health leads we surveyed did not have protected time.

Q103 **Paulette Hamilton:** I am not sure about time, but my last question is, if you were a headteacher or somebody trying to create this in a school environment, what would you prefer: the whole school approach or the direct intervention as a young person needs it?

Dr Mundy: I don't think it can be one or the other.

Professor Ellins: It is about looking at the child in the systemic context. If you have a child who is experiencing mental health issues and those

issues are in any way connected to what is happening in the school environment—and we know that for some children they are; they might be caused or exacerbated by what is happening in the school environment—and all you are providing to the child is an intervention and then putting them back into a school environment that is worsening their mental health, your intervention either will have a very limited impact or will not be sustained. The two have to be seen as part of the same solution. It is not either thinking about interventions or thinking about the environment they are in and learning; it has to be thinking about both together.

Q104 **Layla Moran:** To drill down into CBT, the national evaluation that was published in July 2025 found that 97% of interventions were low level. Have I misunderstood that? The most frequently selected interventions used by MHST were low-intensity CBT. That is 97%, which is a huge percentage. There has been concern that some groups, in particular those with special needs, minority communities, and children who have come from adverse childhood experiences or who have socioeconomic factors such as poverty or domestic abuse, are not well served by that intervention. What it is about those groups that means they are not suited to CBT and what is more appropriate for those groups?

Dr Mundy: Mental health support teams are set up to deliver low-intensity cognitive behavioural therapy. It is not hugely surprising that that was the most commonly selected mode of delivering an intervention. You are right that what we found through our research is that there are certain groups of children who the practitioners feel that CBT does not suit. For children with special educational needs and who are neurodivergent, cognitive behavioural therapy involves a lot of thinking and talking about your emotions, and engaging with and accessing them, which some children with those additional needs find more difficult.

We have also heard that the CBT that EMHPs are trained in is very manualised in the types of activities that they might do in the interventions and the number of sessions that they can offer.

Q105 **Layla Moran:** Can you paint a picture for us? If you are a child who does not have those backgrounds, you are presenting and they think you need low-intensity CBT, how many sessions would you typically get? What might it look like?

Dr Mundy: Usually six to eight sessions.

Layla Moran: Six to eight?

Dr Mundy: Yes.

Q106 **Layla Moran:** The practitioner will have, as you say, a manual in front of them leading them through the activities?

Dr Mundy: Not so much a manual in front of them, but they will have been taught a specific way to deliver the interventions. We are hearing

that MHSTs are making some adaptations to the way that they deliver interventions. That is brilliant. Jo, do you want to talk about SEND and MHST?

Professor Ellins: Yes. We have seen a lot of evolution of the workforce since the first teams went live in 2020. MHSTs are acutely aware that what they were originally set up to offer does not meet all children's needs. For example, an intervention that is about thinking about maladaptive thinking may not be the right thing for a child experiencing mental health problems related to adverse family or social circumstances.

Q107 **Layla Moran:** Is it dangerous? Would you go so far as to say that?

Professor Ellins: It can be. This comes back to the moral dilemma for an MHST that they often feel pressure from schools, fully understandably, to provide support for children in the setting who are experiencing mental health issues, but they have this help/harm boundary that they are trying to straddle. They want to help where they can and where they feel they have skills, but they do not want to do harm, and there is a risk that sometimes, providing something like CBT could do harm or could not fully understand the child's mental health needs—for example if a child is waiting for a CAMHS assessment where there has not been a full assessment yet.

We have seen lots of evolution of the workforce. In the six case study sites, we have seen MHSTs recruit different kinds of roles. They have brought in mental health nurses with specialisms in neurodiversity or SEND or in working with specific groups. We know that there are at least three specialist SEND MHSTs in the country. We know one particularly well. Those are teams where they deliver interventions in special schools, but they also support other MHSTs in their region to support children with SEND in mainstream settings.

Q108 **Layla Moran:** Was that set up by design or by accident?

Professor Ellins: That particular one was set up by design. I can't speak about the other two. MHSTs are really aware of and are trying to evolve within those constraints. They are trying to evolve to be able to better meet young people's needs. The professional registration is a bit of a challenge though.

If I can share what one senior MHST clinical lead said to us, they said, "I can't respond to local needs at the moment." They have identified through their work that quite a lot of young people in this area are experiencing obsessive compulsive disorder and those symptoms, but EMHPs are not trained for that in their initial training. What that clinical lead cannot do, because of the EMHPs' professional registration, is support them to have additional CPD and additional training so they can deliver support to those groups, because they cannot include that on their professional registration. EMHPs cannot be registered to do that because it is outside of scope. Her frustration is, "I cannot develop my

team and their skills to better meet local needs because of these constraints."

Q109 **Layla Moran:** That is helpful for us to pursue. Are the teams that are trying to meet all needs effectively going to have to wait until someone leaves and then replace them with someone with different skills? Is that how they are managing that, or are they just not providing the right services?

Professor Ellins: I don't know. They are working within a limited budget and I would assume that to be the case, but I don't know specifically.

Q110 **Jen Craft:** That leads nicely on to my question. I imagine that the young people with obsessive compulsive disorder, for example, fall within that "missing middle" that we have been speaking about quite a lot. Professor Ellins, you said you would not want to see a broadening of the scope of mental health support teams to potentially capture that "missing middle". Where do you think support for that should come from?

Professor Ellins: I am not sure. We should not see MHSTs broadening scope, but my very clear position is that if we are talking about there being a bit of a service gap between early intervention and CAMHS, we need to understand the nature and size of that gap, and what children are not being supported, before we think about what services would be best to cover it. MHSTs potentially could be part of the thinking about how we address those service gaps, but if we ask them to do that work without addressing the question of their training, or without additional resource, they will only ever be able to do so much.

The issue of resource is fundamental. If those service gaps are of the order that we were discussing earlier, 750,000 children, the only way that MHSTs will be able to stretch to provide support is for there to be an opportunity cost—something will have to give. MHSTs talk about their concern that what will give is the whole school support—that preventive focused work.

Q111 **Jen Craft:** Does it change the whole focus and purpose of MHSTs to then look at that "missing middle" group?

Professor Ellins: That is a really good question. One person said to us in interview that they do not want to become a mini CAMHS—they do not want to become a variant of CAMHS. There is something for MHSTs, and I get the sense that they feel that their distinctiveness and something about the real value of their contribution is the early intervention. It is that upstream work. I have been quite surprised by how much they have embraced that work, and particularly the whole school work. They really do want to do that and can see the potential value of that work. It would possibly change the character, but I do not know for sure.

Professor Mays: There is one aspect of this, particularly in the current debate about medicalisation of life challenges and so on, that the culture of the MHST culture, in so far as there is a culture, is to avoid

medicalising. Partly because of the nature of their training, they do not make formal psychiatric and medical diagnoses. Again, because of this orientation in the Green Paper and throughout, for early intervention, families and children do not have to exaggerate or seek a formal diagnostic label to be engaged with an MHST. The MHST people who we have talked to see that as a positive value. At some point it might be necessary in the experience of a family or a child to have a formal diagnosis, and then they would be put on a different pathway.

Q112 **Jen Craft:** Does that feel like there are two separate things, an acknowledgement of a medical condition versus dealing with underlying mental ill health or mental wellbeing issues, and they perhaps should be looked at in a different cultural context? If you have a support team in a school, perhaps it is not best set up to deal with what might be a complex or lifelong medical condition.

Professor Ellins: This is where integration is crucial. We have effectively seen in some MHSTs—for example, where MHSTs are provided by the CAMHS provider, so they are in the same organisation—an almost step-up type model working so that there is a relatively seamless transfer of some children. Where an MHST have made the first contact, their assessment is that it is an early intervention, but because they work closely with CAMHS, as they are part of the same organisation, they have been able to make this immediate internal referral on to CAMHS so that the child does not have to come out of the referral and start that process all over again. Something like that could work really well, where the MHSTs become more closely fully embedded with other services. A lot are, but not consistently so.

Dr Mundy: To add to that, we have heard something really positive about having an MHST within CAMHS, as Jo described, where the mental health support team sometimes attended MDT meetings with the CAMHS practitioners. They were then able to ask advice from the CAMHS practitioners and say, "There is this child or young person. This is the presenting need. What do you think? Do you think it is for CAMHS? Do you think it is for us? How could we support them in school?" There was that nice sharing of skills and expertise between the two teams.

Q113 **Jen Craft:** You said that happens sometimes, but it is not a consistent approach?

Dr Mundy: It is not consistent. There are some MHSTs where the provider is also the CAMHS provider, but that is definitely not true of all. Some MHSTs are provided by voluntary sector services and local authorities where—

Q114 **Jen Craft:** They are actually having that integration. A few of you have mentioned having a systemic approach, and that "missing middle" is one example of where that could really bear fruit, so it does not fall through the gap. Is there any evidence or research on the comparative impact of people in this "missing middle" not getting the right support, versus

people who have lower mental health or wellbeing needs?

I will just give you a very personal example. I was diagnosed with obsessive compulsive disorder at the age of 13 or 14, and I very much fell through the gaps. I did not have any support given by the local NHS and I went on to develop bipolar disorder. I have had struggles with my mental ill health my entire life. Perhaps the impact on me of not receiving that kind of support early on in life was more than if it had been about not receiving a comparative kind of support to address anxiety or issues around that. Is there any research around that comparative impact and where resource might be best focused?

Professor Mays: I am sure there is.

Professor Ellins: I am sure there is, yes.

Professor Mays: It is not something I am familiar with.

Dr Mundy: No, but it is true that the longer the person experiences mental health issues, the more difficult they are to treat, so that is why the early intervention is so crucial—identifying the problem and providing appropriate support as soon as possible.

There are top-up trainings that we have heard about for EMHPs to address some of the gaps but, as Jo said earlier, that has created an issue with their registration. That needs to be addressed so if they are developing new skills and expertise, they are able to apply them safely.

Chair: I need to move us on to the final question now.

Q115 **Manuela Perteghella:** We have talked a lot about mental health support teams and also, Professor Ellins, you have told us about the challenges in school settings, whether that is about protected time for practitioners or a revision of behaviour and attendance policies by schools. MHSTs are only one part of what we know is a very complex picture of prevention, early intervention, support for children in crisis and support in mental health. What other changes are needed and, most importantly, what would the panel prioritise?

Professor Ellins: I come back to the question of schools being mentally healthy places for children to be and for them to learn in, and what is needed within the schools. They are struggling to prioritise mental health among a raft of competing priorities. While in some ways mental health is a statutory responsibility, because it is embedded in safeguarding on the one hand and in SEND on the other, the focus in safeguarding is often on child protection work, and SEND is a very complex and diverse category, so mental health is perhaps not getting the priority and focus as a specific issue that it should.

We need to think about the investment in schools. If you look at the investment in the Green Paper programme, the overwhelming majority, 95%, went through the NHS route to the creation of MHSTs and a tiny fraction went to schools for the senior mental health leads training, which

was time-limited and does not exist any more. We must think about the investment that schools need to make the changes to become truly mentally healthy places for children to be. They need support, they need time and, I would argue, they need investment to do that properly and sustainably.

Professor Mays: How could I add to that?

Dr Mundy: I was going to say something very similar about investment in schools and supporting schools to do what they need to do to work effectively with the mental health support team and create mentally healthy schools. We had very positive feedback on the training grants. That was funded by the Department for Education but stopped in 2024. We have heard from mental health leads that they would like further training and they would like top-up training, regular training, so that they can stay on top of the policy landscape, but also for other skills that they can bring into their school and then spread to the other staff members. I think that is key.

Chair: Thank you very much. That brings us to the end of our first panel. If there is anything that you could not get across to us in the time that we had available, please do write to the Committees afterwards. We welcome any further evidence. Thank you very much for taking the time to be with us this morning. We will suspend the broadcast and change over to our second panel as quickly as we can.

Examination of witnesses

Witnesses: Claire Evans, Morgan Flack and Catherine Roche.

Q116 **Chair:** Welcome back to the second panel of witnesses in our oral evidence session on children and young people's mental health. I invite our witnesses to introduce themselves to the Committees, please, starting with Morgan Flack.

Morgan Flack: Thank you for inviting us today. I am Morgan Flack. I am a Policy Officer from the National Association of Head Teachers. We represent 38,000 serving school leaders from heads to deputies and assistants as well as other leadership roles within schools, and that is across all phases of education and all school types.

Catherine Roche: Good morning. I am Catherine Roche, Chief Executive of Place2Be. We are a voluntary sector organisation that has been providing school-based mental health services for over 30 years and training child mental health professionals, specialising in working with children and young people.

Claire Evans: Good morning. Thanks for inviting me. I am Claire. I am Deputy CEO of Anna Freud, which is a mental health charity for children, young people and families. I am a systemic psychotherapist by background. I used to run a third sector CAMHS. It was very interesting listening to the panel earlier because part of my role at Anna Freud, in

partnership with UCL, is overseeing the national workforce programmes, which includes the EMHP, CWP and SWP programmes.

Q117 **Chair:** Thank you very much. I will begin our questioning. In your view, what are the main factors driving the growth in prevalence and complexity of mental health needs among children and young people? Who would like to start with that?

Catherine Roche: I am delighted to kick off. I think you heard last week from Abigail Ampofo at YoungMinds about children and young people facing a million pressures. I would go along with that, whether that is about academic pressures, poverty or thinking about longer-term careers and needs, which we are hearing so much about right now, along with social media and the wider world and what is happening on a global scale. It feels like a pressurised environment, and I know we hear from the young people who access support through Place2Be about anxiety, depression and so many of these challenges.

You also have things such as lack of sleep, the pressure of social media, and bullying, so it is a whole host of things. Also, young people feel they are in an increasingly isolated, individualistic society with a lack of connection with other young people and a lack of spaces where they can do more together, which also adds to that pressure.

Morgan Flack: Our members would echo a lot of what Catherine has just said. Our members tell us that there are a lot of factors outside of the school environment that they are aware of. That is things such as the impact of the cost of living crisis. Our members now have to do things such as run food banks, wash clothes and provide support with housing-related queries. All of this creates a picture of the unstable environment in which children are growing up and that affects their mental health and wellbeing.

The online environment is a big issue. Our members tell us about a lot of issues that are happening, often outside of school, because schools do not tend to allow phones. That is things such as large-scale bullying, particularly on messaging services, but also exposure to harmful or discriminatory content.

There is also an element around the policies that shape school systems. I think we will probably touch on those in a bit more detail later, but just to give you the topline, things that can exacerbate poor mental health and wellbeing are things such as the sheer amount of curriculum content and the exam and assessment systems. That is across primary and secondary phases.

The final point I will make before I pass over is that our members are telling us about the system overall being in crisis. When they see an issue at the early stage with some of these pupils and they try to reach out for support, they are not necessarily able to access things at that point, which allows problems to escalate and worsen.

Claire Evans: I agree with what Morgan and Catherine have said. I will also say that the global context at the moment is a very frightening place for adults, and now children are having to hold adult worries at the same time. Childhood should be a time to play, to take risks, to discover yourself, to make relationships with others and to find your place in the world. Instead they are carrying all these worries and anxieties.

We have heard a lot about mental health support teams this morning. That is a small part of helping children and young people, but we keep having the same conversation. At Anna Freud, we are calling for a radical change in how we do things. We cannot keep offering piecemeal support. We need a radical shift in how we offer help or we will continue to have high levels of children and young people in great distress.

Q118 **Chair:** Thank you. We will get into some of the detail around what needs to change a bit further down the line. How are the increasing problems and complexity, and all the pressures that you have talked about, impacting on learning, development and engagement within education settings? I am thinking particularly about issues such as absence and so forth.

Morgan Flack: Of course this increase in prevalence is having a direct impact on pupils, and our members are telling us that they can see the resulting consequences in lower levels of attendance and struggles with engagement in learning. More indirectly, it also has an impact on the staff in the school's operations because it is taking up additional capacity. We have heard a bit about where some of those capacity issues are already this morning, but the level of support that is required for staff to then support these pupils creates a challenge. That challenge then also indirectly affects pupils and we have seen some of those consequences.

It is worth remembering at this point what is within the schools' remit to deliver and how they can support these pupils. They can contribute to promoting good mental health and emotional wellbeing among all their pupils. They absolutely play a part in emerging mental health issues and then referring those pupils on to access specialist support or early intervention, as is deemed appropriate.

Schools do, of course, support and manage the pupils with their mental health in the context of the teaching and learning elements, and try to create an environment in which pupils feel comfortable coming to school and developing really good relationships with the adults there. But it might be worth bearing in mind that it is not within the role of education staff to deliver any kind of early intervention or particular targeted support in that way. It is not within their skillset or qualifications, and that is where we are seeing some of the struggles.

Q119 **Chair:** Catherine, what are you seeing in schools?

Catherine Roche: I think poor mental health really impacts and is communicated through children's behaviour. Some children will withdraw

and you might start to see that then through lack of attendance or lack of engagement in school. For others, you might see it through acting out or disruptive behaviour. That can go from low-level disruption in the classroom right through to school exclusions and ultimately the downward spiral from that. It comes through in children's behaviour and then plays out in how well a child can be in school, how they take on board learning, and their capacity to make friends and connections with others.

Q120 **Chair:** Claire, do you have anything to add?

Claire Evans: I agree with what has been said. One thing that comes across really clearly is that if children do not feel that they belong within the education setting, they struggle to make the best of their education or even to attend. We know that school non-attendance rates were standing at about 19%; they dropped a little bit to 18%, which is progress, post the pandemic. I know that part of the SEND review will be about looking at this but neurodiverse children in particular talk of a sense of not belonging and not fitting in in school, and they talk of really struggling to attend. I think that factor, and how we help children to belong within a school setting, is really important.

Q121 **Manuela Perteghella:** I was a school governor of a small rural primary school for many years and I experienced the hugely important role that school settings play in noticing those difficulties and any decline in mental wellbeing. We also have evidence that suggests the mental health provision in schools is patchy, inconsistent and often insufficient. Can I have your views and assessment of that, please?

Catherine Roche: It is certainly patchy. The mental health support teams are part of the system, and it is good to see some investment and a recognition of schools as a place where you can reach people early, but the measure of coverage is an interesting one. I think you heard earlier about the scale that a single practitioner with a relatively low level of training is expected to cover, with the huge breadth that is in front of them.

Provision is patchy and I think it needs development, and that is where there are many local organisations, including voluntary sector organisations, that provide or play a part in that role. School staff also play a part in that role. Skilled pastoral staff can do a lot but it is also about combining it with more specialist mental health expertise.

Morgan Flack: "Inconsistent" and "insufficient" are terms that absolutely resonate with our members and some of them really struggle to access support even if they are part of MHST, as we heard earlier, because the coverage is so wide. Fundamentally it is clear that access to external specialist support is still a bit of a postcode lottery, when the access to provision of children's mental health services needs to be much more consistent. Our members keep telling us that all their children and young people deserve access to timely, high-quality support when they need it.

It is just that they cannot always access it and I think that is where the struggle is.

Claire Evans: I want to advocate for mental health support teams. As one of the education providers, it is wonderful to see young people entering the mental health workforce. When I listened to one of the Committees from last week I heard Dame Rachel de Souza, the Children's Commissioner, make a plea about the lack of outcomes data from CAMHS. We do have a lot of outcomes data for the CWP and EMHP programme. Since 2017 we have tracked 26,000 interventions and we found that between half and two thirds of all the young people who received an intervention showed a reliable improvement. That is on par with adult IAPT low-intensity provision, so that means mental health support teams can be incredibly helpful to a lot of the young people they work with.

However there are also, as Catherine has intimated, other provisions that might be working alongside mental health support teams or covering schools that do not have a mental health support team. When we hear that there is 50% coverage with mental health support teams, it could be that they are in a school as little as two to three hours a week. Of course their priority will be the one-to-one work, because that is what the education staff are raising with them. They could be doing a lot more.

Sitting on the curriculum groups, I know a lot of thinking has gone into this. The senior wellbeing practitioner programme looks at elements such as neurodiversity; enhances clinical skills, working with OCD; and trains supervisory skills, but it is not enough, and even though those practitioners provide a good intervention, we need more of them. We need a greater expansion in their training but we also need to accept that we need to address the "missing middle" that is not met by CAMHS.

Q122 **Layla Moran:** I will come back to the roll-out—the ideal of the full coverage by 2029-30. Out of 10, what are the chances that we will get to 100% coverage of every school by 2029-30 if we keep going at the current rate?

Catherine Roche: I go back to the word "coverage".

Layla Moran: Yes, what does that mean?

Catherine Roche: It is such a thin spreading. If you have two to three hours in a secondary school of 1,500 pupils, with all the complexity and the range of children's needs in there, what impact can that practitioner have in trying to deliver a whole school approach and targeted work when a session is 50 minutes? You will see probably two, maybe three, students in a giant secondary school. The mental health support team roll-out in its current guise is never going to meet the needs of children and young people.

Q123 **Layla Moran:** Even in its current guise, what are the chances we will get

that minimal coverage by 2029-30 in your view?

Catherine Roche: We hear from schools about the turnover as well, and some of the schools do not engage because there is such a turnover of people or because it takes time for people to—

Q124 **Layla Moran:** So what are the challenges then? The workforce is one we have heard a lot about already. Are there others?

Catherine Roche: It is about the value that the school will get from the investment that is required for a busy, stretched education leader to engage with an external party who is coming in and to get that to work well so that it helps to deliver value in the school. It is a big investment of somebody's time.

Q125 **Layla Moran:** Do you think that the lack of the mental health support leads who did exist has a negative impact on the ability to do that?

Catherine Roche: Yes, because you do not have the person within the school who can make the most of the time of the team's work coming in. We strongly advocate for an integrated, embedded practitioner. If that person has even a day a week to be part of, and consistently part of, the school community so that they are known within that community, you can start to see that drip feed, whether it is at the leadership level or the policies, as well as doing some targeted work.

Q126 **Layla Moran:** Do you have any sense currently of how many practitioners work like that as opposed to in a much more peripatetic way?

Catherine Roche: I would say virtually none. If anything, with the goal of coverage, I have examples of areas where the teams are being pulled into a more NHS-oriented focus, based on a single point of access, and have become more treatment-oriented.

Q127 **Layla Moran:** Right. They will be sent out to the schools, deliver something during school hours and then go back to a base that is an NHS base. Is that what is happening?

Catherine Roche: Exactly, with a treatment approach, whereas I think the fundamentals of having the mental health support team in a school are that we want children to grow up with resilience. It is more strengths-based, and about building capacity, rather than constantly looking at a deficit and a treatment focus.

Q128 **Layla Moran:** Is there something about primary schools? At the moment they have less coverage than secondary. Morgan, why do you think that is and what can we do about it?

Morgan Flack: To be honest, I am not sure that our members would be able to speak to why there is that lack of coverage, but the feedback that we get from members that do have coverage is generally pretty positive. This conversation may sometimes focus on the negatives, but there have been a lot of good developments due to having these mental health

support teams. They are helping schools to think about pupil mental health from a holistic point of view, and to think about prevention and perhaps offer a bit of support as well in the early intervention side of it. It is really crucial. All the feedback we are getting generally is that they would like more coverage, so we don't know why there is this slight disparity where we have only about half of primary schools being covered.

Q129 **Layla Moran:** My colleagues will come on to ask about those who do not have mental health support teams, but if I could focus this question on those who do and the role of the voluntary sector in partnership with mental health support teams in schools. I had a surgery the other day and a gentleman has decided to set up a community interest company to help deliver some of this stuff in his local schools because he is so worried about what he is seeing as a practitioner. I am interested to know if you are aware of other people trying to do this and where it is working well, focused on those who have mental health support teams already, not on those who don't have anything.

Claire Evans: If it is okay, I will just go back to your question about primary school coverage. The low-intensity intervention is looking at low mood, anxiety and behavioural difficulties. The behavioural difficulties intervention is with parents with younger children in primary school. There is less call for that than for low mood and anxiety, so that would be my guess as to why there is less provision in primary schools.

I would also like to answer the implementation roll-out question. We work very closely with NHS England around the commissioned numbers for EMHP training and there is a problem between what is happening in policy and what is happening on the ground. We know that there has been huge turmoil and change in ICBs. We know within services that recruitment is frozen and cuts are being made across the board, whether that is in the third sector, local authority or NHS services, so you have the commissioned numbers and then you have the money that is not necessarily ringfenced on the ground. Even though trainees are salary-supported for the first year, there is not necessarily any money to keep them post-qualification. The feedback that we are getting is that lots of local areas cannot take trainees because they are worried about having the funding to keep them in place.

Q130 **Layla Moran:** So they would rather just not have them in the first place?

Claire Evans: Yes, so we hear that the roll-out should be accelerating, but on the ground it is a very different story. The commissioned numbers are down this year.

Q131 **Layla Moran:** That is helpful insight. What about the VCSE role?

Claire Evans: As Catherine was talking about, we at Anna Freud also deliver an online intervention—the schools and colleges early support service—to many schools that do not have a mental health support team. Sometimes when we talk about mental health support teams, we think it

is just NHS staff. It is not. It is third sector and local authority staff as well as NHS staff.

We never maximise the benefits that third sector staff can bring. They are an incredible workforce. They might not have the fidelity per se as some of these national programmes, but there is no reason why we could not look at the skills that they already bring or offer add-on training to expand the workforce within a population that is already present. A lot of third sector organisations are already working with mental health support teams or supporting with other provision within schools, so we always need to hold them in our mind.

Q132 **Layla Moran:** When they are, how are they getting paid?

Claire Evans: How do they get paid?

Layla Moran: How do they get commissioned? Who is commissioning them?

Claire Evans: Sometimes it is through health, so they might share a CAMHS budget. Predominantly when I was running a mental health service it was local authority funding but we worked very closely with specialist CAMHS.

Q133 **Paulette Hamilton:** One final question. Layla talked predominantly about people who are getting the support and I will ask you the opposite question. What about the schools that are not getting the mental health support teams that they need? How are they coping, that is one of the key things, and what support do you feel that they need?

Catherine Roche: Some schools commission their own services, so they invest; they use funds that might be their pupil premium fund or they find funds to work with organisations such as voluntary sector providers. Some may have somebody, their own counsellor, on their staff.

Q134 **Paulette Hamilton:** But do you feel it is working? It sounds a bit ad hoc.

Catherine Roche: It is incredibly patchy, challenging and massively difficult for schools, especially primary schools where real early intervention and prevention can happen, to be able to afford the services. One of the things that we are looking at is how schools can build their own capacity, so coming at it from the education professionals' point of view to introduce an apprenticeship for a school or community-based counsellor. Somebody within the school setting can train up and professionalise their skills through training as a professional counsellor and be embedded within the school, and then they can be the point of contact to work with the other wider services such as CAMHS and the MHSTs.

Q135 **Paulette Hamilton:** Does anybody else want to say anything before I hand back to the Chair or do you think that has been articulately done?

Morgan Flack: No, I think that pretty much covered it.

Q136 **Mark Sewards:** Layla has already touched on quite a bit of this, but I want to ask about mental health support teams and whole school approaches. They obviously have a dual role in promoting and embedding whole school approaches to mental health and wellbeing, and in their responsibility for delivering direct interventions to individual pupils. How successfully are they doing this and how successfully are they balancing both responsibilities? What changes are needed to strengthen delivery in both areas?

Claire Evans: As you have heard, it is very difficult to provide everything with patchy coverage. As part of the EMHP curriculum, they are taught about the whole school approach, but I think the reality is that one-to-one work takes precedence. The accreditation of these professionals is very important. To meet accreditation, they must have a sufficient number of one-to-one pieces of work. At the same time, if we did not have accreditation, they would not be able to move within the NHS bandings, for example, so it is important for keeping people within the workforce.

The whole school approach is everybody's responsibility. To our knowledge, senior mental health leads are now covering about 70% of schools. We would suggest that schools should be funded and enabled so that all schools have a senior mental health lead, because having one helps to set the context for inclusion within a school setting.

On the research around the helpfulness of a whole school approach, we developed a "5 Steps" framework at Anna Freud. We are working on that with the mayor's office in London at the moment to deliver it across London, but it is also being externally evaluated. Everybody needs to work together but we also need to support teaching staff—I am sure Morgan will say more about this as well. If we do not have a senior mental health lead, and if we have patchy mental health support, a lot of the burden falls on the teaching staff who already have a huge amount to do. I think it starts with all of us, but we need more research in that area too.

Q137 **Mark Sewards:** Great. Any further comments?

Morgan Flack: From our members' point of view, there is inconsistency in the kind of support that the mental health support teams can sometimes provide. I think you are touching on it here by asking whether they are favouring one approach over the other.

Just thinking about the early intervention point, some of our members have told us that they have children who they consider to be eligible for that early stage, but the MHST just does not have capacity to provide the support even if the children have met the threshold. Sometimes that can create uncertainty as to the support the school can access from them. We have even had members told at times that MHSTs were not able to support any pupils who had an unstable home life. These are pupils who

are likely to have struggles with their mental health and wellbeing and who could really benefit from that kind of input.

Going back to the crux of your question about favouring one over the other, we are definitely seeing that, but our members value all the aspects of the role that the MHSTs can bring, so they do not want to see it leaning into just one area such as the early intervention. They believe that it demonstrates that the teams are a bit stretched in their capacity, and they would prefer to see them sufficiently resourced so that they can provide the wide-ranging support that a lot of our members have found very valuable.

Catherine Roche: It is possible to do both when you are integrated and embedded in the school. We have done some research with 20 primary schools in Salford through an externally evaluated research programme, and it shows you can reduce exclusions, improve attendance, reduce classroom disruption, increase engagement, and have a sense of belonging for children in the schools and also the connectivity with parents, which is key, as well as increase the satisfaction of the staff in the school. When you get it right, so you create that capacity and context within the school and you provide the targeted work, you can do both—if you have the capacity.

Q138 **Mark Sewards:** If you have the capacity. Finally from me, Claire, how effectively are these mental health support teams engaging and collaborating with stakeholders across education and NHS settings, and what more should be done to improve joined-up working?

Claire Evans: We talked a bit earlier about mental health support teams being linked into specialist CAMHS, and if there are NHS services we hope that there is a very good step up-step down process in place. Our experience is that they are linked into various settings but it depends again who constitutes the mental health support teams, whether it is local authority or third sector, and what the relationship was prior to the development of the mental health support teams. All the services that take part in the mental health support teams are already established in the community and should have built up those relationships anyway.

We have talked today about the expectations on mental health support teams. They are enormous and they are trained to deliver a guided, self-help CBT-informed model. They are not trained for much higher need, yet often that is what is coming to them, so they are in this very difficult position all the time. Then if they go to specialist CAMHS to ask for help and specialist CAMHS already have huge waiting lists, they are not going to get a lot of positive news there, so what do they do with the population of children who are above their remit? Some of the MHSTs will work with them and work with them successfully, but otherwise these children are waiting for help and cannot get it in either direction. There could be more join-up but the key issue is that there is a missing provision for these children who fall between services.

Q139 **Mark Sewards:** Thank you very much. Any further comments on that one?

Morgan Flack: Just to add on the "missing middle" element, our members have raised this with us for a very long time and they struggle with it. These are children who have been identified as needing additional support but are then also being told that they are not eligible for anything. That leaves schools in an insidious position where they are trying to work out how they effectively support these pupils when they are not mental health professionals and they cannot support them in that particular way.

Our members are very keen to see something to join this gap. How that is done is potentially up for debate, but there certainly needs to be an expansion of capacity for CAMHS and the MHSTs. There could also be a consideration of other approaches—things such as funded counsellors within schools or something—to give that support in the middle.

Catherine Roche: That is very much the group that an organisation such as ours works with when we are providing the targeted work. Roughly 40% to 50% of the children who we see in targeted work have severe mental health needs and are in that category, the "missing middle".

Mark Sewards: That leads neatly on to the next question.

Q140 **Caroline Voaden:** We are going to talk about the "missing middle" now. My first question is to Morgan. How do you think schools are meeting the needs of children in the "missing middle", or the needs of children and young people who are on waiting lists for specialist support? Are schools able to meet that need? How are they addressing that?

Morgan Flack: Schools will endeavour to support those pupils in the best way they can. They will try to support them by improving their school environment, trying to improve their sense of belonging and wellbeing within the school, and trying to improve the teaching and learning, but they would not be able to support or provide any kind of intervention for the mental health element. They do a lot of liaising with other services to try to secure some external support, which might be liaising with third sector services that can provide temporary support, but otherwise it is advocating on the pupil's behalf with CAMHS or their GP, and working with their families to try to bridge the gap in the meantime.

Q141 **Caroline Voaden:** Have you seen a rise in this among your members? Are they worried about it?

Morgan Flack: Yes, they mention it to us pretty frequently, particularly with concerns around the threshold for CAMHS. There is a perception that there is not always a static threshold and sometimes it feels like the threshold is rising. They then must evidence that pupils are in need of even more support to be able to meet what they thought was previously

the threshold. The changing boundaries provide a real challenge for them.

Q142 **Caroline Voaden:** Catherine and Claire, could you tell us a bit more about the role that the MHSTs are playing in supporting these young people in the "missing middle"? It was not initially in their remit to do so. How effectively do you think they are able to identify, engage and meet the needs of this group within the current service constraints?

Catherine Roche: In our experience the MHSTs do not reach this group—hence it being the "missing middle"—but we work very effectively alongside and with the MHSTs in schools to bring that greater capacity. In cases of children with a higher level of need and more severe mental health needs— about 10% of the children we work with are on the waiting list for CAMHS or assessments—we can provide targeted support and that makes a real difference. That is effective. We see improvement in their mental health and changes in their engagement in school. It can work very positively. The MHSTs are at a lower level, and then we have our counsellors and mental health professionals trained in evidence-based practices who are meeting the higher level of need.

Q143 **Caroline Voaden:** Schools that do not have access to your kind of service are not covered when it comes to this section of pupils.

Catherine Roche: Yes, absolutely, and that is the group that I think schools are most worried about, because within that you have children with eating difficulties, self-harm or self-destructive behaviours, complex family backgrounds—they are more complex and more challenging than those acting out behaviours, which are about wider disruption. This is the group that really needs something more.

Q144 **Caroline Voaden:** It is important to get that support to them as early as possible.

Catherine Roche: Exactly, because we do not want them to fall out of the school system.

Q145 **Caroline Voaden:** Is there anything else to add? We are a bit short of time.

Claire Evans: I will just point to the senior wellbeing practitioner programme, which enhances clinical skills and supervisory skills. Those are qualified EMHPs or CWPs. You can go on to do that training and the EMHP SWP—sorry for the acronyms—can sit in mental health support teams. There are some family therapists and some CAMHS nurses in the later waves of MHSTs, so some of them can do this work, but not all of them.

Q146 **Peter Swallow:** I want to zoom out for a moment and talk about the rest of the work that schools can do to support mental health, perhaps in an even more preventive way. Morgan, how does the curriculum currently promote positive mental health, and how successfully it does that

through subjects such as PSHE, PE and—I would also highlight—the arts? How effective do you think it is and how effective do you think the proposed changes in the curriculum and assessment review and the schools White Paper might be in helping us get to a new and better place on that?

Morgan Flack: Thank you for that question. It is a very important area. As you mentioned, one of the key subject areas that promotes mental health and wellbeing is RSHE, which is relationship, sex and health education, although I would just note that this subject was not included as part of the curriculum and assessment review.

From this September, there is strengthened guidance that focuses on promoting good mental health and wellbeing. Our members have welcomed this as a positive development because they see that as key to teaching pupils about strategies, how to identify what good mental health is, what negative influences there might be and what they can do to promote good mental health within themselves. It is about things such as physical activity and socialising and how they can seek support, so all these things are very positive and definitely a step in the right direction.

The curriculum and assessment review recognised that there was too much content in the curriculum overall and our members have told us that they feel that this can create challenges for a pupil's enjoyment of learning. Sometimes it feels as though they are cycling through content because they must cover it all before the end of the year, and that is not necessarily leaving space to explore topics that might be particularly relevant at different times or that could create a bit of space for enjoyment if there is something else that they can think about.

While our members are pleased to see that there was a recognition that there was too much content, I think there is still a bit of nervousness that perhaps the content is not going to be reduced sufficiently to allow school leaders and teachers to have the space and the flexibility to adapt the curriculum to meet their pupils' needs. At times, that might be about being able to focus more on mental health and wellbeing content, but also just thinking about mental health more holistically and creating an enjoyment of learning. It is an area that NAHT are engaging sensibly with the Department on at the moment, so we are still hoping to see an improvement in that, but these are definitely steps in the right direction.

Q147 **Peter Swallow:** Catherine or Claire, do you want to add to that?

Catherine Roche: Access to sport, the arts, creativity and all of that wider aspect, which is about enrichment, is so important in building a child's capacity and building aspiration, and that underpins a child's wellbeing. If we focus on wellbeing—which is what we want, that positive end—that rich curriculum is very important.

Q148 **Peter Swallow:** That brings me on to my next question, which is about the climate of a school, which is something that I think MPs are very

familiar with. You can visit one of your local schools and you can tell immediately what that school feels like for the students—their experience. We know there is research that shows that a good school climate, how safe children feel at school and school cohesion have a marked, positive impact on children and young people's mental health and narrow the mental health gap between girls and boys. Is this research that you are aware of and how do you think that mental health support teams and other initiatives can help to create a more positive school climate?

Claire Evans: I agree with what has been said that a curriculum cannot just be about academic attainment. Schools need to focus on pupil wellbeing and part of that is about creating an environment that enables young people to want to go to school and to feel that they belong, and one where there is less bullying. We know in the UK we have incredibly high rates of bullying. That impacts on children's wellbeing, children's attainment, and children's wish and desire to go to school.

For me it comes back to the fact that if teachers are going to be enabled to set these climates, they must be supported; they cannot do that alone because of the huge expectations on teaching staff currently. We all need to work together, whether that is Government Departments or different professional groups, to support children in a similar way. The kind of environment that you are describing works well when you have mental health support—whether that is from the third sector, CAMHS, mental health support teams; where you have training and development for teaching staff; and where the holistic approach is working together. Without it, schools often juggle all these things themselves.

Q149 **Peter Swallow:** Very briefly, where is the voice of the child in this? We talk about trying to engage children more in school life, and of course that involves actually engaging with them. What role could children themselves play in shaping some of this culture and the broader offering that affects their wellbeing?

Catherine Roche: It is a huge role. Think about school councils also helping to shape the environment and feeling like they are part of it. I mentioned earlier the research programme that we have done in Salford and that was where the majority of children felt that there was always an adult in school who believed they would be a success. That is huge. That is a whole set of schools that have created an environment where children said they felt a real sense of belonging and that there were adults who believed in them. That is incredibly powerful.

Q150 **Jen Craft:** Part of the delivery of mental health support will be via school staff. Do they currently feel equipped to manage the increasing levels of mental health need among children and young people? For example, I notice that an NEU survey says something about the very small number of school staff who feel that they have received sufficient mental health training. Do you think they are sufficiently equipped?

Morgan Flack: It is just worth remembering my point right from the very beginning of this session about what the education staff role is in this: it is not to provide targeted support around mental health. But our members have raised several times that it would be very beneficial for them to have access to further training. A lot of our members valued the senior mental health lead training but the only slight concern that our members have sometimes raised is that there could be an increase in the kind of support that they are expected to provide if they have training. I think they want to make sure that there are still really clear expectations about what their role is within the school and what the mental health professional's role is.

That being said, on the whole members tell us that navigating the CPD landscape can be a bit challenging. There is a range of providers out there and with that comes a range of quality. Sometimes it can be difficult for them to identify what will provide them with the expert knowledge to be able to deal with these challenging and sensitive conversations confidently and knowledgeably, when they are not necessarily equipped to even be able to identify that. Our members have made it clear to us that they would appreciate it, if the Government have identified a particular training need, that that should be then fully funded so that they can access it without worrying about the clarity of their school budget.

We have received some comments about the kinds of things they think would be useful, such as the whole school approach. I know that has come up a lot today, but that is an area that our members have identified as having potential benefits, building children and young people's confidence and resilience. I think it was the year before last that our members specifically highlighted through a conference resolution the potential benefit of trauma-informed training so that they can support children with particular and more complex needs, and do that confidently.

Catherine Roche: A school leader just yesterday said that the biggest difference in his staff training was understanding that behaviour is a means of communication. When staff and schools get that and recognise that, and then have access to somewhere they can talk through where children might need more specialist support, that is incredibly valuable and powerful.

Q151 **Jen Craft:** Do you think it is clear where teachers fit into this mental health landscape? Do you think there is enough clarity for teachers on this? We have heard in a previous session as well that there is some pushback around what teachers should and should not be expected to deliver in their role. Do you think there is sufficient clarity as to what their role is when it comes to delivering mental health support?

Claire Evans: I think we need to help them with that. We know that relationships are a key part of supporting young people and often it is the teacher who has the best relationship with a pupil. For a low-level presentation it might be the teacher who will do the best work with that

young person. However, if that teacher does not have space for consultation and supervision, and space to make sense of what is going on for that young person, they will find it really difficult. It is not always that a mental health support team, a counsellor or whoever needs to offer that intervention to a young person, but we need to think much more about how we support the teaching professional to build that relationship with a young person.

Q152 **Jen Craft:** Are there any further support training specialist inputs that teachers need—either off the shelf or more bespoke stuff that needs to be rolled out—so that they can provide that level of support?

Claire Evans: I think neurodiversity training is really key here because we know how difficult it can be for neurodiverse young people to attend school. I would say that is definitely one of the key issues. At Anna Freud we also host the UK Trauma Council and we do a lot of research around trauma and complex presentations in children and young people. There is a difference between equipping teaching staff with some knowledge, skills and understanding in this area, and being a trauma-informed therapist. It is about differentiating but also talking to teaching staff and understanding what they think the need is as well, and then addressing that.

Q153 **Jen Craft:** You have talked about holistic care and a whole school approach, but something that has been very lightly touched on is attendance and the impact that mental health can have on attendance and vice versa. Do you think the Government's approach to attendance is right or do you think that might have an impact on some wellbeing and mental health issues?

Claire Evans: I agree very much with what Morgan said earlier that we need to move away from a punitive approach. We need to build relationships with families, parents and carers to enable young people. I don't think that the stick approach is most helpful and we lose young people and families to the education system.

Q154 **Jen Craft:** Do you think it can actively be harmful?

Morgan Flack: I think our members would agree with that. They have identified that it has improved in recent years, that the DFE now has a position of support first, but how that works in practice does not always quite play out that way. It can be particularly challenging if a school is still trying to meet attendance targets, which are part of the accountability system. They then see some pupils drop down who maybe do not necessarily have an identified mental health and wellbeing concern yet, and they are following through on the punitive approach, which can exacerbate some of these issues. In short, yes.

Catherine Roche: Relationships and trust are key and then that also has to extend to the parents. If I think of a primary school, if you have the parents on board, they play such a powerful role in the whole piece.

Chair: Thank you. That almost brings our evidence session to a close for today. If there is anything that you did not manage to get across to the Committees in the time that we had available, please write to us afterwards. We would welcome that. Thank you all for coming to give your evidence to us this morning. That does bring our evidence session to a close.