NHS England

Mental Health Support Teams for Children and Young People in Education

A Manual

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Mental Health Support Teams for Children and Young People in Education

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Foreword

I have been delighted to chair the Expert Reference Group charged with producing this manual. I would like to thank everyone who has given their time and enthusiasm to the project, with particular reference to the experts by experience whose pragmatic and honest approach always makes such a difference. Special thanks also to the technical team at the National Collaborating Centre for Mental Health (NCCMH) whose tireless attempts to capture the rich and diverse conversations are truly impressive.

The manual is a small, but important, part of a much bigger programme. It tries to look at the heart of some of the challenges that multi-agency programmes face and build principles and frameworks for success.

The worlds of health and education are really very different – the very separate training to date of professionals in these fields has led to differing approaches to intervention, differing cultures and often separation by a common language. So, conversations about things like the framing of interventions for children, and the defining of mild and moderate mental health issues are challenging but important.

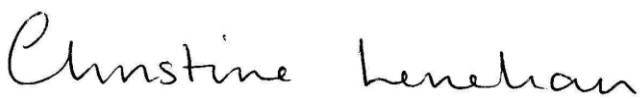
It is also easy for professionals to go into their own comfort zones; for health professionals, this is often the concentration on individual clinical interventions; for education, it is often a default to a whole-school/college approach *or* problem solving for individual children and young people.

And yet for success, to really make a difference to outcomes for children and young people, all of the elements need to come together, and this has been the task of the manual: to understand how to speak to both teachers and clinical staff in ways that make sense to them and enable them to see this area of work as a priority and a key part of how we support children and young people.

We have been really well supported in this by some excellent practitioners and I would want to pay particular tribute to the work going on in Liverpool and Barnsley. The fact they have taken on these challenges and can now demonstrate the real difference this makes to children and young people gave us the real impetus to continue.

This manual is being produced at the very early stages of the work of the trailblazers which are not yet fully operational, and in future versions we will want to incorporate the learning from this key practice as it develops.

The really important thing about the manual is its underlying belief that children's mental health and wellbeing matters. Working in partnership with education at an early stage can make a real difference to young people's outcomes and we can move mental health, for many children and young people, from clinics into education settings and communities, destigmatise it and promote positive mental health.



Dame Christine Lenehan
Chair of the Expert Reference Group
Director, Council for Disabled Children

Dear Mental Health Support Team – a letter from a young person

I am currently both scared and confused; my mind is consumed with overwhelming feelings and emotions, making even the smallest tasks so incredibly difficult. Asking for help is something I have wanted to do, but until now have felt unable. I've always known that opening up about my difficulties was the first step towards feeling better, but I don't think even I knew how much courage it would take. Now I have reached out, there are a few things that you could do to make this journey a little easier for me.

It took me many weeks to gain the courage to ask for help, and now I would like to be seen as soon as possible. In many ways, just being able to talk to someone else will help by making me feel less alone and isolated. Although, I am worried about my friends finding out about me seeing you, so I would like my appointments to be somewhere I feel comfortable. Having a safe space where we always meet will make attending so much easier.

My thoughts are like a tangled ball of wool, and my emotions are confusing even to me. I don't find talking about how I am feeling easy, as I see it as a sign of weakness. So, feeling comfortable enough to truly open up may take me time, but please do not give up on me. I have had a difficult past, so trusting people is hard. Please be patient and compassionate and help build our positive relationship. I know it must be frustrating for you when I can't be honest, but you need to respect that it isn't my fault, it is just the place I am in currently.

Although I want my current difficulties to be respected, I would hate to be viewed just as my illness, as I am so much more than that! I enjoy writing, playing football and eating ice cream, and these are the things that make me who I am, not my mental state. Connecting with me on a human level will help me get to know and trust you. Just talking about the things I love will allow me to feel more relaxed and comfortable.

I would also appreciate it if you could be transparent with me from the start. Being open about things like when you would have to tell my parents what I have said will help me in deciding when I am ready to share things. When I do finally choose to reveal something, please be careful with how you respond. I don't want my experiences to be belittled, as they are very significant to me. I know you may not understand my thoughts, and that this can make responding hard. If you are unsure of what to do or say, please just ask me what I want and need!

Sometimes I feel really motivated to get better, and other days it all feels too much. This may mean that I don’t attend appointments or may not speak much. Please don't write me off if I am unable to engage, it is just because I am scared. In fact, if I suddenly isolate myself, it is probably a sign I need your help more than ever.

I am hopeful that we can work together so I can start to feel a little more like me again. I know that seeing you individually will help me with that. But it is very easy to feel like you are the only person struggling with your mental health and wellbeing. I would really like the option to receive other types of help like support groups. This would be especially important if I do have to wait to see you. But please let this be my decision, as what is right for someone else you see might not be right for me.

I know your job is demanding, and this must all seem like a lot to consider. When young people like myself are seeing you, we are at our most vulnerable. I didn’t ever choose to feel this way and I want nothing more than for my life to go back to how it was. You are now in a position to

help me and so many young people by not only transforming, but also saving lives! I know your role isn't easy, but the work you are doing is very much needed and appreciated.

Best wishes,

A young person

Glossary

This glossary provides definitions for key terms used throughout the document. In addition, it seeks to identify and provide definitions for key terminology used by both health and education which can be referred to differently but mean similar things. Additional terms may be added as the manual continues to be developed.

Term	Definition
Child in Need (subject to a Child in Need plan, Child Protection plan, or are a Looked After Child)	Child in Need is a broad definition spanning a wide range of children and adolescents, in need of varying types of support and intervention, for a variety of reasons. A child is defined as 'in need' under section 17 of the Children Act 1989, where: • They are unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for them of services by a local authority • Their health or development is likely to be significantly impaired, or further impaired, without the provision for them of such services; or • They are disabled The overall group of Children in Need of help and protection is made up of children who are designated under a number of different social care classifications: children on a Child in Need Plan; children on a Child Protection Plan; and Looked After Children.
Clinical Commissioning Group	A health organisation responsible for implementing the commissioning roles as set out in the Health and Social Care Act 2012. The funding to plan for, set up and run Mental Health Support Teams has been provided to specific CCGs by NHS England. CCGs are also expected to provide strategic governance and oversight of MHSTs, and work with a range of local partners to guide implementation.
Complexity	Reflects different requirements for services that people with mental health problems have; people may move through different levels of complexity as their needs change (from less complex to more complex). Complexity can be affected by the interaction between biological, psychological, social and environmental factors. **Less complex problems** may reflect situations where a person may have a diagnosed mental health problem, but they function very well and require limited help and support in managing their condition. **More complex problems** may include a comorbid mental health or physical health problem, or current social difficulties, and may require more intensive input or support from a multidisciplinary mental health team.
Developing or emerging need or problem	An initial problem or need with which a child or young person presents, but which may be at risk of developing into a diagnosable condition and which would benefit from intervention and support.

Disadvantage	Often used in the context of education initiatives, it relates to a condition or situation that means that children with certain backgrounds or experiences tend to achieve worse outcomes than their peers. The term 'disadvantaged pupils' is often used to describe those who come from low-income families and are eligible for free school meals. However, it can also include a broader set of pupils beyond just those who are economically disadvantaged, including those who have needed a social worker, those with SEND and other factors such as where children live, their ethnicity and their home environment.
Education, health and care plan (EHCP)	A plan detailing the education, health and care support that is to be provided to a child or young person who has a SEND. It is drawn up by the local authority after an education, health and care needs assessment of the child or young person, in consultation with relevant partner agencies, parents and the child or young person themselves.
Education Mental Health Practitioner (EMHP)	The core workforce for the Mental Health Support Teams. They are new and specifically trained to provide: • Evidence-based interventions for mild-to-moderate mental health and emotional wellbeing issues • Support to the senior mental health lead in each school or college to introduce or develop their whole setting approach • Timely advice to staff in schools and colleges, and liaison with external specialist services, to help children and young people to get the right support and stay in education
Education setting[1]	Includes primary, secondary and all-through schools, Further Education and 6th Form colleges, special schools, alternative provision, pupil referral units, virtual schools, home education and hospital schools.
Education setting MHST coordinator or school/college MHST coordinator* ****please note that this term may change***	The senior point of contact in a school or college for liaising with Mental Health Support Teams (MHSTs). This is primarily a logistical and collaborative role, involving planning for MHST implementation and managing interactions with statutory roles, and may or may not be performed by the senior mental health lead. Please note that this role was previously referred to as 'senior point of contact' and has been changed to avoid confusion with the single point of contact referred to in the Link Programme training.
Evidence-based interventions	EMHPs will intervene based on evidence of what works best for children, young people, and their parents and carers. For example, brief, low-intensity interventions for those experiencing anxiety, low mood, friendship difficulties and behavioural difficulties. They will also carry out group work, such as cognitive behavioural therapy for children and young people with conditions such as anxiety; or classes for parents on issues such as conduct disorder or communication difficulties.
Health inequalities and equality	Health inequalities are the avoidable differences in people's health status including outcomes across a population or between groups and individuals. The Department for Health and Social Care, NHS England and Clinical

[1] We have coined the term 'education setting' in order to encourage MHST sites to select a wide range of types of schools/colleges. It is not commonly recognised or understood in the education sector, so its external use should be restricted to technical communications where the audience is those involved in the delivery of MHSTs.

	Commissioning Groups have legal duties to have regard to the need to reduce health inequalities through delivery of services. These duties translate to the need to try and ensure that no person's chance of enjoying good health and a longer life is determined by the social and economic conditions in which they are born, grow, work, live and age. All public sector bodies are covered by the Public Sector Equality Duty; to give due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and foster good relations between people.
Mental Health Support Team (MHST)	MHSTs are a new service designed to support mental health in schools and colleges. They are largely comprised of Education Mental Health Practitioners (EMHPs), supervised by senior clinicians and higher-level therapists. MHSTs may also involve a range of other professionals, including for example Family Resilience Workers, Youth Workers and Peer Support Educators.
MHST school/college or MHST education setting	A school or college receiving support from an MHST.
MHST site	The area within which the MHST has been set up (referred to as trailblazers for the 2018-19 phase). Normally this is the patch covered by the Clinical Commissioning Group(s) funded by NHS England to plan for, set up and run each MHST. Each MHST will support a number of education settings within the site.
Mild to moderate mental health issue	A range of mental health needs that may be less complex or may be managed by time-limited interventions. For example, children and young people who demonstrate anxiety, low mood and behavioural difficulties which do not meet the diagnostic threshold for specialist clinical support. A mild mental health issue is when a person has a small number of symptoms that have a limited effect on their daily life. A moderate mental health issue is when a person has more symptoms that can make their daily life much more difficult than usual. A severe mental health issue is when a person has many symptoms that can make their daily life extremely difficult. A person may experience different levels at different times.
NHS Children and Young People's Mental Health Services	Specialist services funded by the NHS, provided either by an NHS Trust / Foundation Trust or an independent sector provider. Formerly (and often still colloquially) known as CAMHS: Child and Adolescent Mental Health Services. The formal name used nationally was changed in response to feedback from young people.
Senior mental health lead in a school or college	Most schools and colleges have a mental health lead. Each school or college will be able to send a member of staff, who is either on or has the support of the senior leadership team, on free-of-charge training to support them in developing a whole-school/college approach to mental health. This role may or may not be performed by the MHST coordinator. Please note that this role was previously referred to as 'Designated Senior Lead' and has been changed to avoid confusion with the Designated Safeguarding Lead.

Senior mental health lead training	The training referred to above which will equip senior mental health leads to establish or develop their whole-school or whole-college approach to mental health and provide strategic oversight of it.
Single point of contact for CYPMHS/ Link Programme Lead	The senior member of staff in a school or college who attends the Link Programme workshops and, beyond the training, is the liaison between the school/college and children and young people's mental health services. It will be for schools and colleges to determine whether the Link Programme Lead also carries out the roles of the MHST coordinator and senior mental health lead or not.
Support network	A generic term to encompass any member of a child or young person's family, care system or extended professional network who acts as a source of support to the child or young person over the course of their presentation to mental health services, or within the community. This may include a parent, foster carer, sibling, close friend or other community advocate.
Trailblazer, or trailblazer site	An MHST site from the first wave in 2018-19. These were the first places in the country to develop and introduce MHSTs in partnership with local stakeholders.
Whole-school/college approach to mental health	A holistic approach to mental health in schools and colleges that goes beyond the teaching in the classroom. This will be reflected in, for example, the design of the school or college's policies, values and ethos, curriculum, pastoral support, how staff are supported with their own wellbeing, and partnerships with families and the community. More information is available in Public Health England's guidance for headteachers and college principals on promoting emotional health and wellbeing: https://www.gov.uk/government/publications/promoting-children-and-young-peoples-emotional-health-and-wellbeing

Mental Health Support Team (MHST) Operating Principles

The following operating principles have been developed to support the delivery of the MHST programme, as part of the wider MHST operating model. They should be implemented by MHST governance and education settings to ensure the effective roll out of the programme.

There should be clear and appropriate local governance involving health and education

The MHST project board/oversight group should include representatives from health and education backgrounds working collaboratively. As a minimum, governance should include representation from the leadership of local NHS funded mental health care providers, education leaders from MHST education settings, commissioners, Local Authorities, children and young people, families and carers. Governance could also helpfully include representation from voluntary, community and social enterprise organisations (VCSE), Public Health England, school and college heads or principals, and/or governors and representatives from the wider education sector. Governance arrangements should have clear feedback and escalation processes in place.

MHSTs should be additional to and integrated with existing support

MHSTs are trained to deliver specific mental health support to children and young people and to support schools and colleges. The team's contribution should always be considered additional and complementary to existing support available in education settings and the wider community. The MHSTs should work with the mental health support that is already provided by existing professionals, such as school or college-based counsellors, educational psychologists, school nurses, pastoral care, educational welfare officers, voluntary, community and social enterprise organisations, local authority provision, primary care and NHS Children Young People Mental Health (CYPMH) services.

The approach to allocating MHST time and resources to education settings should be transparent and agreed by the local governance board

The allocation of MHST time and resources should be agreed by the governance board, in partnership with education settings and should be broadly based on pupil and student numbers. This could be adjusted for disadvantage or inequality or other factors known to influence prevalence such as age, gender and other demographic indicators if the governance board agrees there is a case to do so.

MHST support should be responsive to individual education settings needs, not 'one size fits all'

MHSTs should work with the senior mental health lead in each education setting to scope and design - within the skills, capabilities and capacity of the MHST staff - the support offer, gaining an understanding of the characteristics relevant to the particular setting and needs of their children and young people.

Children and young people should be able to access appropriate support all year (not just during term time).

The MHST service provider will ensure that children, young people and their families and carers who require interventions during educational holidays receive them, where possible from an MHST. Where this is not possible, the MHST should make the necessary arrangements to ensure the continuity of treatments where this is clinically indicated. The location of support given out of term will be determined by the resources available to the MHST.

MHSTs should co-produce their approach and service offer with users

MHSTs approach should be planned, developed and delivered in true partnership with children and young people, and their families and carers, to adequately reflect the needs of the individual, their support network, the education setting needs and the wider community.

MHSTs should be delivered in a way to take account of disadvantage and seek to reduce health inequalities

MHSTs should work to consider ways in which health needs and inequalities are addressed and that take account of disadvantage. They may need to develop specific protocols for working with particular groups to achieve this.

Purpose of this document

Please note that this manual has been developed during the early stages of implementation to support trailblazer sites to roll out the programme. This manual is therefore a work in progress and will be refined periodically as learning and feedback from trailblazer sites is received. Revisions to the manual will be clearly communicated to those involved in trailblazer implementation.

This manual is for all commissioners, managers and providers of Mental Health Support Teams (MHSTs), to support the development, implementation and delivery of these teams. It may also be of interest to partner education settings. The manual was developed by the National Collaborating Centre for Mental Health (NCCMH); with an Expert Reference Group, and with young people, parents and carers who have experience of using services, it was refined and updated by NHS England and Department for Education (see Section 11 for a full list of membership of the Expert Reference Group).

Furthermore, this manual is not intended to be fully prescriptive, as the development and implementation of MHSTs will vary depending on local partnerships and resources. It will be refined in line with any learning and outcomes from the trailblazers, particularly through the evaluation, to help inform future rollout. However, please note that there are 7 operating principles that should be implemented to ensure effective roll out of the programme. A number of key points have also been extracted and highlighted at the beginning of each section throughout the manual that will be key in supporting successful delivery.

MHSTs are primarily for children and young people in primary, secondary and further education (ages 5 to 18) and the education settings in which they learn across England. Young people in education settings who have their 18th birthday within the academic year should also be entitled to a service from the MHST. The extent of this service, and the links to adult mental health services, should be established at a local level. The MHSTs will form part of the mental health approach within education settings,[2] providing timely, evidence-based support, care and interventions for children and young people who are experiencing mild-to-moderate mental health problems. They will also support children and young people who present with developing or emerging problems and may provide support for those who present with more complex needs, which will require joint working with and signposting to appropriate services. The MHSTs will also work with senior mental health leads to support wider, whole-school/college approaches to mental health and wellbeing across the education setting, including advice, consultation, training and psychoeducation.

[2] Education settings refer to primary schools, secondary schools, special schools, independent schools, sixth form colleges, general further education colleges and any other settings where a child or young person may receive formal education or alternative education provision such as pupil referral units, virtual schools, home education networks, outreach tutors, or apprentice and vocational training programmes.

1. Introduction and background

1.1 What is a Mental Health Support Team (MHST)?

"Mental health is like the weather. Some days the sun will shine, and I will remove my coat and enjoy the warmth. Other days it will be windy, and I may need to wear a scarf. If the rain pours, I will put up my umbrella. But whatever the weather I seek to continue with my day, knowing that it is forever changing."

A young person's thoughts on mental health

Summary of Key Points

- MHSTs are a new service designed to help meet the mental health needs of children and young people in education settings. They are made up of senior clinicians and higher-level therapists, and Education Mental Health Practitioners (EMHPs).
- MHSTs should work within the mental health supports that already exist, such as counselling, educational psychologist, school nurses, pastoral care, educational welfare officers, Voluntary Community and Social Enterprises (VCSE), the local authority, including children's social care, and NHS Children and Young People's Mental Health (CYPMH) services.
- Staff from each MHST will be responsible for a defined cluster or group of education settings, building a relationship with each, including the senior mental health lead.
- MHSTs should work with each setting to evaluate and co-design the support offer required.
- MHSTs should work to ensure that the support offer reflects the needs of children and young people and education settings using clearly established expectations and ways of working that fit with the setting and the local system.

The MHSTs are a new service designed to help meet the mental health needs of children and young people in education settings. They are made up of senior clinicians and higher-level therapists and Education Mental Health Practitioners (EMHPs). Senior clinicians and higher-level therapists within the team will be responsible for the supervision and management of EMHPs within the team. The MHSTs will work with the mental health supports that already exist, such as counselling, educational psychology, school nurses, pastoral care, educational welfare officers, VCSEs, the local authority, including children's social care, and NHS CYPMH services. They will be based across education settings as an additional resource within a whole-system approach to promote resilience and wellbeing, support earlier intervention, enable appropriate signposting and deliver evidence-based support, care and interventions. The MHST should not displace or replace any support which already exists.

Staff from each team will be responsible for a defined cluster or group of education settings, building a relationship with each child and young person/stakeholder, including with the senior mental health lead and senior point of contact. MHSTs will work with each setting to understand the particular characteristics and needs of their students, to establish clear expectations and ways of working that fit with the setting and the local area and ensure they become an embedded part of the overall mental health support system. Recognising the respective expertise of education

and mental health professionals in addressing the needs of children and young people will support this process of integration.

The MHSTs will primarily support students from the age of 5 to their 18th birthday. Outcomes from the trailblazers will provide further clarity on who would most benefit from MHST input.

1.2 Background and context

The MHST approach was set out in Transforming Children and Young People's Mental Health Provision: a Green Paper[1] (the 'Green Paper' hereafter), which builds on existing government commitments, set out in Future in Mind[2] and The Five Year Forward View for Mental Health,[3] to create integrated partnerships between health, education, social care and voluntary, community and social enterprises (VCSEs) to keep children and young people at the heart of mental health care, and ensure that everyone is able to access the right help, in the right setting, when they need it.

In England today, approximately one in eight (12.8%) children and young people aged 5 to 19 have a diagnosable mental health problem.[4] Children and young people with mental health problems are more likely to have negative life experiences early on, which can damage their life chances into adulthood.[1] Half of all mental health problems emerge before the age of 14, and there is clear evidence that early interventions can prevent problems escalating and can have major societal benefits.[2] Many more children and young people will also benefit from support for mental health and wellbeing needs that would not reach the threshold to be a 'diagnosable mental health' problem. In the main, the MHSTs are intended to support these children and young people and help prevent more serious problems developing by providing them with low intensity support for mild/moderate difficulties, focusing particularly on low mood, anxiety and behavioural difficulties.

The NHS Long Term Plan (published January 2019) built on the Green Paper, announcing that by 2023/24, an extra 345,000 children and young people aged 0–25 will receive mental health support via NHS-funded mental health services and education-based MHSTs. Under the Long-Term Plan, mental health services will continue to receive a growing share of the NHS budget, with funding to grow by at least £2.3bn a year by 2023/24. This includes funding for the MHSTs over the next 5 years, rolling out teams to at least a fifth to a quarter of the country by the end of 2023.

The Green Paper set out 3 major proposals to transform children and young people's mental health (CYPMH) provision, with a focus on improving mental health in education:

1. incentivise all schools and colleges to identify and train senior mental health leads in education settings
2. new MHSTs across education settings to provide early intervention and support the promotion of good mental health and wellbeing
3. Pilot 4-week waiting times to access specialist NHS CYPMH services.

These 3elements will be trialled in new trailblazer sites, with the first wave to be fully operational by the end of December 2019. The trailblazer sites will undergo a robust evaluation of the costs, benefits and implementation challenges to understand best practice and what works.

1.3 Core functions of Mental Health Support Teams (MHSTs)

The MHSTs will deliver 3 core functions:

Delivering evidence-based interventions for children and young people with mild-to-moderate mental health problems (see Section 3.1)	Supporting the senior mental health lead in each education setting to introduce or develop their whole school/college approach (see Section 3.2)	Giving timely advice to school and college staff, and liaising with external specialist services, to help children and young people to get the right support and stay in education (see Section 3.3)

Implementing the 3 core MHST functions is expected to achieve a number of positive outcomes, including:

- Better mental health and wellbeing amongst children and young people with improved quality of life for children, young people and their families and carers, including better functioning in all aspects of life and greater continuity in education, leading to better educational outcomes and improved long-term job prospects
- A reduction in mental health problems extending into adulthood, leading to a reduction in the associated financial and social costs of mental health care across the lifespan
- Education settings feel better equipped and supported to provide support to children and young people to look after their own mental health and encourage children and young people to seek help if required, gaining a better understanding of their mental health and wellbeing needs
- An improvement in appropriate referrals (to NHS CYPMH services) through improved identification of need and assessment, and by addressing emerging problems that would otherwise escalate and lead to children and young people requiring treatment from NHS CYPMH services
- A more positive experience for children and young people and parents and carer with improved knowledge and confidence in dealing with mental health issues

2. Working with education to improve mental health

Summary of Key Points

- Senior mental health leads and MHST coordinators within the leadership team in education settings should work with MHSTs to develop a whole school approach to mental health and the mechanism for doing this.
- All education settings should aim to identify and train a senior lead for mental health.
- MHSTs should support education settings with their processes for assessing and monitoring need.
- MHSTs may work directly with staff members to provide training and consultation to support them in their role within the education setting.
- MHSTs should empower children and young people and parents/carers to be active participants in the whole school approach.

Future in Mind emphasised the importance of education settings in promoting good mental health, identifying the needs of children and young people and in providing initial support.[2] Education settings across the country already play a key role in supporting children and young people's mental health in a variety of ways.[5] For example, a Department for Education survey of schools and colleges in 2017 found that the majority of schools offer a range of different approaches to support their children and young peoples' mental health and wellbeing. In addition, most schools and colleges have an individual who leads on mental health as part of their role: 82% of schools, including those with a sixth form (81% of primary, 86% of secondary) (school snapshot survey: winter 2018), and 77% of post-16 education settings, including sixth forms, (91% of FE colleges) (Post-16 institutions and providers omnibus, summer 2018).

Transforming mental health will require a cultural change across health, education and social care and partnership working across these domains to create a shared context that is inclusive and equal. Having a national approach that delivers a mental health support service within an education setting is a huge step towards advancing mental health equality; it makes mental health care more accessible to a wider range of children, young people, and their families and carers.

2.1 Understanding the school and college landscape

It is important that MHSTs are aware of the different education settings that they may come across and how these settings differ from and interact with one another. This is particularly important when it comes to understanding the journey and transitions that children and young people may go through in any given area. MHSTs should familiarise themselves with the different education settings they are working with. It should be the responsibility of the MHST Team Manager/Project Lead to establish and develop the relationship between the MHST and the education setting. The following is a generic overview of some of the types of education settings you may come across or work in. Local contexts will need to be taken into account. Further information can be found at https://www.gov.uk/types-of-school.

Types of educational setting

- Mainstream school
    - Ages 5-16 (sometimes with sixth forms up to 18/19).

    - Local Authority maintained or academies (including free schools which are a type of academy).
    - Academies are directly funded by the Department for Education (DfE) and are independent of local authority control. Their governance is different from that of maintained schools in that they are established as companies limited by guarantee, with a Board of Directors that acts as a Trust. Their freedoms include the ability to set their own pay and conditions, and greater control over their budgets.
    - Free schools are new academies but established under the Free School programme. They are also state-funded and created to deliver high quality places where they are needed. This includes the need for pupil places in an area, an alternative to low quality local provision, or a new type of provision (including through providing innovative and distinctive educational offers).
- Faith schools
    - Ages 5-16 (sometimes with sixth forms up to 18/19).
    - Local Authority maintained or academies/free schools.
    - Have a religious charter.
- Sixth Form Colleges
    - Ages 16-19.
    - Like Further Education colleges, they are independent, autonomous institutions and can cater for thousands of students.
- Independent (Private) schools
    - Ages 5-16 (sometimes with sixth forms up to 18/19).
    - Not state funded.
- Further Education colleges (FE)
    - Age 16 plus.
    - Often split site settings which cater for up to 5,000 children and young people, as a result their needs and structure is different to that of a mainstream school.
    - Varying levels of mental health experience in these settings, although most will have above average.
- University Technical Colleges (UTCs)
    - Typically ages 14-19.
    - Type of academy that focuses on technical qualifications.
- Special Schools (either maintained or non-maintained)
    - Ages 3-19.
    - Non maintained special schools are independent of local authority control and are generally not profit making.
    - There are many different types of special schools that support a vast array of needs from social, emotional and mental health to profound learning difficulties. You will need to be aware of how to communicate with children and young people with barriers to expressing their needs.
    - May be spread across different sites.
    - Special school staff on the whole will have above average mental health experience.
    - In most special schools, there are often more adults on the site than there are children.
- Hospital schools/Medical PRUs
    - Ages 5-18/19.

    - A small number of students who will be unwell.
    - Like special schools, staff on the whole will have above average mental health experience.
- Alternative Provision (AP)
    - Includes AP academies, AP free schools, Pupil Referral Units (PRUs), and other providers such as independent providers and Further Education colleges.
    - Ages 5-16.
    - Settings for young people of compulsory school age who are unable to attend mainstream school for a variety of reasons, including illness and permanent exclusion. Students may attend part time or full time and may be directed into Alternative Provision by their schools as a temporary intervention to improve behaviour.
    - May be spread across different sites.
    - The ratio of staff to children and young people will be higher than mainstream schools, and AP staff, self-reported as part of Department for Education's research, above average mental health experience.

Home educated is where your child is taught at home either full or part time. The work of the MHST could include non-mainstream 'settings' such as home school networks and work-based learning.

2.2 The role of schools and colleges

Successful implementation of the MHSTs will require the team and those supporting them to have good knowledge of the education system and existing mental health practice within schools and colleges. Education settings are in a unique position, as they are able to help prevent mental health problems by promoting resilience as part of an integrated, whole school/college approach that is tailored to the needs of their children and young people as outlined in 2.3.

On signing up to the MHST programme schools and colleges are asked to agree to the following in order to ensure successful implementation and delivery of the programme:

- Give the name of a senior lead/point of contact to work with the programme lead in setting up MHSTs; (to act in the role of school/college MHST co-ordinator)
- Commit to involve children and young people and their families/carers in the design and set-up of the teams;
- Commit to engage fully with monitoring and evaluation requirements;
- Commit to the principle that the introduction of the MHST will complement, rather than substitute existing support.

Settings will also have been asked if they can:

- Offer trainee placements for Education Mental Health Practitioners during their training year
- If they have existing appropriate accommodation that could be used for group work and individual interventions, and potentially office space for the MHSTs.
- If there are opportunities to use the accommodation within the settings during the school holidays

Further details of the roles within education settings can be found in section 5.2.

2.3 What is a whole school/college approach?

It is important for MHSTs to be aware of the action government is taking to support mental health and wellbeing in education, as outlined below, to help them understand how they can support settings and the framework their support fits into. MHSTs should have an understanding of the wider policies and guidance schools operate within, for example the different key stages, statutory testing and assessment, exclusions and behaviour policy and attendance, safeguarding duties etc. It is crucial for MHSTs to understand the particular context of the individual settings they are working with and whether they are part of any of the initiatives outlined below to understand how they can work to support and complement what is already being delivered. One of the core functions of the teams is to support the introduction or development of the whole school/college approach as outlined below.

A whole school/college approach is one that pervades all aspects of school/college life, including:

- Culture, ethos and environment: the health and wellbeing of children and young people and staff is promoted through the 'hidden' or 'informal' curriculum, including leadership practice, the school's policies, values and attitudes, together with the social and physical environment;
- Teaching: using the curriculum to develop children and young people's knowledge about health and wellbeing; and
- Partnerships with families and the community: proactive engagement with families, outside agencies, and the wider community to promote consistent support for children's health and wellbeing

The Department for Education wants to encourage more schools and colleges to put in place a whole school/college approach, and are rolling out a number of key initiatives to help schools and colleges to support the mental health and wellbeing of their pupils and students, including:

- Trialling approaches to promoting positive mental wellbeing to ensure children and young people have access to evidence based early support and interventions;
- Providing a package of support for schools to teach children and young people about mental wellbeing through the introduction of compulsory health education; and
- Improving collaboration with external agencies, to ensure those children and young people that need specialist support and treatment get it quickly through the Link Programme.

It is important that the MHSTs have an awareness of these changes and how they will impact the education settings they are working with.

Elements of a whole school/college approach

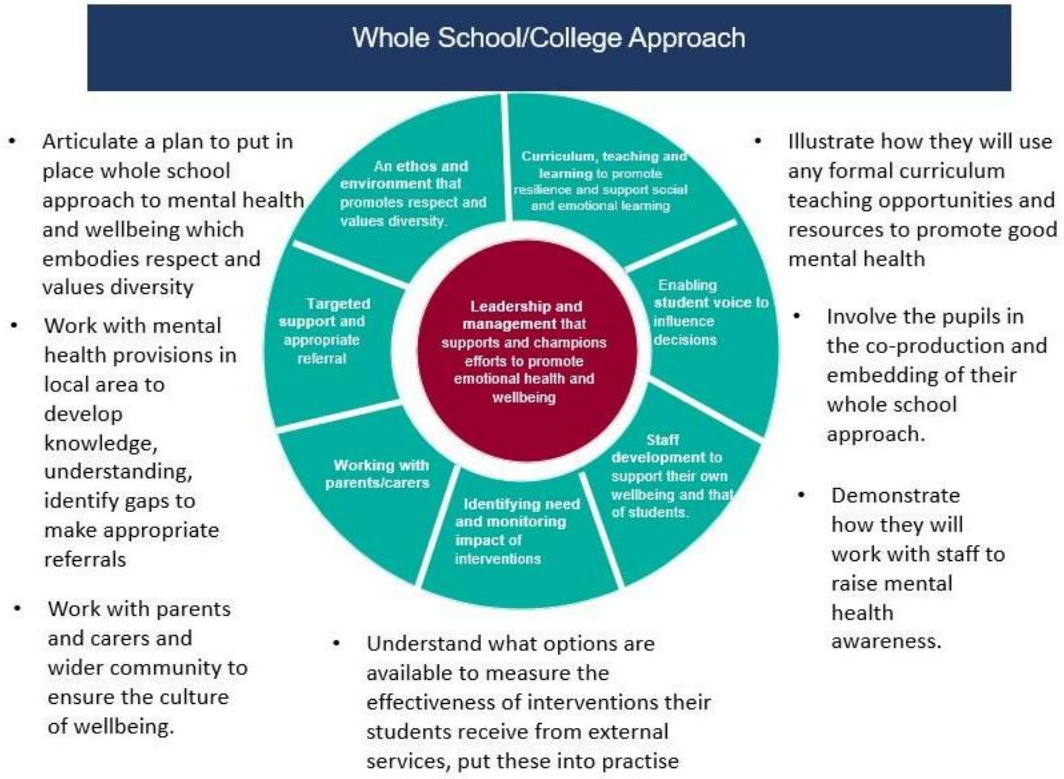


Figure 2. Public Health England's whole school/college approach model.

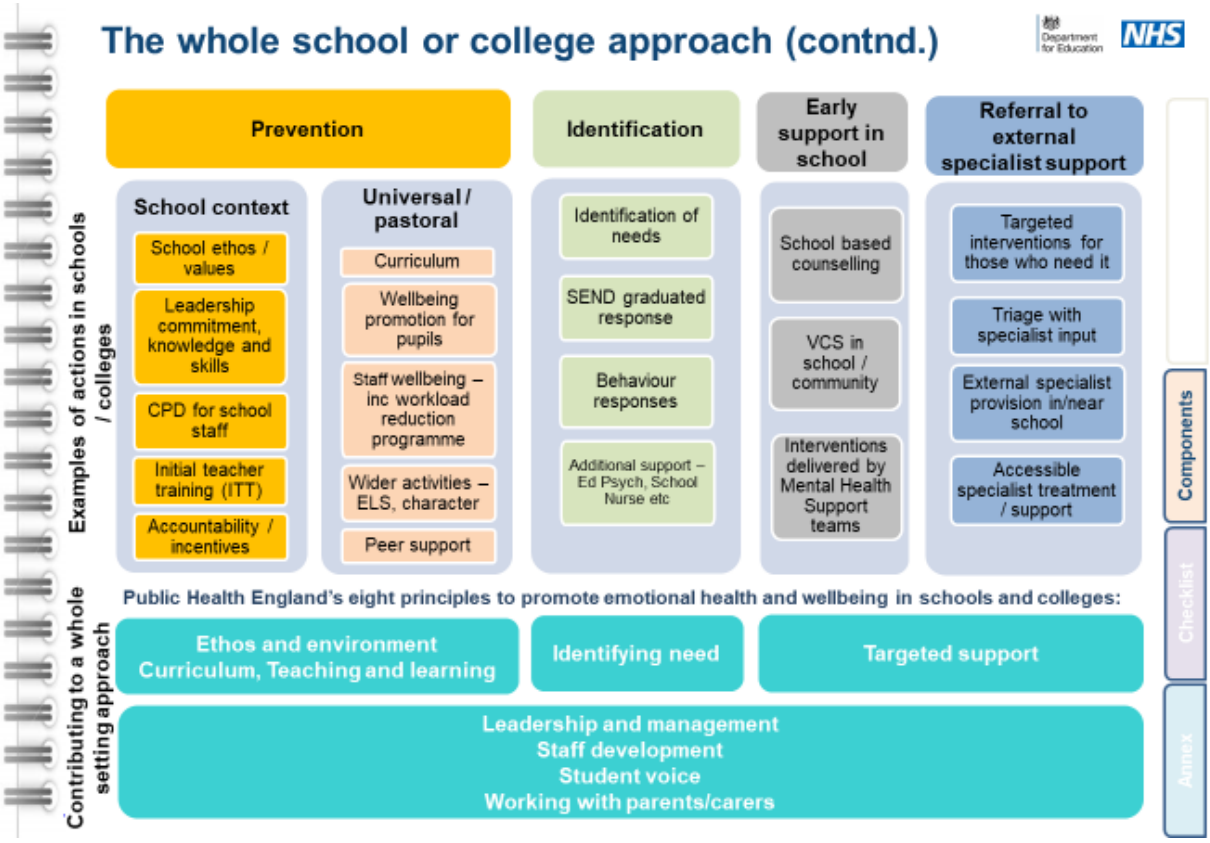


Figure 3. DfE: school/college roles in mental health and wellbeing

The Department for Education published a report in May 2018 providing case study examples of the work schools and colleges have undertaken in 9 key areas to support mental health including the whole school/college approach, identifying mental health needs and the role of the mental health lead. The case studies can be found here and illustrate the type of actions a setting may take as part of a whole school/college approach to mental health.

Leadership and Management

One of the key Green Paper proposals was to incentivise and support all education settings to identify and train a senior lead for mental health with a new offer of training to help leads and staff to deliver whole school/college approaches to promote better mental health. To support this the Department for Education will be rolling out free training for the nominated senior mental health lead to be available from the summer of the academic year 19/20, subject to procurement. This training has been built to align with Public Health England's whole school/college approach model (see figure 2).

In addition, the Department for Education has also committed to rolling out the Link Programme nationally from 2019 to all education settings that have not already received it. The Link Programme is designed to support joint partnership working and communication between education settings and children and young people's mental health services (CYPMH) and will help support schools in the referrals they make to CYPMH. The training is provided to named points of contact in CYPMH and mental health leads in schools. This training will complement the MHST programme by helping establish good working relationships between settings and specialist mental health services.

Identifying need and monitoring impact

An important element of a whole school/college approach is ensuring that appropriate mechanisms are in place to identify emerging issues, and to help students access appropriate support. The following guidance helps to frame how education settings take these decisions:

- The statutory Special Educational Needs and Disability (SEND) Code of Practice 2015, sets out the graduated approach that schools and colleges should take, when a member of staff spots an emerging issue, which includes mental health issues. It sets out that the school should work with parents to plan what action to take and then review whether it works. It is part of deciding whether or not a child and young person needs special education provision and also applies to children and young people regardless of whether they have a SEND. The graduated approach allows immediate assessment, treatment and support if necessary. The Code is clear that support and the involvement of other professionals should not require a specific diagnosis and can be used from an early stage.
- The Department for Education's Mental Health and Behaviour in Schools Advice (2018) reflects the implementation of the SEND reforms. It includes information about what to look for in terms of underlying mental health issues, linked to the graduated response and the sort of support that might be suitable. It emphasises the importance of continuous professional development to ensure staff have the knowledge and confidence to identify: the early signs of mental health problems; what is and isn't a cause for concern; and what to do if they think they have spotted a developing problem and provides links to further support and guidance.

As well as the core functions providing interventions and facilitating referral where a mental health need is identified, the MHST could also support the SEND graduated response for example by providing 'consultation' support to school and college staff on cases, getting involved in conversations with staff and parents to decide what support to put in place and training staff in how to spot problems and respond to different behaviours. Furthermore, EMHPs will also be trained in conducting audits of educational settings emotional and wellbeing needs, supporting the implementation of peer mentoring approaches and providing support in relation to common problems such as bullying and exam stress.

MHSTs will want to plan how they will review the impact of the full range of their activities and learn from this to enable continuous improvement. We are keen to learn from local areas on this to inform what is measured nationally in relation to MHSTs' other functions and to outcomes.

Curriculum, teaching and learning - health education

From September 2020, state funded schools in England will be required to teach health education, which has a strong focus on mental wellbeing, including a recognition that mental wellbeing and physical health are linked. Children and young people will be taught at an age-appropriate point about how to recognise signs of mental health problems in themselves and others.

The Department for Education will provide an implementation guide, targeted support materials, and training; and are encouraging as many schools to start teaching the subjects from September 2019. MHSTs will need to be aware that some schools will be teaching health education from September 2019 but not all will. It will be important that MHSTs are aware of what is being taught

through health education and how content may be able to be reinforced in other areas of school life.

Staff development

Building the capability to identify, and promote awareness of mental health needs is an important part of improving the quality of support that children and young people receive. The Department for Health and Social Care is funding the delivery of Mental Health Awareness Training for all state secondary schools in England by March 2020. The training helps with the identification of mental health issues amongst young people to help them receive appropriate support. As of March 2019, 2,067 state secondary schools have received this training.

This training is distinct from the senior mental health lead training, it is specifically provided to teachers to equip them with the skills and confidence to spot common signs and triggers of mental health issues, as well as building knowledge and confidence to help.

Targeted support

One of the key functions of the MHSTs is to deliver evidence-based interventions for children and young people with mild-to-moderate mental health problems. The Department for Education is working to improve evidence on what works to support children and young people's mental health and wellbeing and how it can be delivered effectively in a school setting. The programme consists of two large Randomised Control Trials, which are testing five different intervention approaches. The trials are:

- AWARE – trialling two mental health awareness interventions (Youth Aware of Mental Health (YAM) and The Guide)
- INSPIRE – trialling three lighter-touch interventions of mindfulness, relaxation and strategies for safety and wellbeing.

Up to 370 schools will be participating by the end of the project in 2020. These trials will provide robust evidence about the effectiveness of such interventions when they are delivered in school settings. MHSTs should be aware of whether the settings they are supporting are part of the trials so they can take into account what is already on offer when designing their service and the other professions which may be operating within the school.

Ethos and environment

In 2018, the Department for Education published 'respectful school communities', a self-review and signposting tool to support schools to develop a whole-school approach which promotes respect and discipline. This can combat bullying, harassment and prejudice of any kind – which we know can have serious and lasting effects on children and young people's education and mental health. The signposting element of the tool supports schools to: easily access details of the requirements and powers that can support a preventative approach to tackling bullying, harassment and prejudice; identify any gaps in their current practice; and access relevant government guidance as well as practical support from external partners. The self-review element of the tool allows schools to record information about their practice in each area. This will help them see the gaps in current practice or areas for improvement.

School leaders are responsible for making sure the curriculum has breadth and balance and benefits pupils' outcomes and behaviour, and schools have a statutory duty, through section 78 of the Education Act 2002, to promote the spiritual, moral and social and cultural development of pupils. In doing so, schools will be providing character education. The duty applies to academies and free schools through the Independent School Standards.

There is a growing body of literature that shows clear associations between character traits and a broad range of outcomes. They also support positive health and wellbeing. DfE has initiated work to support schools in developing and improving the delivery of character education. An advisory group will make recommendations to the department in the autumn on how best to support schools.

MHSTs should also be aware that the Department for Education, Department for Digital, Culture, Media and Sport and Department of Health and Social Care have published the School Sport and Activity Action Plan. The plan sets out steps to increase the opportunities for sport, PE and physical activity for children and young people and also recognises the clear link between physical and mental health.

Enabling Student Voice – children and young people involvement in design and approach

Peer support programmes can be an effective way of creating a supportive environment and enabling pupil voice. The Department for Education is currently working with the Anna Freud National Centre for Children and Families to pilot different approaches to peer support.

The pilot aims to support educational settings and youth organisations in setting up and delivering peer support programmes for mental health, that are tailored to their individual needs and circumstances. Delivery of the programme completed in March 2019, and the evaluation is expected to be published late 2019. The evidence and impact will be shared nationally, to support more schools to set up and deliver school-based peer support programmes for mental health.

MHSTs may be able to further support this through helping to make sure that any peer support programmes are run safely; facilitating the participation of the children and young people they are working with in the programme; and advising how to put something in place that does include them. In order to support this, EMHPs will receive specific training on developing and implementing peer support programmes.

Working with parents and carers

Education settings will have different ways of engaging with parents and carers, providing them with information and involving them with the universal teaching, activities and support offered by the school or college. Teams should work with the education setting to establish how they should operate in relation to this universal provision and providing information about what they do for parents and carers at the setting.

The graduated response set out in the SEND Code of Practice is clear that education settings should engage with parents and carers in taking decisions on what action to take and in reviewing its effectiveness. Teams should work with the education setting to decide on a case by case basis how they should be involved in this engagement. Where a referral is made to a particular

intervention offered by the team, engagement with parents and carers in relation to the intervention will be governed by the team's operating protocols. MHSTs will need to work with education settings to ensure that parents and carers are aware of their services and they know how they can be involved. Settings and MHSTs will also need to consider whether and how to enable referrals for support by parents, how to involve them in the design of services, whether they are able to involve them in the delivery or receipt of interventions and to what extent they need to give consent for interventions. EMHPs will also be trained in and will need to show competence in working directly with parents and carers; with a specific focus on 1:1 parenting work for behavioural difficulties, parent led CBT for anxiety (for children under 12) and parenting groups.

MHSTs should also consider the Gillick competency and Fraser guidelines when considering how best to engage with parents and carers in their child and young person's care. This will allow them to balance the need to listen to the child's wishes whilst balancing the responsibility to keep them safe.

2.4 The Role of Local Authorities and Regional School Commissioners

Local Authorities have statutory responsibilities for delivering effective children's services and providing corporate leadership to champion the needs and improved outcomes for children and young people and alongside Regional School Commissioners play a key role in the provision of education. This makes them vital partners in initiating, growing and maintaining good relationships with education settings, as well as the wider partnerships within which MHSTs will operate.

Local Authorities:

- have specific duties to safeguard and promote the welfare of all children in their area, under the Children Acts of 1989 and 2004, and must make arrangements to promote co-operation between itself and organisations and agencies to improve the wellbeing of local children
- ensure that strategic coherence is in place which enables schools to collaborate and develop purposeful partnerships to improve the quality of teaching and learning
- build capacity across the education system so there is a willing, skilled and ambitious workforce to lead a sector-led model of school improvement
- champion the needs of vulnerable children and young people so there is an inclusive social care and learning system for all, including identifying and assessing special education needs, maintaining education, health and care plans, arranging the education of those who are excluded from school and monitoring and tracking those who are missing education. This will also include the provision or commissioning of Education Psychology Services.
- commission home to school transport in an efficient way, promoting appropriate independence for young people
- ensure a sufficient supply of good education places including early education and child care and sufficient local provision for pupils with special education needs.

Through children's social care, local authorities will be engaged in safeguarding and promoting the welfare or their most vulnerable children. Through their Public Health function, local authorities are responsible for a range of relevant provisions, including School Nursing and through their

wider children's services operate a system of social care to safeguard children and young people and protect them from harm. They will have established relationships with education settings within their area that will be helpful in establishing the partnership working arrangements that will be needed in setting up and maintaining MHSTs.

Local authorities also have a very good understanding of local needs, particularly through their Public Health responsibilities, but also through good local knowledge of services and links with other groups such as third sector and community organisations. They will also be a key agency in coordinating the local systems around Early Help for children through their local safeguarding arrangements. MHSTs will need to coordinate their referral functions with these local systems.

The local authorities have responsibility for coordinating a Schools Forum within their area. Schools Forums bring together representatives from all local education sectors and these forums will be an extremely helpful way to engage with local education providers and systems. All Local Authorities will have a senior Education Lead who will be a key officer to assist in developing local relationships. The Director of Children's Services will be able to direct teams to the relevant staff.

Regional Schools Commissioners:

There are 8 Regional Schools Commissioners (RSCs) who are civil servant Directors appointed because of their extensive knowledge of the education system. They are based in regional offices around England. RSCs commission support for schools, either because Ofsted has given an LA-maintained school or an academy an overall judgement of 'inadequate' or because an academy has asked for help.

Each RSC is supported by an advisory body called a Headteacher Board (HTB). The majority of HTB members are, or have recently served as, outstanding academy headteachers, though some HTB members have been appointed from other backgrounds to fill a gap in expertise or regional experience. The role of the HTB is to provide advice, scrutiny and challenge to the RSCs' decision making, contributing local knowledge and professional expertise.

Regional schools commissioners (RSCs) act on behalf of the Secretary of State for Education and are accountable to both ministers and the National Schools Commissioner. The National Schools Commissioner and RSCs play a key role in the academies system. They work closely with a number of partners including local authorities, leaders from the education sector, Ofsted and local dioceses.

RSCs' main responsibilities include:

- taking action where academies and free schools are underperforming
- intervening in academies where governance is inadequate
- deciding on applications from local-authority-maintained schools to convert to academy status
- improving underperforming maintained schools by providing them with support from a strong sponsor
- encouraging and deciding on applications from sponsors to operate in a region

- taking action to improve poorly performing sponsors
- advising on proposals for new free schools
- advising on whether to cancel, defer or enter into funding agreements with free school projects
- deciding on applications to make significant changes to academies and free schools

RSCs commission teaching schools, national leaders in education, multi-academy trusts (MATs) and other leaders in education to improve underperforming schools.

The role of Ofsted

Ofsted is the body which inspects services providing education and skills for children and young people of all ages against a Common Inspection Framework. The inspections give head teachers/principal's an independent, rounded judgement of their school or college's performance and the information they need to raise standards. Provision is assessed on a 4 point grading scale: outstanding, good, requires improvement and inadequate with an overall effectiveness judgement. The frequency of inspection depends upon the settings last report, the type of school or if any concerns have been raised.

Ofsted has launched a new inspection framework which comes into force in September 2019. The new framework aims to re-balance inspections, broadening the emphasis on attainment to consider wider aspects of the school or college environment including personal development and behaviour and attitudes which might include looking at how they are adopting whole school/college approaches to mental health.

The new framework will bring in changes so that inspectors will be required to evaluate the extent to which the curriculum and the providers work to support learners to develop their character – including their resilience, confidence and independence help them know how to keep physically and mentally healthy. Both the current and new framework include a judgement on safeguarding which is not just about protecting children from deliberate harm but relates to other aspects of life in the school or setting including intimate care and emotional wellbeing.

3 Delivering the core functions

Note to trailblazers:

Please note that this area of the manual requires additional work and we want to gather feedback from trailblazer sites in order to refine it further and provide additional information. This section will therefore be updated shortly, to take account for the feedback we receive from trailblazers carrying out these functions on the ground.

Summary of Key Points

MHSTs will be trained to deliver the following 3 functions:

1) Deliver evidence-based interventions for children and young people with mild-to-moderate mental health problems.
2) Supporting the senior mental health lead in each education setting to introduce, develop and support in the delivery of their whole school/ college approach.
3) Giving timely advice to school and college staff, and liaising with external specialist services, to help children and young people get the right support and stay in education.

MHSTs should work with the senior lead in each setting to scope and design – within the skills and capabilities and capacity of the MHST staff – the support offer, gaining an understanding of the characteristics relevant to the particular setting and needs of their pupils and students.

3.1 Deliver evidence-based interventions for children and young people with mild-to-moderate mental health problems

The new teams will carry out interventions alongside established provision such as counselling, educational psychologists, and school nurses building on the menu of support already available and not replacing it. The MHST will provide:

- Individual face to face work: for example, effective, brief, low-intensity interventions for children, young people and families experiencing **anxiety, low mood, friendship or behavioural difficulties**, based on up to date evidence

- Group work for children and young people, students or parents for conditions such as self-harm and **anxiety**.

- Group parenting classes to include low intensity group approaches to issues around conduct disorder, communication difficulties

The MHSTs will work with children, young people, families and carers to:

- Help them better understand their own mental health and to advocate for themselves
- Make use of assets or resources in the education setting or wider community, such as parent support groups and anti-bullying programmes, and linking with community groups or activities

- Help them engage in meaningful activities such as sports, leisure and social groups, or activities that focus on recovery and mental wellbeing, including those that build resilience and encourage self-care
- Prevent developing or emerging mental health problems from deteriorating into more complex conditions
- Liaise and coordinate with other services who may be involved in the child or young person's care.

Table 1 outlines some of the common mental health difficulties that MHSTs might encounter, along with evidence-based interventions and links to associated NICE guidelines.

Please note that this is not a prescriptive list of the interventions each MHST will provide and some of these interventions may be provided by other existing MH services. Please also note that for some of these difficulties support may be provided by an EMHP, whereas other difficulties (depending on complexity and severity) may be seen by a more senior member of the MHST. As highlighted in the operating principles, MHST support provided to each education setting should be determined at a local level based on MHST skills, capability and capacity and the needs of individual settings.

Description	Interventions an MHST might provide	NICE Guidance reference
Behavioural problems Persistent challenging behaviour (such as disobedience or aggression) and/or behaviour that seriously violates the rules of an individual's home or school. This is much more than ordinary childish mischief or adolescent rebelliousness.	● Work with other professionals who know the child (such as an educational psychologist, teacher or counsellor), adopting a needs-based approach to differentiate between classroom behaviour and what may indicate a diagnosable problem ● Link with behaviour policies and processes of the education setting on behavioural assessments and interventions ● Offer classroom-based emotional learning and problem-solving programmes (typically for children aged between 3 and 7 years) ● Work with families and carers around behaviour management ● Individual 1:1 Low intensity work with parents/carers	CG158
Conduct disorders Describes a range of serious emotional and behavioural problems	● Parent/carer training programmes (individual or group) ● Group social and cognitive problem-solving programmes ● Multimodal therapy (for ages 11-17) ● Liaise with, and signpost to, NHS CYPMH services for further assessment or interventions	CG158
Depression/low mood A mental health problem characterised by pervasive low mood, a loss of interest and enjoyment in ordinary things, and a range of associated emotional, physical and behavioural symptoms. Depressive episodes can vary in severity, from mild to severe.	● Group non-directive supportive therapy ● Provide advice around exercise, sleep, nutrition ● Individual Cognitive Behavioural Therapy (CBT) ● Group CBT ● Guided self-help ● Digital / computerised CCBT	NG134

	● Liaise with, and signpost to, NHS CYPMH services for moderate to severe depression	
Generalised anxiety disorder An anxiety disorder characterised by persistent and excessive worry (apprehensive expectation) about many different things, and difficulty controlling that worry. This is often accompanied by restlessness, difficulties with concentration, irritability, muscular tension and disturbed sleep.	● CBT ● Parent led CBT ● Individual guided self-help ● Psychoeducational groups	QS53
Mixed anxiety and depressive disorder Characterised by symptoms of depression and anxiety that are not intense enough to meet criteria for any of the conditions described above but are nevertheless troublesome. The diagnosis should not be used when an individual meets the criteria for a depressive disorder and one or more of the anxiety disorders above – such people should be described as being comorbid for depression and the relevant anxiety disorder(s).	● Individual non-directive supportive therapy ● Provide advice around exercise, sleep, nutrition ● Individual or group CBT ● Individual guided self-help ● Psychoeducational groups	CG28 QS53
Self-harm Intentional engagement in behaviours that inflict injury or damage to one's body, such as cutting, burning and overdosing	● Liaise with NHS CYPMH services ● Psychological intervention specifically structured for people who self-harm – can include CBT, psychodynamic therapy or problem-solving elements	CG133
Social anxiety disorder (social phobia) Characterised by intense fear of social or performance situations, resulting in considerable distress which in turn impacts on a person's ability to function effectively in aspects of their daily life. Central to the disorder is the fear that the person will do or say something that will lead to being judged negatively by others and being embarrassed or humiliated. Feared situations are avoided or endured with intense distress.	● Individual or group CBT; involve parents or carers to ensure effective delivery of the intervention	CG159

Identifying and understanding the needs of children, young people, and their families and carers

During the set-up phase, several referrals appropriate for the MHSTs will probably be sent directly to specialist mental health services from GPs and nurse practitioners, while waiting for the services to be embedded within the education settings. It is encouraged that a nominated practitioner from the MHSTs requests to take part in a weekly single point of access meeting at their local specialist NHS CYPMH to ensure referrals for children and young people are appropriately triaged and not missed.

Most education settings will already have systems in place to identify and triage children and young people with mental health needs. It will be important for the MHST to work with the senior mental health lead within the settings to agree how these identification and triage processes lead to referrals – either to existing support systems within the school or college, to additional support provided by the MHSTs or to external support services where specialist input is needed. The process for identifying and referring pupils or students for additional support should be clearly defined and understood by setting and pastoral staff, MHST staff other support services provided within the setting, pupils and students and, where possible, parents and carers.

Initial assessment

An initial assessment should aim to bring together information from education (linking with SEND processes around identifying concerns and providing support), other involved professionals e.g. (social workers, virtual school heads, designated teachers for looked-after and previously looked-after children, and designated safeguarding leads) and the family to make sense of the child or young person's needs. Ensuring the child or young person, and their family or carer, feel heard and understood will enable them to engage and share collaboratively in the process of making decisions about next steps.

The aim of the assessment is to understand the nature of the problem, help the child or young person identify their goals and help deliver an appropriate level of support or intervention at an individual, classroom, or wider education or community level. Assessments should also determine any risks or safeguarding issues to the child or young person, with any immediate risks discussed and a clear plan agreed, to ensure direct action is taken.

An initial assessment by the MHST should be person-centred, with the aim of understanding whether the child or young person needs:

- further assessment or input by the MHST
- further diagnostic assessment or input from another service (such as other mental health, physical health, social care or neurodevelopmental services)
- linking with other resources in the community, such as a VCSE or leisure or sports group to facilitate engagement in meaningful activities
- support for the family or carer
- support within the classroom or wider education setting.

If a child or young person presents with an urgent or emergency mental health need, the MHST should have identified processes in place to help them access a local crisis service. The MHSTs should also have processes in place with the education setting to ensure there is a clear process for responding to an urgent or emergency mental health need.

Further assessment by Mental Health Support Teams (MHSTs)

The MHST may need to conduct further assessments to clarify the child or young person's needs or possible diagnoses, to ensure they receive the right intervention. The assessment should be

carried out by professionals with the appropriate skills, competences (including cultural competence) and knowledge. This assessment gathers information from the child or young person, their parents or carers, and other sources such as education staff, to help further understand the nature of the child or young person's difficulties. This may include observations of the child or young person in different settings, observations and reports of interactions with their family or carers, the use of standardised measures including screening and assessment questionnaires, and reports and information from other professionals and agencies involved with the child or young person and their family or carer.

MHSTs will need to have the right skills and knowledge to understand the differing levels of complexity and identify when a child or young person may be presenting with more complex needs or will require input from another service. MHSTs' ability to identify and support children and young people with complex needs should be facilitated through continuous training, professional development and clinical supervision.

- Complexity reflects different requirements for services that people with mental health problems have; people may move through different levels of complexity as their needs change (from less complex to more complex).
- Complexity can be affected by the interaction between biological, psychological, social and environmental factors.
- Less complex problems may reflect situations where a person may have a diagnosed mental health problem, but they function very well and require limited help and support in managing their condition.
- More complex problems may include a comorbid mental health or physical health problem, or current social difficulties, and may require more intensive input or support from a multidisciplinary mental health team.

MHSTs will need to work alongside professionals from other mental health services (such as educational psychologists, SEND support professionals and early help practitioners) as well as other education staff to integrate any previous assessments, including behavioural assessments or SEND assessments, into their current work.

At this point, the MHST professional may wish to signpost the child or young person to a senior clinician within the team, to an NHS specialist children and young people's mental health (CYPMH) service or to another service (such as social care or a dedicated service such as early intervention in psychosis (EIP) services, eating disorder services or crisis services). If the child or young person needs an intervention from another service, then the MHST professional should follow up proactively to ensure that any referrals are received and actioned by that service.

During the initial assessment, if a child or young person presents with a complex mental health problem, there should be signposting to more specialist services such as specialist CYPMH services or specialist domestic abuse services or even agreeing a multi-agency management plan with a lead practitioner.

Formulation

The outcome of an assessment should be a formulation which is a shared understanding of the presenting problem or needs, including any relevant diagnoses, to develop an agreed care plan to meet those needs. The formulation should consider a range of factors, including predisposing (antecedent), precipitating, perpetuating (maintaining) and protective factors across multiple domains, as well as strengths, vulnerabilities, and actual or potential risk of harm. This shared understanding should lead to a collaborative decision about how to effectively address the

identified needs and the development of a care plan. EMHPs will be trained in low intensity approaches which will enable them to develop shared problem statements with children and young people and parents/carers. Formulation itself should be conducted under the supervision of a senior member of the MHST.

Components of a good assessment

An effective, person-centred, holistic assessment, focused on the needs of the child or young person, can be therapeutic in its own right. An assessment should be an ongoing process that leads to a shared understanding of the problem, further formulation and development of a care plan. At the outset, professionals should provide children and young people with information about the service, the purpose of the assessment and what the expected outcome might be. Assessments should not be repeated unnecessarily but should build on any previous assessments completed by other services. The process of assessment should allow the child or young person and their family or carer to make an informed choice about what they need and want, including their goals, and what services they might want to seek help from.

The process of assessment should allow the child or young person and their family or carer to make an informed choice about what they need and want from the range of interventions discussed and agreed to help them achieve their personal goals.

Understanding the nature of the problem and its impact on the pupil, student or their family or carers includes:

- Liaising and working with the education setting to agree an appropriate plan
- Identifying what the person can do for themselves and how families and carers and education settings and staff can provide effective support
- Obtaining information from education, the family or carer and the child or young person to help understand their needs and what may underlie specific behaviours (i.e. mode of communication, expressing distress)
- Identifying what has been tried before and what has felt helpful, or unhelpful, to the child or young person
- Identifying and understanding the person's social networks and whether these are sources of support or distress
- Determining the complexity of a person's needs
- Discussing and using relevant outcome measures (see Section 4)

Where possible, the MHST should allow the child or young person to request who does the assessment, acknowledging potential sensitivities around gender, culture and language.

Care plans

Following the assessment, identification and formulation of the child or young person's needs, a written care plan should be developed in collaboration with the person, their family or carer (as appropriate), or other member of their support network, and with any other services involved. A care plan is used to drive things forward and ensure consistency in the care and support that someone receives. Care plans should be owned by the child or young person or their family or carer, as a way to empower them towards their goals.

A care plan should include:

- A focus on the child, young person's or family's goals, ways to measure progress and things they can do to stay well

- Information regarding the interventions (including self-management, guided self-help, or digital resources) to be provided to the child or young person, or their family or carer, including individual or group work (including parent /carer groups) and the expected number of sessions
- Any strategies or plans around safety and managing mental health crises
- Links with any other care plans for the child or young person (or family or carer) or planning processes already commonly used in education, such as a safeguarding or Child Protection Plan, early help plan, Educational Health Care Plan (EHCP), SEND support plan or Child In Need plan
- Details and responsibilities of other services involved in their care
- Any support the child or young person might require in the classroom, strategies they can use within class, or signs they can use to indicate an emerging problem or distress that means they need to leave the classroom (this could be flashcards with written information for the teacher)
- Whether the child or young person needs to leave the classroom to attend an MHST appointment
- Other supports the child or young person, or their family or carer, can access on days when the MHST is not in the education setting
- Meaningful activities the child or young person, or their family or carer, may wish to engage in, such as sports, groups or clubs
- Support for any transitions or planning endings to care
- Details for when the care plan or intervention will be reviewed.

A Mental Health Services Passport provides a way to empower children and young people to own and communicate their story when moving between different providers. Each child (with their parent or carer) or young person creates their own passport, including a summary of their experience, which they can then share with any future agencies, when they wish.

MHSTs will also need to ensure that they prepare the child, young person or their family or carers for the conclusion of their work together. Effectively managing the end of a therapeutic relationship is crucial to ensuring the child, young person or their family or carer maintains their mental health and wellbeing beyond the time-limited intervention delivered by the MHST.

MHSTs will need to refer to the Care and Treatment Review: Policy and Guidance[33] and the SEND Code of Practice: 0 to 25 years (2015)[32] to inform approaches to collaborative case management when a child or young person has an autism spectrum disorder, neurodevelopmental disorder, learning disabilities or behaviour that challenges.

3.2 Supporting the senior mental health lead in each education setting to introduce, develop and support in the delivery of their whole school/college approach

The setting senior mental health lead and/or MHST coordinator should agree with the MHST how they can support a whole school/college approach within the skills and capabilities of the MHST staff, as set out in section 2.1. This should include working with the education setting to map what arrangements are already in place to identify need and to look at where the gaps are. In mapping the provision, MHSTs should work with settings to look at what is already being provided through existing pastoral services and any positive mental health promotion programmes. MHSTs should also look at what the setting might already have in place in terms of support services such as

school/college-based counselling services or services provided by the voluntary and community sector or by the Local Authority as well as the existing activities the schools might be already doing to promote positive mental health.

The analysis of existing provision should be set within the context of the elements of the whole school/college approach. Settings may have already identified specific areas which should be prioritised or may need assistance to understand their needs and the gaps better.

Once the settings have assessed existing provision and gaps, with the support of the MHST, they can work together to assess what provision should be put in place in agreement with the lead to facilitate prevention and a swift response to individual cases. Activity to support the senior mental health lead in the whole school approach might include some of the following activities (please note this list is not exhaustive):

- Once the MHSTs and the settings have assessed existing provision and gaps, with the support of the MHST, they can work together to assess what provision should be put in place in agreement with the lead to facilitate prevention and a swift response to individual cases. Activity to support the senior mental health lead in the whole school approach might include some of the following activities (please note this list is not exhaustive): Help with **pupil surveys** to identify key issues to address via emotional wellbeing work in school and help schools plan how to address these to best effect.

- Supporting **positive mental health promotion** in school, for example: the development of wellbeing displays; assemblies; consultation on how mental health is covered in the curriculum; or hosting “market place” events so pupils and staff can find out about support services locally available.

- Supporting schools to create **safe spaces** where pupils can take a break or helping and advising on the set-up of breakfast or lunchtime **wellbeing clubs**, which might be open to all or provide targeted support for pupils with particular issues.

- Leading assemblies or **workshops/ whole class work with pupils** on specific issues, for example: how to manage your worries; the importance of sleep; or transition (between key stages, and coping strategies for secondary school).

- **Training** pupils as **peer mentors** or staff **and** pupil **mental health champions**.

Teams should also help to assess what training needs there may be within the setting and establish where the MHST can provide this training (See Section 5.3) and help to identify external opportunities if more appropriate. This training could be to train others to help children and young people, to train parents/carers or to help teachers to identify and manage stress and anxiety.

3.3 Giving timely advice to school and college staff, and liaising with external specialist services, to help children and young people to get the right support and stay in education

The MHST should work with education settings and help and advise them to get appropriate levels of support for children and young people and help them stay in education. Education staff have expertise in areas such as behavioural problems and will know about particular issues within the

education setting such as friendship dynamics and the wider background of individual students. MHSTs should:

- work as part of an integrated referral system with community and social services and within the setting to ensure that children and young people who need it receive appropriate support as quickly as possible and to provide advice to the setting on how to make appropriate and high quality referrals to specialist services or other external support.
- external support could include more specialist NHS mental health support, support for Autism Spectrum Disorder, Learning Difficulties or physical needs, or for issues such as substance misuse.
- ensure smooth transition from specialist services.

Children and young people with more complex needs often experience challenges accessing the right level of help, which can have a long-term impact on their educational, psychological, physical and social outcomes. The MHSTs may have a role in supporting children and young people who may be waiting to receive, or are currently receiving, an intervention from specialist NHS Children and Young People's Mental Health (CYPMH) services or other services; these children or young people may benefit from a low-level brief intervention or support around self-management to prevent further deterioration. Additional support will also be provided to children and young people who are returning to education following an inpatient admission (through joint working with specialist NHS CYPMH services and the education setting) and those who may be making a mental health or education-based transition (see Section 7.7). To ensure children and young people with more complex needs get the right level of care, MHSTs should:

- Work with other professionals and agencies, both within the education setting and the wider community, and the child, young person, or their family, parent or carer, to develop a multi-agency management plan to support the child or young person to stay in education
- Build on any support already in place and provide additional support where needed
- Work with families and support them to access other services if they require specific family-focused interventions
- Support children and young people to access other services as needed, especially when they require an urgent referral
- Ensure children, young people, and their families, parents or carers can re-access help quickly when needed
- Advise education staff on how they might best support pupils and students complex needs to help them stay in education and to implement effective strategies in the education setting environment and classroom.

Examples of activities to support school and college staff might include:

- Providing **case-by-case advice on higher level/ more complex presentations** in individual pupils and strategies for supporting those pupils in school.
- Supporting schools and colleges on their day to day interactions with vulnerable pupils and approaches to make their experience of school as positive as possible to encourage attendance and facilitate good outcomes
- Consulting with schools on training for staff and linking schools with third party [providers if and where needs for training on specific issues, e.g. attachment

awareness, suicide prevention

- providing **training** or workshops for school staff **on thresholds for CYPMHS referrals** and how CYPMHS processes work and have facilitated partnership working and access to other local services and partners.

4 Monitoring Outcomes and Impact

Summary of Key Points

- MHSTs are required to collect a range of experience and outcome measures including self-rated goal-based outcomes, symptom ratings and experience of service questionnaire.
- NHS England and Department for Education have specified a range of metrics and data that MHSTs will collect and flow to the MHSDS.
- MHSTs should be given appropriate tools and resources to be able to collect, review and flow outcomes data to the Mental Health Services Data Set (MHSDS).
- The MHSTs will require appropriate electronic systems in place to routinely measure, evaluate and communicate outcomes data at an individual, service and education setting-based level.

Young people, parents and carers need to be involved in evaluating and measuring the performance of the MHSTs. Feedback needs to be used in the right way to ensure people get the right care.

Young person and carer group

Regular assessment of the quality of services will help provide consistent support, care and interventions to children, young people and their families, parents and carers across England. People's experiences of the care they receive, as well as feedback from other professionals working with the teams, are central to measuring the quality of services and determining priorities for improvement. The MHSTs will need to deliver care in line with the Care Quality Commission's (CQC) framework for delivering safe, effective, caring, responsive and well-led services, and ensure that they meet the quality standards set out by NICE.

A quality improvement approach should be used to underpin implementation of the recommendations in this manual. Each area should create its own theory of change (for example, a driver diagram) and a measurement strategy for improvement. Ideas should be tested and allowed to fail as well as succeed, with both failure and successes contributing to learning and improvements. This approach will ensure that staff and service users are fully involved in developing services, and that services know whether they are improving or not through the use of data tracked over time (for example by using run charts).

4.1 Data collection

Commissioners will need to ensure that systems are in place to enable efficient and consistent data collection and recording. They will also need to ensure that secure systems are in place to share information across services (education, health, local authority-commissioned services and the VCSE sector) and that different organisations' data systems are able to communicate with each other. This will allow for a more complete and accurate picture of care, including outcomes and experience.[39] This will also support joined-up care and joined-up decisions about care.[39]

Children, young people, their families, parents and carers, should be appropriately involved in co-producing decisions about how data is collected; staff in MHSTs should be supported with the skills and training to understand and use data to monitor and improve quality of care.[39]

MHSTs will need the appropriate systems in place to routinely collect and flow data to the Mental Health Services Data Set MHSDS, a secondary uses dataset which enables collection, measurement and reporting of service data. Service level data will support the sustainability of MHSTs and will help to establish local baselines in order to monitor the effect of teams on referrals to other services, without creating an additional burden for education settings.[35] Regularly collected data can support the evaluation of the service and contribute to service improvements.

NHS England has developed guidance for MHSTs on data collection and reporting including the required indicators and data items for MHST activity. This guidance has been circulated to trailblazer sites and can also be accessed on the MHST NHS Future Collaboration Platform. NHS England and the Department for Education are working together to define a range of metrics to help MHSTs and settings to monitor outcomes on the range of activities that the MHST might be carrying out.

Teams are already completing quarterly returns to NHS regions ahead of flowing data to MHSDS and we are looking at how to build in additional measures within this process. We will keep teams updated on the development of these measures and will ensure adequate notice is given of any changes needed.

4.2 Routine collection of outcomes of evidence based interventions

Quality care depends on using outcome measures that track people's progress and experience of care. They should be collected on a session-by-session basis, and can be used as a therapeutic tool and to inform supervision.[34] Education settings already collect information on progress by measuring SMART outcomes (specific, measurable, achievable, realistic and time-limited) in relation to EHCPs (Educational Health Care Plans) and the SEND Code of Practice: 0 to 25 years (2015).[32] MHSTs should work with education settings to understand how outcomes can be collected across both health and education.

Outcome measures should also be used to allow MHSTs and children and young people and their families/carers to track their progress over time and monitor their goals during their sessions. Children and young people should be able to review their progress at each session using graphs and it is recommended that local IT systems generate progress graphs for every child/young person so that they can be reviewed in each session, and by MHST staff and their supervisors in supervision sessions.

Routine collection and use of outcomes data can help to:

- **Monitor and support the delivery of evidence based care**, this includes helping to ensure that treatments are being delivered in a manner that is most effective for the individual (for example, appropriate therapy, adequate number of sessions, short waiting times).
- **Provide information to the MHST staff and CYP** that will help identify appropriate areas of focus or goals for treatment (for example, attendance at school, building of relationships, suicidal thoughts, avoidance behaviours, intrusive memories, and so on).
- **Help CYP to follow their progress** Learning from CYP IAPT and programmes like IAPT shows that people have reported that they value seeing their scores from

completed clinical outcome measures, and how their scores change over time. Therefore, it is important that each person using CYP services is given this opportunity. As well as helping the person to understand more about their condition, outcomes can support the development of the therapeutic relationship and help to show improvement.

- **Help support shared decision making** In combination with person-centred care, outcome measurement tools are essential for informing the continuing appropriateness of the chosen treatment and managing the therapy process (including deciding if a different step or type of intervention is required).
- **Support supervision**. During a supervision session the clinician and their supervisor will carefully review the outcome measures, including individual items to assess progress.
- **Enhance the overall quality of services.** Service leads and team managers can use an outcomes framework to engage in constructive discussions with commissioners and clinicians to improve service delivery and outcomes. Local, regional and national leads will also benefit from having accurate, comprehensive outcome data to inform policy-making.

The MHSTs will require appropriate electronic systems in place to routinely measure, evaluate and communicate outcomes data at a number of levels:

Individual level: person-centred, goal-based outcomes, as well as symptom and impact measures, to determine the progress of a child or young person, their level of functioning, as well as their experience of care; this may incorporate outcomes collected as part of other plans such as SMART outcomes within EHCPs

Service level: to evaluate the team's delivery of the core functions; this includes the number of interventions delivered, onward referrals to specialist services, average waiting times and feedback from children, young people, families, parents and carers

Education setting level: to demonstrate how well the MHST has integrated with the whole-school/college approach to mental health, and the impact it has had on issues such as academic performance, exclusions, attendance and Ofsted ratings.

Staff should be trained and competent in using, and in supervising the use of, outcome measures, including knowledge of when to use them, their strengths and limitations, and how to use outcomes to inform clinical decisions and interventions. It is important that the MHST regularly collects both qualitative and quantitative data in a meaningful way. They should be able to demonstrate how the outcomes and experience of care for children, young people and their families, parents and carers, are used to improve the service.

In signing up to the programme education settings have committed to engaging fully with the evaluation and data requirements.

The Child Outcomes Research Consortium (CORC) collects and uses evidence related to mental health and wellbeing outcomes to improve CYPMH and wellbeing. They have developed whole school outcomes frameworks, such as the Wellbeing Measurement Framework, to measure mental health, wellbeing and resilience across primary schools, secondary schools and colleges.

5 Workforce

Summary of Key Points

- A MHST is expected to typically cover a population of 7500-8000 children and young people, across an average of 20 settings.
- The team should typically be made up of 8 WTEs; including 4 WTE EMHPs, 3 WTE senior clinicians/higher level therapists, 0.5 WTE team manager and 0.5 WTE admin support.
- Supervision of MHST staff is essential in order to ensure the provision of high-quality care, support and advice

Mental health is everybody's responsibility. Mental health professionals, teachers and other staff are all accountable for acting in a caring, kind and compassionate way towards students with mental health needs.

Young person and carer group

5.1 Workforce model

The MHSTs will represent a major expansion in the Children and Young People Mental Health, estimated to be in region of 8,000 additional staff if the programme were staff to cover all education settings (there are more than 20,000 across England).[5] This is comparable in size to the entire current NHS Children and Young People Mental Health workforce (around 7,000 whole time equivalent (WTE) staff). MHSTs should reflect the needs of the local population by recruiting a diverse workforce that matches the gender, cultural and religious makeup of the local demographic as far as possible. Young people, parents or carers should be included in the recruitment process.

Delivery

The set-up and delivery of each MHST should consider existing resources, reference to principle need and demand in local areas, alongside the mental health assessment of each education setting, and how MHSTs can support these, to ensure the national rollout of MHSTs is responsive to local needs and populations. It should be the responsibility of the MHST Team Manager/Project Lead to establish and develop the relationship between the MHST and the education setting. Delivery should be responsive and reflect the education setting and their pupil and students' needs. Education settings, children, young people and their families, parents and carers, as well as other local partners, will have a central role in designing the MHSTs and leading delivery. Trailblazer sites' experiences with different numbers and mixes of staff will help local areas determine their workforce needs in due course.[35]

The table below outlines the proposed model for an MHST (subject to learning from the trailblazer sites).

Senior Mental Health Clinicians

The MHSTs will also comprise senior clinicians responsible for management of the team, supervision of the EMHPs, as well as providing consultation and advice and delivering interventions. These clinicians may be professionals (such as clinical psychologists or senior nurses) who have had training and experience in managing a team and providing supervision. The responsibilities and functions of this role will be further informed by the trailblazers.

Education Mental Health Practitioners (EMHPs)

EMHPs will represent the majority of the MHST workforce. Under supervision, EMHPs will deliver and assess outcome focused, evidence-based interventions to children and young people with mild-to-moderate mental health problems, and their families, parents and carers. They will support the senior mental health lead to introduce or develop their whole school/college approach and give timely advice to education setting staff, and liaise with external specialists, to help children and young people stay in education. They will also liaise with supervisors to agree appropriate signposting and referrals for children and young people. EMHPs will play an important role in supporting and working with education to identify and manage issues related to mental health, and work with them to improve access to mental health services.

Table 2 Workforce model for MHSTs.

Education setting coverage	• Each team supports a cluster of approximately 20 education settings (this may vary depending on geographical area, mental health prevalence data and size or composition of education settings) • Population of approximately 7,500 to 8,000 children and young people • Professionals working across a number of education settings • Time spent in each setting may vary depending on population size, needs of the education setting and existing support
Staffing (approximate numbers)	• 8 WTEs total (this will vary by locality), of which: - 4 WTE EMHPs (Band 4 during training and band 5 once qualified) - 3 WTE senior clinicians (Band 7 and Band 8a manager/supervisor) - 0.5 WTE team manager - 0.5 WTE administrative support
Other considerations (in addition to core functions outlined in section 3)	• How staff manage caseloads over larger geographical areas • Location of main team hub (for team meetings or supervision) – could be an education setting, NHS CYPMH service location, or VCSE or community location • Travel time between education settings if the MHST is based in a more rural area • Centralised contact number (to manage general requests, complaints, feedback) • Ensure a diverse staff from a range of backgrounds, who are sensitive to issues around culture, gender, sexuality, language and religion • There must be an appropriate physical environment/space provided within school settings for interventions to be undertaken.
Hours of operation	To be determined locally
Cover during holidays, annual leave, sick leave	• Teams will be expected to ensure children and young people and students can access appropriate support all year • Will need to have appropriate cover for annual leave and sick leave • Consider working agreements for term breaks; whether this would include home visits, linking with VCSEs, running groups or workshops, encouraging self-management or online support, or working as usual • Will need safeguarding processes in place for operating out of term time and a suitable location (either on or off site)

Plans

The service lead for each MHST within an area will need to ensure there is a workforce plan in place, as the structure of each MHST may vary according to local circumstances and will likely evolve according to emerging insights from trailblazer sites.[6] The Project Lead in the CCG (or STP/ICS) for the MHSTs covering an area should also ensure an overarching workforce plan for all the teams is developed and implemented. Each team will need a clear management structure, outlining the lead or coordinator within the team and how they will report to an oversight or governance group, the structure for line management and clinical supervision and how the structure will fit within existing educational settings reporting structures, particularly around issues such as safeguarding. The outcomes of the trailblazer sites will further inform workforce models for future rollout.

MHST staff wellbeing

A supportive culture within the education setting is essential to maintaining staff wellbeing. Staff within MHSTs should be actively supported through: access to support services, appropriate and regular clinical supervision, monitoring of staff sickness, assessing and implementing strategies to improve morale and encouraging staff feedback on the service. Opportunities for diversity in workload, professional development and career progression are also important elements to promoting staff wellbeing and improving staff retention. Commissioners and providers should consult Thriving at work,[36] which sets out recommendations for improving mental health in the workplace, and NHS England's framework for employers to support their employees' health and wellbeing.

5.2 Mental health roles in education settings

Each of the roles outlined below may be undertaken by the same person or three different people depending on how a setting choose to organise itself. The roles should be performed by an individual(s) who is part of the setting's senior leadership team or have their express endorsement.

School/ college MHST coordinator

As a condition of taking part in the MHSTs programme, all education settings with MHSTs will have nominated an MHST coordinator within the setting with the time and support available to engage fully within the MHST and work with the CCGs to plan for implementation. The coordinator will be part of the education setting senior leadership team or with the express senior team endorsement. All coordinators should have committed to achieving key aims and principles of the programme, including sharing best practice and lessons learnt and engaging fully with the monitoring and evaluation of the programme. As part of this role, they are expected to support the team's engagement and fit with statutory roles in the school including the SENCO, Designated Safeguarding Lead and Designated Teachers for Looked-After and Previously Looked-After Children. These coordinators should play a key part in representing the education setting in designing what the MHST service looks like in their school or college.

Senior mental health lead

In addition to the nominated MHST coordinator who will work with MHSTs to plan for implementation, the Department for Education is incentivising all education settings to have a senior mental health lead who will have a wider strategic remit across the setting. In reality the responsibility for working with the MHST and the strategic senior mental health lead role could be undertaken by the same person but this will depend on how the setting chooses to organise itself.

We know that most schools and colleges already have an individual who leads on mental health as part of their role. This is a non-mandatory role and it will be up to education settings to shape it according to their needs and staffing arrangements.

To support this strategic role, the Department for Education will be providing training, with the first cohorts starting from June 2020, subject to contract award. The training will aim to equip the senior mental health lead with knowledge and skills to act as strategic lead for mental health, put in place whole school/college approaches that promote mental wellbeing and co-ordinate effective links with external services. The Department for Education has also committed to rolling out training to improve joint working between health and education, following evaluation of pilots. Education settings with MHSTs will be prioritised in the delivery of these two training programmes.

The senior mental health lead will support the mental health of children and young people, by ensuring educational settings are equipped to have an effective process for supporting mental health problems and promoting positive mental health so it can be reflected appropriately in everything the organisation does. Working closely with the Designated Safeguarding Lead, SENCO and Designated Teacher for Looked-After Previously Looked-After Children, the senior mental health lead will encourage, empower and support all staff, pupils and students to develop a positive whole setting approach to mental health. As the role will span multiple layers and components, the most appropriate person for this role, and how it is carried out in practice, will vary across settings. It will depend on existing mental health roles within each education setting. We would expect however that the role should be held by a senior member of the leadership group, or be endorsed by senior staff, to enable them to effect change and to be involved in higher level decision-making processes. The functions and responsibilities of the senior mental health lead need to be made clear to all staff, pupils, students, parents and carers across each setting, to ensure there is clarity as to the difference between them and the MHSTs.

Responsibilities of the senior mental health lead:

- Support the identification of at-risk children and young people and those exhibiting signs of mental ill health
- Knowledge of the local mental health services and working with clear links into children and young people's mental health services to refer children and young people into NHS services where it is appropriate to do so
- Coordination of the mental health needs of young people within the school or college and awareness of the delivery of interventions where these are being delivered in the educational setting – including by the new Mental Health Support Teams
- Support staff in contact with children with mental health needs to help raise awareness, and give all staff the confidence to work with young people and parents;
- Support the measurement of outcomes of interventions on children and young people's education and wellbeing;
- Support a positive whole school/college approach to mental health and wellbeing, including advising on how this is reflected in the design of behaviour policies, curriculum and pastoral support, working with parents, how staff are supported with their own mental wellbeing and how children and young people are engaged.

Single point of contact for CYPMHS/ Link Programme Lead

This is the individual within the setting who will attend the Link Programme training and develop the working relationships with a named CYPMHS person.

5.3 Training

Mental Health Support Teams (MHSTs)

There will be an initial period of training for EMHPs and supervisors (through higher education programmes) as the MHSTs are established across the country. This will ensure that all practicing members of the MHST workforce are competent in delivering evidence-based interventions for mild-to-moderate mental health issues and are able to support schools and colleges to introduce or develop their whole school/ college approach. However, commissioners and providers should establish a training programme to further develop and maintain the skill mix required to deliver good mental health care. Regular training should include:

- recognising, responding to and assessing a range of mental health needs, and how these may interact with comorbid mental health, physical health, social or neurodevelopmental problems
- child protection and safeguarding procedures
- information sharing, consent, confidentiality, capacity and competence.
- MHSTs should also receive support to deliver training on mental health to other professionals, parents, carers and students.

Training for education professionals

The training needs of education staff should be identified through assessing the needs of the education setting (see Section 7.2), with a strategy for implementation in place. Teachers and other professionals working within education settings should receive training and information to improve their awareness of mental health problems and provide them with skills to support children and young people with mental health needs more effectively in the classroom. Education settings should link with VCSE providers who may be able to deliver this training or should consider whether training on Mental Health First Aid may be appropriate. Training on mental health should be routinely included in professional development days for education staff and should also be offered to administrative, janitorial or hospitality staff. MHSTs can support this through group workshops providing psychoeducation on general mental health, or through individual training sessions with teachers who have a child or young person who needs adjustments in the classroom.

Teachers and other professionals may benefit from online resources or training around CYPMH, such as that provided by MindEd, an E-learning resource for all adults supporting children and young people; which provides knowledge and supporting and information on how to identify children at risk of developing mental health difficulties.

Training for pupils, students, parents and carers

Pupils, students, parents, carers and other family members may benefit from workshops or general psychoeducation sessions around mental health. This could be delivered through VCSE providers or through group sessions facilitated by an MHST professional. Further options for

training may include Mental Health First Aid for young people and for concerned adults, or training for students to become peer mentors or mental health ambassadors.

5.4 Competences

MHSTs will be trained in the following competences:

- De-escalate particular situations (such as self-harm, emotional distress) without having to send the child or young person to an emergency department
- Know the limits of their skills or competences, and when referral or signposting to another service is appropriate
- Understand and respond to concerns around safeguarding
- Identify a range of mental health problems, including early signs, from a holistic or biopsychosocial perspective.

The MHSTs should obtain regular feedback from children and young people, and their families, parents and carers, about their experience of care in order to ensure staff competence and plan appropriate professional development. University College London's (UCL's) Centre for Outcomes Research and Effectiveness (CORE) has developed a competence framework[37] specifically for staff working in CYPMH services. This framework outlines competences across several domains, each of which represents a broad area of practice, and describes the various assessment and intervention functions, as well as the knowledge and skills required to carry out each function.

Practitioners within the MHST should also be familiar with the Self-harm and Suicide Prevention Competence Framework which describes the various activities that need to be brought together to support children and young people who self-harm and/or are suicidal.

5.5 Supervision

The role of the supervisor within the initial training period of EMHPs is pivotal with high-quality supervision of trainee therapists being key to ensuring the successful delivery and sustainability of the MHSTs. It is expected that a 'Community of Children and Young People's MHST Supervisors' will evolve, which will become a growing resource to facilitate the development of MHSTs across a wider region beyond a given CCG footprint, and this will provide further support into the future for the sustainability of the EMHP programme.

Supervision training as provided by universities delivering the EMHP training is mandatory for all higher level/senior staff providing supervision for EMHP trainees.

Key aims of the training are to enable supervisors:

- To develop competency in supervising EHMP evidence-based interventions set out in the EHMP curriculum.
- To evidence a critical knowledge of the theoretical, research and implementation literature that underpins the supervision of trainees on the EHMP programme.
- To enable supervisors to develop sustainable skills in supervising EHMPs in order to drive the ongoing development of these quality-driven, outcomes-informed services.

The Care Quality Commission (CQC) provides further guidance on supporting effective clinical supervision.

The senior clinicians within each team will supervise the EMHPs and provide managerial support around reviewing performance, setting priorities and objectives in line with the employing organisation, and identifying training and continuing development needs. However, the structures of each education setting may determine whether the EMHPs will receive separate line management from senior education staff.

Health Education England (HEE) have made a number of recommendations for the selection of appropriate MHST supervisors during the training period:

- Supervisors will need to be experienced Mental Health professionals as evidenced by a minimum of 2-4 years working therapeutically within a CYP Mental Health Setting.
- Ideally, they will also have experience of delivering and supervising mental health approaches in education settings.
- They will need to supervise two elements of EHMP practice: 1. low intensity cognitive behavioural interventions and 2. whole school/college approaches to mental health in education settings. They will therefore need to demonstrate existing knowledge and competencies in both areas.
- It is possible that some teams may decide to put forward a mix of EHMP supervisors where individual supervisors are limited to one of these two core areas of EMHP practice. Regions may be able to support this approach as long as there is a spread of supervisory knowledge and expertise that covers both core areas within each MHST'. Furthermore, the training programmes must set up the training in a way that allows for one but not both core areas to be demonstrated as part of a successful completion of the training programme.
- In addition to the above clinical knowledge, experience and competencies, supervisors will be expected to have experience of delivering CBT informed supervision, ideally of practice related to education settings. A minimum of 2 years' supervisory experience in a CYP mental health setting post-qualification is desirable.
- For supervisor training programmes delivered as PostGraduate Certificates, supervisors will need to demonstrate the ability to study at a Post-Graduate level. Furthermore, supervisors will need to be either willing to or already trained on the EMHP supervisors programmes at one of the universities delivering the training.

6 Governance, Accountability and Senior Leadership of the Mental Health Support Teams (MHSTs)

Summary of Key Points

- Local governance structures should be established, linking with existing structures, to provide operational and strategic governance and service quality assurance.
- There is an expectation that there is a project board/oversight group in place where there isn't an existing governance structure.
- The project board/oversight group should include representatives from health and education, working in collaboration.
- The project board/oversight group should consist of representatives from NHS CYPMH services, the VCSE sector, the Local Authority(ies), Public Health England, school and college representatives, commissioners, representatives from already existing support services within education settings, local councillors and children and young people, parents and carers.
- There are a number of operational governance processes that should be implemented and communicated to MHSTs from the beginning of the programme to ensure the day to day running of MHSTs

6.1 Governance and Oversight

MHSTs need strong leadership, oversight and governance structures to work effectively within education settings. Oversight and governance of the MHSTs should fit within existing governance structures and functions across both mental health and education systems; this might include links with school governors, MAT trustees or leadership, local transformation plan boards, health and wellbeing boards, safeguarding boards, sustainability and transformation partnership (STP) boards, integrated commissioning boards and any other relevant local organisations. Governance and oversight of the MHSTs should be embedded in local processes, and be based on agreements with partners across health, the local authority, education and other organisations. To ensure joined up governance and oversight, it is recommended that local governance networks are developed to ensure that representation at different levels is provided and the opportunity to share ideas is available. All elements of the partnership should be represented in the governance structure.

Three main functions of governance need to be covered:

1. **Operational:** covers the structural management of the teams, including clear lines of reporting and how they function in line with education and mental health governance, the process for escalating any problems or issues
2. **Quality assurance:** ensuring the MHSTs are delivering consistent, high-quality mental health support, care and interventions, with appropriate and adequate clinical supervision; ensure there are clear processes around data collection, record keeping, information sharing and managing complaints

3. **Strategic:** Developing and implementing a strategic plan for the service; monitoring key outcomes and implementing regular evaluations to allow for continued learning, innovation and improvement.

Oversight and governance of the MHSTs may be provided by a multi-agency oversight group or project board, representing a range of stakeholders across health, education and community sectors. This could include: NHS CYPMH services, the VCSE sector, the local authority, Public Health England, school and college representatives or commissioners (including school governors, head teachers or principals), Clinical Commissioning Groups (CCGs), representatives from already existing support services within education settings (such as the senior mental health lead or the safeguarding lead), local councillors who may be Mental Health Champions and representation from young people, parents and carers.

Case Study Examples Governance Structures:

Please note this is place marker for additional content providing case study examples of good governance structures.

6.2 Operational Governance

There are a number of day to day operational/governance procedures that should be considered during the early stages of MHST implementation. It should be the responsibility of the MHST Project Lead and the school/college MHST co-ordinator to ensure that the right operational processes are in place prior to MHSTs starting the programme. Operational processes should include:

- Ensuring that each member of the team has received and signed a contract outlining the terms and conditions of their employment
- Ensuring that processes are in place for any employment changes from year 1 (training year) to year 2 (when MHSTs will be fully operational). This is particularly important where MHSTs will be employed by a different provider in year 2
- Ensuring that any salary changes and High Cost Area Supplements (HCAS) are communicated to each member of the MHST, particularly in light of any expected contract changes
- Annual leave entitlement
- Sickness absences
- Induction and statutory training requirements
- Ensuring that MHSTs are trained and competent in using local reporting and recording systems, for example, Electronic Patient Record Systems (EPRS)
- Ensuring that feedback mechanisms across health and education settings are in place for MHSTs
- Ensuring that policies around complaints processes are in place and are joined up across health and education settings

7 Developing and implementing the Mental Health Support Teams (MHSTs)

Summary of Key Points

- The planning, developing, delivering and evaluating of services should be done in true partnership with service users, providers and others who may be affected by the service.
- Children and young people, families, parents and carers should be involved throughout the development, implementation and evaluation of MHSTs
- MHSTs should promote equality and reduce inequalities by ensuring access to support for children and young people, families, parents and carers with known vulnerabilities, at higher risk of developing mental health problems or who may experience barriers to accessing support
- Information sharing between professionals, children and young people, and their families, parents or carers should be encouraged in order to provide the best support, while respecting the principles of confidentiality and the need for appropriate consent.
- MHSTs should offer flexibility around where they see the child or young person or their family, parent or carer. Locations away from the education setting should be available.
- MHSTs should have access to a safe, calm, neutral environment with no stigma attached, within the education setting in an appropriate alternative.
- As part of the mental health support provide, MHSTs will be expected to provide support to children and young people, and their families, parents and carers throughout the year, including educational holidays. If education settings are not able to provide accommodation to support their work, consideration should be given to the use of additional accommodation for example community centres, local libraries and GP surgeries.

Building relationships and developing trust across services, professionals, parents, carers, and children and young people will take time.

Expert Reference Group

7.1 Co-production

Planning, developing, delivering and evaluating services in true partnership with service users, providers, and others who may be affected is sometimes known as co-production. A co-production approach will help MHSTs to stay focused on children and young people, and their families, parents and carers, to adequately reflect the needs of the individual, their support network, the education setting needs and the wider community, rather than focusing on the needs of the service.

*Co-production is an **ongoing partnership** between people who design, deliver and commission services, people who use the services and people who need them.*

7.1.1 How to ensure genuine co-production

The recommendations below were developed with young people, parents and carers who have experience accessing mental health care. Co-production ensures the MHSTs are responsive to the evolving needs of the education community. MHSTs can genuinely engage in co-production by:

- Giving the opportunity for children, young people, their families, parents and carers to take part in developing, implementing and reviewing MHSTs, including recruitment and training, with regular opportunities for them to participate in advisory groups, advocacy groups or governance groups or forums
- Include children, young people, families, parents and carers in specifying what they would like from a MHST
- Ask people for their feedback, anonymously and in person, and show evidence of how this feedback has been used (such as 'you said, we did…')
- Use children, young people, families and peer support workers to help engage others in accessing the service; this includes working with children and young people to develop digital resources such as user-friendly podcasts, websites, forums and surveys
- Link with other organisations who do co-production well
- Check that co-production is embedded at every stage of the process by obtaining feedback and conducting evaluations and being transparent in demonstrating outcomes from these.
- Providers and commissioners should consider developing user-friendly, accessible information on MHSTs for children and young people, their families, parents and carers, and non-mental health professionals. This could include guidance at a local level on mental health and what people can expect from the MHSTs.

7.2 Understanding the needs of the local population and education setting

Local population

To ensure a successful whole-system approach, services need to understand the current mental health provision in a particular area (including online and face-to-face groups and forums) and how joint working can be established to reduce gaps in the current provision. Assessing and understanding the needs of the local area and the education setting, and learning from other services, will help determine local priorities for the MHSTs as well as how to make the best use of existing provision. Some local areas may have a directory of services and resources to assist in this process.

Public Health England brings together guidance, resources and data already collected around mental health and wellbeing, including a Children and Young People's Mental Health and Wellbeing Profiling Tool, to help services understand demand and prevalence in their area.

Education setting

The governance or oversight group, senior mental health leads and existing support services should come together to understand various aspects of the education setting's mental health and wellbeing policies/approach, including already existing support, gaps in support, characteristics and needs of the students, leadership and culture, and training needs for education staff to enable them to design the MHST ways of working to reflect need. Any assessment should include the

views of children, young people, and families, parents and carers, with timeframes for regular review to ensure it remains up to date.

7.3 Accessing Mental Health Support Teams (MHSTs)

Setting up the MHST service

During the set-up phase, MHSTs will need to consider ways in which their service can be bespoke to the needs of education settings and children and young people within their local population, working with the senior leads or school/college MHST co-ordinator within education settings, to ensure the service appropriately reflects these needs. It should be the responsibility of the MHST Team Manager/Project Lead or a Senior Clinician (subject to local agreement) to establish and develop the relationship between the MHST and the education setting. The MHST should work with the local systems to establish clear communication routes and ensure that feedback loops are established early. They should also be working closely with education setting leads and head teachers/principals to establish the high-level support offer to each setting. This will allow the MHST to scope out the support required to individual settings and also provide the setting with clear expectations on the offer. Children and young people and their parents/carers should be key to these feedback loops, for example, working with them to ensure that the correct consent procedures are put in place.

Increasing awareness of the service

It will be important to establish and communicate the presence and functions of MHSTs within each education setting, as part of the overall mental health support offer. This includes information sessions with children and young people and students, staff, families, parents and carers, having an online or digital presence, co-produced posters or leaflets, as well as sending out written information to ensure people know what to expect from the teams, how they will work and how to access them. Improving the awareness of the service within the education setting and wider community will encourage people to engage with the teams. Working with staff, young person advocates, student councils and mental health ambassadors can also encourage people to link with the teams.

Contacting the service

People should be able to contact the MHST in a number of ways, including self-referral (if available), text or phone call, online forms or email, and in person (drop-in options), with a central point of access for each education setting, based on clear and agreed criteria. Access to the teams will need to be carefully coordinated with other forms of support within each education setting. This might be through a direct link to other support services or the senior mental health lead to avoid duplication of requests, or as part of an integrated access hub for all mental health support services within that setting. This will ensure the child or young person is seen by the appropriate service as soon as possible. What precise form this central point takes will depend on the needs and resources of the setting, but it should include clear lines of communication with the senior mental health lead.

Availability

As part of the mental health support provided, MHSTs will be expected to provide support to children and young people, and their families, parents and carers throughout the year, including educational holidays. This may offer additional opportunities for differentiated support for those children and young people who may find these times challenging.

Location of Mental Health Support Teams

MHSTs will need to have access to an appropriately safe and calm environment; this should be a neutral room, with no stigma attached, which means the room should not be the same location used for exclusion or isolation. Other considerations include:

- Flexibility around where sessions will take place; it may be necessary to have additional safeguarding processes in place to allow for off-campus sessions, which might require agreements with community or VCSE organisations to make use of their space (particularly for working over the holiday period)
- An option for students to visit the environment or office before they have to attend a session – this could be included as part of a new student induction or facilitated by other staff or peer support mentors or ambassadors
- Some children and young people may prefer not to be seen at the education setting – there will need to be some flexibility to work with the setting, the child or young person, and their family, parents or carers to determine alternative, appropriate locations, or whether telephone or video technologies, such as Skype, may be useful
- Informal meetings may help to build rapport with some children and young people; these can be alternated with formal sessions to avoid delays in the delivery of interventions.

7.4 Information sharing, confidentiality and consent

Information sharing is key to improving the mental health and wellbeing of children and young people and ensuring their safety. Information sharing needs to be timely, particularly during transition points or when a child or young person presents with a significant need or may be experiencing a mental health crisis. Issues around information sharing, consent and confidentiality should not become a barrier to providing or receiving care. Instead, there should be clear local information sharing protocols to enable appropriate information sharing across agencies, building on existing practices.

Systems

Information sharing systems need to be appropriate for use by the MHST and within the education setting. Developing and maintaining shared information systems to securely collect good quality data will require investment in IT infrastructure and clear information governance processes. This could include shared access to information across services, so that everyone has access to the same care record.

Consent

Information sharing should be based on consent, as well as the nature of the child or young person's presenting need, or their family's, parents' or carers' needs, and what might be involved in meeting these. There should be clear discussions around confidentiality, information sharing and consent with the child, young person or their family, parent or carer from the start, so that they are aware of when information needs to be shared across services. This discussion may need to be revisited throughout the period of providing support, care or interventions.

Teams that provide self-referral or a walk-in service will need to have a protocol to allow for an initial conversation with a child or young person before contacting family, parents or carers and obtaining consent for follow-up care. They will also need clear processes for instances where a child or young person does not want the education setting to know about their mental health, and how this will be managed appropriately.

Teams should also empower children, young people, parents and carers to hold their own information and be responsible for sharing this across services (if they are receiving input from more than one service).

Professionals

Professionals should have sufficient knowledge of the specific issues and legislation relevant to competence, capacity, consent and information sharing as outlined in the Mental Health Act 1983 Code of Practice,[16] the Mental Capacity Act 2005[17] and the Mental Capacity Act 2005 Code of Practice,[18] and should refer to these documents for further guidance on this topic (also see Section 3.6 in Helpful Resources). Professionals should also review the Information Sharing and Suicide Prevention Consensus Statement[19] and government advice on Information sharing[20] to inform their decisions about sharing information.

7.5 Safeguarding

All professionals should be alert to signs of bullying, teasing, abuse (emotional, physical and sexual) and neglect. As part of the training curriculum, EMHPs will also receive training on how to implement safeguarding protocols within education settings.

Keeping Children Safe in Education is statutory guidance for schools and colleges on safeguarding children and safer recruitment. All staff in education settings must read and sign up to part 1 of the guidance which sets out what staff must know and do in relation to any safeguarding concerns.

Safeguarding enquiries should always be undertaken as part of the assessment and review process. Any safeguarding concerns should be addressed in a timely manner in conjunction with the safeguarding lead in each education setting and local safeguarding partners (local authorities, police and CCGs). MHSTs should have the appropriate knowledge and understanding of safeguarding and should follow the safeguarding procedures of each education setting, to comply with Section 11 of the Children Act 2004[21] (see Helpful Resources for links to safeguarding guidance).

7.6 Utilising digital resources

MHSTs should consider and explore how technology and digital resources can improve access for people and enable them to receive care. Digital platforms or technologies such as Skype, apps or online tools can be useful in maintaining communication or providing interventions when people are unable to travel or as an appropriate alternative to delivering care.

Digital resources include:

- Guided self-help online tools or apps to support the child or young person, or their family or carer
- Mood tracker apps for use in between sessions
- Using a mixture of digital and face-to-face interventions
- Mental Health Services Passport

To optimise their use of digital resources, MHSTs should consider their desired outcomes and the following questions:

- Is the use of digital resources appropriate to the problem?

- Will the use of digital resources benefit someone?
- Can digital resources be used at an appropriate stage of intervention?
- Are there opportunities to connect local services and providers into a digital offer?

As digital resources are continuously expanding and improving, services will need to have a process to keep themselves up to date with the latest technology, but also be aware of any issues relating to security, quality, evidence and information governance. Section 3 of the Helpful Resources document provides links to further digital resources.

7.7 Support for transitions

Transitions refer to changes in circumstance that may include moving to a new location, changing schools, graduating to a higher education level, returning to school after inpatient care or moving from NHS CYPMH services to adult services. Transitions often present risks to children and young people as they can result in gaps in the support or care received. MHSTs working in partnership with the service discharging the child or young person should ensure there are clear processes in place to support a successful transition.

Any transition should involve the child or young person, and their family, parents or carers where appropriate, in developing and agreeing on a transition plan to reflect their needs.

For further guidance around transfers of care, MHSTs should refer to NICE guidance on Transition From Children's to Adult's Services for Young People Using Health or Social Care Services and Transition Between Inpatient Mental Health Settings and Community or Care Home Settings, as well as guidance from NHS England on Model Specification for Transition from Child and Adolescent Mental Health Services.

8 Addressing disadvantage, inequalities and need

Summary of Key Points

- Consideration should be given to supporting children and young people who are at risk of developing mental health problems, or who may experience health inequalities or disadvantage. MHSTs should support children and young people throughout, without question.
- The assessment and formulation of need for an individual child or young person should be carried out by a professional with appropriate skills, competence and experience.
- Every effort should be made to build on information already gathered to avoid duplication and so the child or young person does not have to repeat their story.
- The impact of MHSTs should be regularly evaluated to determine how well they are meeting the needs of different groups of children and young people. MHSTs may need to develop specific protocols for working with particular groups, including children and young people who are home educated, to further advance mental health equality.

8.1 Advancing mental health equality, and narrowing health inequalities and disadvantage

Some groups of vulnerable children have a higher prevalence or are at higher risk of developing mental health problems or may experience barriers to accessing support.[22] This section makes reference to health inequalities and disadvantage. Health inequalities are the avoidable differences in people's health status including outcomes across a population or between groups and individuals. The term disadvantage is often used in the context of education initiatives, it relates to a condition or situation that means that children with certain backgrounds or experiences tend to achieve worse outcomes than their peers.

Children who are at higher risk of developing mental health problems or experiencing barriers to accessing support include those:

- with special educational needs, communication difficulties, learning disabilities and behavioural difficulties
- with comorbid neurodevelopmental problems, or physical health problems
- with drug and alcohol problems or issues such as problem gambling
- for whom English is not their first language
- who identify as lesbian, gay or bisexual
- who identify as transgender or non-binary
- who may have experienced, or been witness to, abuse, violence, child sexual exploitation or female genital mutilation
- who may be affiliated with a gang
- who are children of military personnel and those dependent on military personnel
- from a lower socioeconomic background
- who do not have a fixed address
- who may be geographically isolated, or live in areas where there are fewer resources to support their mental health and wellbeing
- who are not enrolled in schools or colleges, who are home educated, have left or are excluded from formal education, and those not in training or employment – these people may be difficult to identify
- who are from Black, Asian and Minority Ethnic (BAME) communities
- who are asylum seekers or refugees
- who may be a part of travelling communities
- who are in contact with the youth justice system

● with caring responsibilities ● who may be in care, are about to leave care, are on the edge of care, or are on a Child Protection Plan or a Child in Need Plan ● previously looked-after children e.g. adopted children	● who are about to transition to adult services – these young people are at greater risk of falling through gaps between services

Services have a legal duty to give due regard to reducing health inequalities through the delivery of services, thereby working to ensure that a person's chance of experiencing good health and a longer life is not determined by social and economic conditions in which they are born, grow, work, live and age. The NHS Long Term Plan published in January 2019 gives further emphasis to this aim. As such, MHSTs and the wider local system should work to consider ways in which health needs and inequalities are addressed.

8.2 Strategies to proactively advance mental health equality

MHSTs are well placed to engage a wide range of children and young people, and working in partnership across education, health, social care and the VCSE sector can help deliver care that meets the needs of vulnerable groups. MHSTs can advance equality through:

- Involving children, young people, and families, parents and carers in the development and planning of services and giving them a voice
- Actively monitoring access to the service by different groups and creating an action plan if inequalities are evident or access does not match the student or local demographics
- Using translators and interpreters for those whose preferred language is not English
- Using alternative means of communication including large text, braille or communication aids such as the Mental Health Pack
- Working with education settings and staff to understand how they are addressing inequalities
- Engaging specific communities or at-risk groups through community projects, link workers, mental health ambassadors, outreach services or liaising with youth workers or groups
- Building knowledge and sensitivity around culture, gender, sexuality, religion and language, the factors that contribute to inequality and how to address them through shared training, professional development and individual supervision (see Section 7.4)
- Working to promote wellbeing and reduce stigma surrounding mental health problems, linking with the whole-system approach to mental health and wellbeing in terms of prevention and awareness
- Linking with local authorities and implementing the recommendations from the Social Care Institute for Excellence (SCIE) on improving the mental health of children and young people in care
- Linking with local councils, local authorities, primary care or VCSE organisations who may engage with children and young people who are home educated; how MHSTs work with home-schooled students will need to be defined locally.

The impact of MHSTs should be regularly evaluated to determine how well they are meeting the needs of different groups of children and young people. MHSTs may need to develop specific protocols for working with particular groups, including children and young people who are home educated, to further advance mental health equality.

9 Learning from the Trailblazers

All schools and colleges working with a Mental Health Support Team are expected to engage with a range of evaluation activities such as data collection, surveys, interviews, and focus groups so that we can evaluate whether MHSTs are successful. There will be an independent evaluation of the development, delivery and outcomes of this children and young people's mental health programme, commissioned by the National Institute for Health Research (NIHR) and conducted by BRACE and PIERU to help inform future implementation plans. The evaluation will involve information gathering from participating areas and schools and colleges, with some more in-depth work in a few areas e.g. to create case studies.

10 Abbreviations

BAME	Black, Asian and Minority Ethnic
CCG	Clinical Commissioning Group
CCQI	College Centre for Quality Improvement
CORC	Child Outcomes Research Consortium
CORE	Centre for Outcomes Research and Effectiveness
CQC	Care Quality Commission
CYPMH	Children and young people's mental health
DCMS	Department of Digital, Culture, Media and Sport
DHSC	Department of Health and Social Care
EHCP	Education, health and care plan
EIP	Early intervention in psychosis
EMHP	Education mental health practitioner
ESCaSS	Effective, Safe, Compassionate and Sustainable Staffing
IAPT	Improving Access to Psychological Therapies
IT	Information technology
LTP	Local transformation planning
MHSDS	Mental Health Services Data Set
MHST	Mental Health Support Team
NICE	National Institute for Health and Care Excellence
NCCMH	National Collaborating Centre for Mental Health
PSHE	Personal, Social and Health Education
SCIE	Social Care Institute for Excellence
SEAL	Social and Emotional Aspects of Learning
SENDCO	Special educational needs coordinator
SEND	Special educational needs and disabilities
STP	Sustainability and transformation partnership
UCL	University College London
VCSE	Voluntary, community and social enterprise
WTE	Whole time equivalent

11 How was this document developed?

The National Collaborating Centre for Mental Health (NCCMH) was commissioned by NHS England and the Department for Education to develop this manual. The NCCMH established an Expert Reference Group, including experts by experience (young people and parents/carers) and commissioning, clinical, operational and service leaders across health, social care, education and the VCSE sector. The manual was then refined and iterated through a process of testing with its key audience.

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