Nottingham Trent University

Social Work, Care and Community Department

Nottingham and Nottinghamshire Mental Health Support Teams Evaluation: Final Report

Evaluation Team: Professor Geraldine Brady, Dr Gabriella Mutale and Bailey Foster

31/07/2025

Contents

Contents....2
Acronyms....4
Executive summary....5
1. Introduction....9
Overview....9
Evaluation Aims....9
Mental Health Support Teams....9
The Whole School / College Approach....11
Previous Evaluations....11
Scope of Delivery in Nottingham and Nottinghamshire....12
Demographics of Nottingham and Nottinghamshire....13
Mental Health and Emotional Wellbeing Provision in Nottingham and Nottinghamshire 16
2. Methodology....18
Evaluation Design....18
Data Collection and Analysis....19
Staff members....20
Survey with staff....20
Interviews with staff....21
Mental Health and Emotional Wellbeing Outcomes....22
Cost Analysis....23
Ethics....26
3. Findings....27
Research Question: What impact are the MHSTs, including the Whole School Approach, having on mental health and emotional wellbeing outcomes for children and young people?....27
Measured outcomes....27
Service Utilisation....33
Research Question: What is staff experience of the MHSTs and delivering the WSA and to what extent has the WSA been delivered effectively?....35
Staff survey....35
Qualitative Data: Staff Experiences....44
Research Question: What is the cost effectiveness of the MHSTs?....57
Cost Analysis....57

Research Question: How are the main principles of the WSA contributing to changes in mental health and emotional wellbeing outcomes? 62
Future Development of MHSTs 66
Success 66
Feedback from Children and Young People 67
Reflections from Research Questions 68
4. Limitations 69
5. Recommendations 70
Research Question: How could the model be improved further? 70
6. Conclusions 72
7. Acknowledgements 72
8. References 73
Appendices 76

Acronyms

ANOVA – Analysis of Variance

BPS – British Psychological Society

CAMHS – Child and Adolescent Mental Health Services

CGAS – Children's Global Assessment Scale

DWP – Department of Work and Pensions

EMHP – Educational Mental Health Practitioner

GMCA – Greater Manchester Combined Authority

HMRC – His Majesty's Revenue and Customs

HM Treasury – His Majesty's Treasury

ICB - Integrated Care Board

MHST - Mental Health Support Teams

NEET – Not in Education, Employment or Training

NHS - National Health Service

NICE - National Institute for Health and Care Excellence

NTU – Nottingham Trent University

RCADS – Revised Child Anxiety and Depression Scale

WSA – Whole School Approach

EWMH – Emotional Wellbeing and Mental Health

SDQ – Strengths and Difficulties Questionnaire

SEND – Special Education Needs and Disabilities

SPA – Single Point of Access

Executive summary

Level of Evaluation & Research Questions	Key Findings
Context • **In what context are the MHSTs situated?** • **What are the enablers and barriers to implementing the MHSTs?** • **What are the critical success factors?**	• **Critical success factors that were identified from the survey with staff included:** • Communication • Teamwork • Passionate staff • MHSTs giving a timely response according to the needs of the children, young people, professionals and families and carers they engage with • Staff understanding each other's roles • MHSTs providing an early intervention • **Barriers identified from the survey with staff:** • Staffing problems/lack of funding • Schools not engaging • MHSTs remit being too limited • Problems with referral and waiting times • MHSTs and schools not working in collaboration • Existing school structures/policies not supporting positive mental health and emotional wellbeing
Inputs • **How are the MHSTs being delivered?** • **What is staff's experience of the MHSTs and delivering the WSA?** • **How are the main principles of the WSA contributing to outcomes?**	• Staff from MHSTs and Education settings who completed the survey were positive in their views of the MHSTs and 92% of staff asked through the staff survey thought that MHSTs improve the mental health and emotional wellbeing of children and young people • Staff who were interviewed were also positive about their experience of working within or with MHSTs. They felt that MHSTs have a clear remit and are effectively addressing mild to moderate children and young people's mental health and emotional wellbeing needs • Communication with schools can be very good, so that the WSA becomes embedded and

	positively influences the culture around mental health and emotional wellbeing for the benefit of children, young people, parents, carers and school staff • Staff work with young people at an early stage, before their mental health and emotional wellbeing deteriorates, providing an early intervention • WSA increases understanding of mental health and reduces stigma amongst children, young people, parents, carers and the wider school community • However, whilst engagement from some schools is strong others are more difficult to persuade to engage to take up the offer • Partnership working is needed to achieve the delivery of all WSA principles, it is not possible for MHSTs to achieve this without the support and active engagement of the wider education and mental health systems
Outcomes • **What impact are the MHSTs having on outcomes for children and young people and what are the outcomes for services?** • **What impact are the MHSTs and WSA having on mental health and emotional wellbeing outcomes for children and young people?** • **Are there any cost savings resulting from the MHSTs?** • **Has service utilisation been**	• **Analysis of outcome data taken pre and post the 1:1 and group interventions provided by the MHSTs (under Function 1 of the model) showed that children and young people made statistically significant improvements in their mental health and emotional wellbeing following intervention** • In Nottingham City children and young people showed significant improvement in their mental health and emotional wellbeing evidenced by RCADS measures • In Nottinghamshire County children and young people showed significant improvement in their mental health and emotional wellbeing evidenced by RCADS, CGAS and SDQ measures • **Cost analysis relating to 1:1 and group interventions provided by the MHSTs (under Function 1 of the model) found that cost savings are being made by the MHSTs due to**

altered by the MHSTs? • **How could the model be improved?**	**them delivering successful early interventions in childhood** • This means children and young people get the right help for their mental health at an earlier point in their life, indicating cost savings are then made through the rest of childhood and adulthood • **Cost analysis related to the 1:1 and group interventions provided by the MHSTs showed that in Nottingham City an initial saving of £3,602.51 per child is made and then an additional saving of £871.77 each year through childhood. Lifetime savings are £7,432.68 per child per year in adulthood from 18 to 24 years and then £3861.08 per child per year till retirement age.** • **For Nottinghamshire County a saving of £1,570.55 per child treated is made and then an additional yearly saving of £380.06 is made through childhood. A lifetime saving of £3,240.33 per child treated is made every year from 18-24 years and then an annual saving of £1683.27 is made** • These cost savings (related to the 1:1 and group interventions) are due to the potential the MHSTs have to save money to a) NHS mental health services due to early intervention preventing further referrals to other services within CAMHS and early intervention in childhood reducing the chance of mental health conditions in adulthood (Mulraney et al.,2021) consequently reducing the use of Adult Mental Health services b) the Local Authority due to the negative effects of childhood mental health conditions on attendance at school (NHS Digital, 2022) c) the Economy due to negative effects of childhood mental health conditions on GCSE attainment (Smith et al.,2021) d) the criminal justice system due to childhood mental health conditions being linked to youth offending (HM Inspectorate of Education, 2020). e) HMRC, DWP and the Economy due to the relationship between adults

	aged 18-24 years who are Not in Education, Employment or Training and mental health conditions (Gariepy et al.,2021) **<u>Recommendations made include:</u>** • MHSTs need existing funding increased to enable to expand the capacity of the service to reduce waiting times and enable them to potentially develop specialist roles within the teams, for example, SEND roles, specialised mental health and emotional wellbeing support. • Further recurrent funding is also needed to facilitate the expansion of MHSTs so that every school and college has access to an MHST. Although this is closer to being achieved currently in Nottingham City (c.76% coverage when accounting for primary schools, secondary schools, colleges and special schools – less when accounting for alternative provisions, independent schools or home schooling networks) in some areas of Nottinghamshire the provision of MHSTs is still relatively low (c.44% coverage when accounting for primary schools, secondary schools, colleges and special schools – less when accounting for alternative provisions, independent schools or homeschooling networks) and this needs to be increased.

1. Introduction

Overview

This evaluation report presents key findings from a study evaluating the experiences of professionals commissioning, managing and delivering Mental Health Support Teams, professionals working within education settings who receive MHST support and children and young people who have received the support provided. The evaluation report details the evaluation framework, including the methodology, participants and data collected. The main body of the report is based on the data generated for this evaluation, and secondary data is also used to quantify the impact of MHST provision on children and young people's outcomes. The evaluation concludes with a summary and reflection, which includes key learning points and recommendations.

Evaluation Aims

Nottingham Trent University was commissioned by Nottingham and Nottinghamshire Integrated Care Board to undertake an evaluation of MHSTs and the Whole School Approach (WSA).The primary data collection period for the evaluation ran from 2024-2025. Secondary data from 2019-2024 was also used and analysed in the evaluation.

The evaluation aimed to understand and evidence the effectiveness of the MHSTs (including the WSA) by addressing the following questions:

1. What impact are the MHSTs (including the WSA) having on mental health and emotional wellbeing outcomes for children and young people?
2. How are the main principles of the WSA contributing to these outcomes?
3. What is the cost effectiveness of the MHSTs?
4. What is staff's (MHST staff and Education Setting staff) experience of the MHSTs, including the WSA, and to what extent has the WSA been effectively embedded and goals achieved?
5. How could the model be improved further?

Mental Health Support Teams

In 2017, a Green Paper titled 'Transforming Children and Young People's Mental Health Provision: A Green Paper' (Department for Education 2017), set out several strategies to improve children and young people's mental health services. Among them was the creation of Mental Health Support Teams, which set out to provide extra capacity at the early intervention stage for children and young people. The first trailblazer MHSTs were mobilised in 2019. The MHSTs were developed in partnership between NHS ICBs, service providers and schools and colleges.

There are 3 core functions of the MHSTs:

Function 1: Delivering evidence-based interventions to children and young people with mild to moderate mental health issues

Function 2: Supporting the Senior Mental Health Lead in each education setting to introduce or develop their whole school or college approach to mental health and emotional wellbeing.

Function 3: Giving timely advice to education setting staff, and liaising with external specialist services, to help children and young people to get the right support and stay in education.

All three functions are essential to the MHST model, but the delivery and prioritisation of the s may vary locally depending on local need.

With the creation of the MHSTs there was also the creation of a new qualification and job role titled Educational Mental Health Practitioner (EMHP). Staff in this role make up the majority of an MHST, with the national model prescribing 4 full time equivalent EMHPs per team. The British Psychological Society (BPS) defines this role as,

> *New members of the mental health workforce who will be trained to deliver evidence-based psychological interventions in, or close to, schools and colleges. Their focus will be on addressing 'mild to moderate mental health difficulties'. Each team will support up to 8000 children and young people and will be responsible for a cluster of between 10 and 20 education settings – Including schools and colleges as well as settings such as alternative provision, pupil referral units, special schools, home school networks and work-based learning* (BPS 2019, p. 3).

According to the national MHST model, one MHST comprises 9 members of staff, including:

1. 4 EMHPs
2. 3 Senior Clinicians
3. 1 Team Manager
4. 1 Administrative support

There are also Senior Mental Health Leads assigned within each school/college. Their primary goals are to coordinate opportunities for intervention delivery within the wider school/college curriculum; support and sustain the engagement of MHSTs in the school/college setting and to promote the WSA, championing its adoption throughout school/college policy reform and curriculum development.

The Whole School / College Approach

The National Institute for Health and Care Excellence (NICE) recommends both primary and secondary schools should be supported to adopt a WSA to the promotion of social and emotional wellbeing in children and young people, including people with neurodiverse conditions (NICE 2022).

Procter et al, (2021, p. 6) defines a WSA to mental health and emotional wellbeing as:

> …a coordinated multi-component approach across an educational setting to promote emotional wellbeing, identify emotional and mental health difficulties at an early stage, and provide support to those who need it (either in school or by signposting to external agencies).

To implement the WSA to mental health and emotional wellbeing, Public Health England published 8 key principles:

1. An ethos and environment that promotes respect, and values diversity
2. Leadership and management that supports and champions efforts to promote emotional health and wellbeing
3. Staff development to support their own wellbeing and that of pupils and learners
4. Curriculum teaching and learning to promote resilience and support social and emotional learning
5. Enabling student voice to influence decisions
6. Identifying the need for and monitoring the impact of interventions
7. Targeted support and appropriate referral
8. Working with parents and carers (Public Health England 2021).

A key aim of MHSTs is to support the implementation of the WSA, by providing additional capacity and early intervention to children and young people with mild to moderate mental health needs within the context of an education setting. The colocation of MHSTs in school/college settings is a deliberate aspect of their design, enabling them to enact true early intervention by bringing support to children and young people where they are, rather than requiring them to seek out and access support themselves. The goal of the WSA is to sustainably improve mental health and emotional wellbeing responses in whole school/college communities, the adoption of mental health and emotional wellbeing as a priority and the changing of schools/colleges policy and procedures to reflect this, and a belief that mental health and emotional wellbeing is the collective responsibility of everyone in the education setting community.

Previous Evaluations

MHSTs were first introduced in 2017, with several evaluations already being conducted. National monitoring and evaluation of MHSTs has been criticised for

leaning towards clinical outcomes, leaving a knowledge gap in understanding how local services are adapting and developing their MHSTs (Procter, Roberts, MacDonald, Morgan-Clare, Randell and Banerjee, 2021). Recent evaluations, such as this current study, aim to address this knowledge gap. MacLennan (2024) has demonstrated some of the cost savings that can be achieved from delivering interventions in educational settings through the MHST model. The current evaluation uses a mixed method approach to enable examination of the cost effectiveness of MHSTs alongside qualitative data from professionals and children and young people.

Scope of Delivery in Nottingham and Nottinghamshire

In Nottingham City and Nottinghamshire County MHSTs operate in schools and colleges who are partnered with an MHST. All schools and colleges are eligible for MHST support, however incomplete MHST coverage means MHSTs do not currently have capacity to support all education settings meaningfully, therefore, at the time of writing, only c.76% of Nottingham City education settings are engaged with MHSTs (excluding alternative provisions, independent schools and home schooling networks who are not currently accounted for in national coverage calculations) and c.44% of Nottinghamshire County education settings are engaged with MHSTs (also excluding alternative provisions, independent schools and home schooling networks).

In Nottinghamshire, MHSTs are delivered by Nottinghamshire Healthcare NHS Foundation Trust, whilst in Nottingham City MHSTs are delivered by Nottingham City Council. These Providers deliver the national MHST model but vary this according to the needs of the local populations, resource and expertise available within the Provider organisations, and the strength and quality of relationships between the MHST and education settings. Variance from the national MHST model and its delivery is encouraged, where it is identified that this is needed, in the 2022 MHST Operating Manual, therefore it is expected that aspects of service design and delivery differ between Providers and within locality teams in both MHST services.

As within the rest of UK, the mobilisation and launch of MHSTs in Nottingham and Nottinghamshire has historically taken place in waves. This is the result of a national competitive bidding process, whereby ICBs and Providers were invited to bid for MHST wave allocations at various intervals between 2019 and 2024. NHS England allocated waves in response to these bids. Priority was given to localities of high deprivation, which accounts for Nottingham City currently having much higher coverage than areas of Nottinghamshire County. In Nottingham and Nottinghamshire, wave allocation from 2019 to 2024 has been as follows:

Table 1 Waves of MHSTs

NHS England Wave	Local Wave	Mobilisation	Operational	Area
Trailblazer	1	Jan 2019 – Dec 2019	Dec 2019	Notts County - Gedling
Trailblazer	1	Jan 2019 – Dec 2019	Dec 2019	Notts County - Rushcliffe
1	2	Sep 2019 - Aug 2020	Nov 2020	Notts County Mansfield & Ashfield
1	3	Sep 2019 - Aug 2020	Nov 2020	Nottingham City
1	4	Sep 2019 - Aug 2020	Nov 2020	Nottingham City
1	4	Jan 2021 - Dec 2021	Jan 2022	Notts County - Bassetlaw
4	4	Jan 2021 - Dec 2021	Jan 2022	Notts County - Newark & Sherwood
4	4	Jan 2021 - Dec 2021	Jan 2022	Notts County - Broxtowe
6	6	Jan 2022 - Dec 2022	Jan 2023	Nottingham City
7	8	Sep 2022 - Aug 2023	Sep 2023	Nottingham City
8	9	Jan 2023 – Dec 2023	Jan 2024	Nottingham City
9	9	Sep 2023 – Aug 2024	Sep 2024	Notts County - Gedling
9	9	Sep 2023 – Aug 2024	Sep 2024	Notts County - Mansfield & Ashfield
10	10	Jan 2024 – Dec 2024	Jan 2025	Notts County - Newark & Sherwood

Demographics of Nottingham and Nottinghamshire

Nottinghamshire County sits around Nottingham City and is made up of Bassetlaw, Newark & Sherwood, Mansfield, Ashfield, Gedling, Broxtowe and Rushcliffe. Figure 1 shows the geographical lay out of Nottinghamshire County in relation to Nottingham City.

Figure 1 Nottingham and Nottinghamshire

(Image from Nottinghamshire County Council)

For the purposes of MHST locality team set-up, Mansfield and Ashfield districts share an MHST locality team. This is on account of the similarities in population need and the desire to ensure continuity for children and young people who may progress to the Community CAMHS locality team which, at the time of writing, also covered Mansfield and Ashfield jointly.

Due to the different demographics of children and young people across the City and County, as well as the physical geography of Nottingham and Nottinghamshire, the MHSTs in these areas will have different challenges.

Levels of deprivation are higher in Nottingham City and some areas of Nottinghamshire. The CORE20PLUS5 is an NHS approach aimed at reducing health inequalities in children and young people. The Plus element relates to inclusion of ethnic minority groups and other marginalised groups. The approach has a focus on 5 clinical areas of which mental health is one. The CORE20PLUS5 approach has identified Nottingham City and some areas of Mansfield and Ashfield as being in the

20% of the most deprived areas in England. Therefore, these areas will face unique challenges with mental health that may not be apparent in other areas For example, it has been shown that the prevalence of severe mental illness is three times higher for those living in the most deprived areas compared to the least deprived areas (Public Health England, 2016) suggesting need may be higher in Nottingham City, Mansfield and Ashfield.

Furthermore, Nottingham City has a much higher ethnic minority population than Nottinghamshire meaning additional challenges may be faced here. In mental healthcare ethnic inequalities have been consistently found with many ethnic groups experiencing barriers to mental health support (Bansall, 2022). However, this is despite levels of severe mental illness being much higher in ethnic minority groups (Public Health England, 2016). It has been suggested that mental health provision needs a model that is responsive to the lived experiences of people in ethnic minority groups (Bansall, 2022) meaning Nottingham City MHSTs will have different considerations than those in the County.

Nottinghamshire

Ethnic Minority populations are relatively low across Nottinghamshire particularly in some areas for example, around 95 - 96% of the population are White in the Ashfield, Mansfield, Newark & Sherwood, and Bassetlaw Districts. In Gedling, Rushcliffe and Broxtowe Districts around 89% of the population are classed as White (ONS, 2021).

Parts of Nottinghamshire are very affluent with other parts being among the most deprived in England. These differences result in health inequalities and disparities in the County which need to be considered when reflecting on variance from the national MHST model, as additional funding may be required to better meet the needs of these populations and gain good outcomes for children and young people.

To examine health inequalities Public Health England produce health profiles for every Local Authority area to show if areas are significantly “better” or “worse” than the England average. In Nottinghamshire it is shown that in Ashfield 21.1% of children live in low-income families and in Mansfield 20.4% of children do which is significantly higher than the national average (Public Health England 2020a, 2020b). In contrast in Rushcliffe only 6.9% of children live in low-income families which is significantly better than the national average (Public Health England, 2020c). In Mansfield and in Ashfield, GCSE attainment is significantly worse than the national average (Public Health England 2020a, 2020b). However, in Rushcliffe GCSE attainment is significantly better than the national average (Public Health England, 2020c).

This means outcomes for children and young people are not the same across the County and any approaches provided should take this into consideration if they aim

to improve outcomes, including health and educational outcomes, for children and young people equitably.

Nottingham City

In Nottingham City there is a higher percentage of ethnic minorities with 34.1% of the population being part of an ethnic minority group (Asian 14.9 %, Black 10%, Mixed 5.9%, Other 3.3%) and 65.9% of the population being White (ONS, 2021)

In Nottingham City 29.5% of children live in low-income families which is significantly worse than the national average. GCSE attainment is significantly worse than the national average (Public Health England, 2020d). Nottingham was ranked in the bottom 10% of local authority areas in England for health in 2021 (ONS, 2021).

Mental Health and Emotional Wellbeing Provision in Nottingham and Nottinghamshire

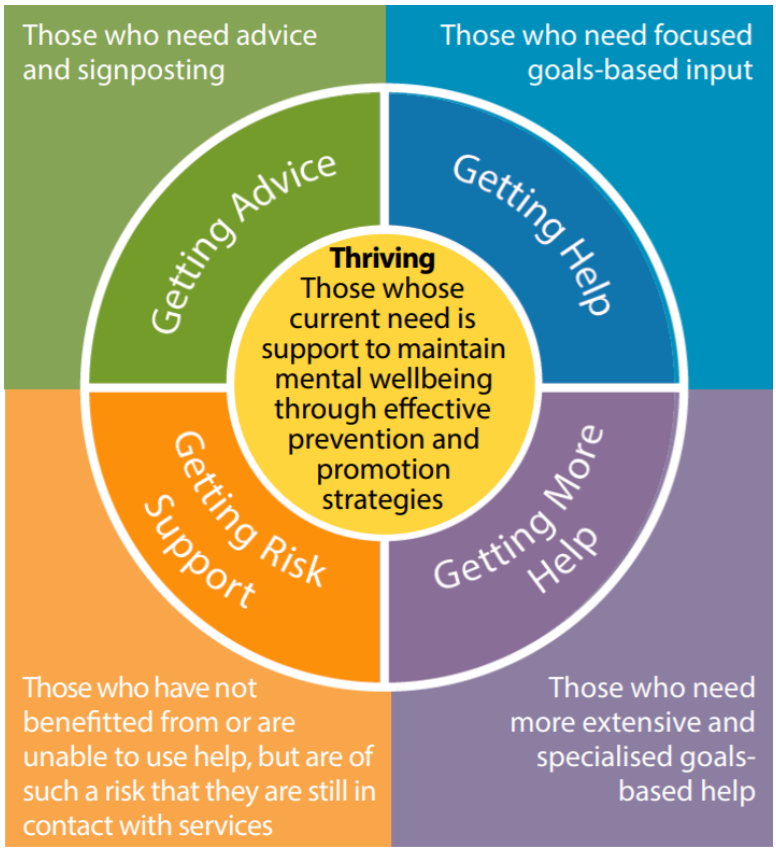
The full children and young people's mental health and emotional wellbeing pathway in Nottingham and Nottinghamshire is made up of several services including specialist mental health and emotional wellbeing provision as well as universal services with a mental health and emotional wellbeing offer. CAMHS services (delivered by both Nottinghamshire Healthcare NHS Foundation Trust and Nottingham City Council) make up the largest part of this pathway, however it must be acknowledged that charity and voluntary sector services (including those commissioned by the ICB), independent sector services (including those commissioned by the ICB), Local Authority commissioned services, Office for the Police and Crime Commissioner commissioned services, and in-house Local Authority children and young people's provision, such as Family Hubs and Youth Service offers, also contribute towards this pathway.

Whilst it is acknowledged that the full range of provision described above plays an essential role in the wider local Children and Young People's Mental Health and Emotional Wellbeing Pathway, the scope of this evaluation has been to analyse the impact of MHSTs. As a result, data collection and analysis has focussed primarily on data collected through and/or provided by the MHSTs, so data from other early intervention and prevention mental health and emotional wellbeing provision has not been sought. Consideration of the impact of MHSTs on more intensive CAMHS services has, however, been considered throughout this evaluation in acknowledgement of the key ambitions of early intervention and prevention being to avoid the deterioration of children and young people's mental health and emotional wellbeing and to subsequently reduce the need for more intensive support. This evaluation therefore considers MHSTs within the context of the local CAMHS offer, rather than the full mental health and emotional wellbeing pathway and uses data from more intensive CAMHS services alongside MHST data to establish impact.

All children and young people's mental health and emotional wellbeing provision, including CAMHS provision, operates within the THRIVE framework (Wolpert et

al.,2019) which is an integrated, person centred, and needs led approach to organising and delivering mental health and emotional wellbeing support. The THRIVE framework encourages and enables services to treat children and young people based on need rather than diagnosis and shifts away from strict threshold criteria towards integrated care offers which treat children and young people for their current needs, rather than requiring them to deteriorate before they meet the remit of a specific service. The THRIVE framework is an evidence-based approach to pathway design and is endorsed as a best practice approach by NHS England.

Thrive Framework



MHSTs primarily sit within the Getting Advice and Getting Help quadrants of the THRIVE framework and work closely with other services with the same and/or similar level of clinical expertise.

As of 2025, core CAMHS services provided in Nottingham and Nottinghamshire are:

- **MHSTs** - provide early interventions for mental health and emotional wellbeing in schools and colleges. The service provides support for children, young people and families and carers for mild to moderate mental health and emotional wellbeing needs

- **Targeted CAMHS (including SPA)** (Nottingham City only) - provides support for children and young people with moderate emotional and/or mental health needs
- **Community CAMHS (including SPA)**
- **Specialist CAMHS (includes Eating Disorders, Tics and Tourettes, Paediatric Liaison, ID, Head 2 Head etc)**
- **CAMHS Crisis, Liaison and Home Treatment**

These services include smaller sub-teams based on locality and/or specialism, acknowledging the need for variance in offer based on population differences, physical geographical differences, and complexity of presentations.

2. Methodology

Evaluation Design

The design of the evaluation was informed by a multi-level evaluation framework developed through previous research (e.g. Bailey & Mutale, 2020, 2022; Bailey et al., 2020; Mutale, et al., 2020). This multi-level evaluation design has been used in similar evaluations that have been intended to evidence efficacy of interventions in both mental health and social care provision (e.g. Bailey & Mutale, 2020, 2022; Bailey et al., 2020; Mutale, et al., 2020). The evaluation framework proposed allowed us to measure the satisfaction and experience of the MHSTs including the WSA by using both qualitative methods, such as semi-structured interviews, in conjunction with quantitative methods for assessing MHST impact, such as reviewing standardised outcomes measures. In addition, we developed a cost analysis using quantitative data in relation to the preventative impact of the MHST.

The multi-level framework includes **(1) Context, (2) Inputs and (3) Outcomes.**

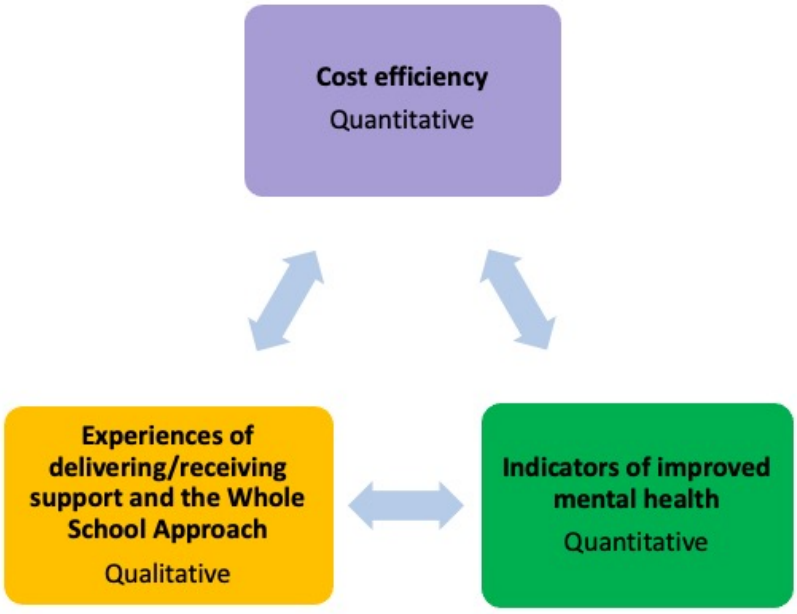
1. The **context** of the MHSTs. What are the critical success factors? What are the barriers and enablers to implementing the WSA and the MHSTs.
2. The **inputs** the MHSTs are able to deliver. How are the main principles of the WSA contributing to outcomes? What is staff's experience of the MHSTs and delivering the WSA? To what extent has the WSA been effectively delivered from staff perspective?
3. a)The **outcomes** for children and young people. What changes have the MHSTs including the WSA made to the lives of children and young people and how have they impacted on their mental health, emotional wellbeing and educational experience?

b)The **outcomes** for services. Has service utilisation been altered by the MHSTs and the approach? What cost savings can the MHSTs make?

c) The **outcomes** for the system. How have mental health and emotional wellbeing pathways changed with the introduction of MHSTs? What are educational outcomes, societal outcomes, economic outcomes, etc. like?

The framework supported the triangulation of qualitative and quantitative data (see Figure 3). This enables us to understand and evidence the relationship between, mental health and emotional wellbeing outcomes, the experience and satisfaction for both children/young people and staff members, both those delivering the MHST and those within education settings, and the cost effectiveness of the MHSTs. The qualitative data helps to contextualise findings from the quantitative data analysis and give insights that cannot be gained by quantitative data alone.

Figure 3 Triangulation of data



Data Collection and Analysis

We have collected data relating to each level of the evaluation, as summarised in Table 2.

Table 2 Levels of Evaluation

Level of Evaluation	Questions to Answer	Data Sources
Contexts	• What are the enablers and barriers to implementing the MHSTs?	• Interviews with MHST staff members • Interviews with MHST leads (service

	• What are the critical success factors?	managers and commissioners) • Staff survey (MHST and Education Settings)
Inputs	• How are the main principles of the WSA contributing to outcomes? • What is staff's experience of the MHSTs and delivering the WSA? • To what extent has the WSA been effectively delivered from the perspective of staff?	• Interviews with MHST staff members • Interviews with MHST leads (service managers and commissioners) • Staff (MHST and Education Setting) survey
Outcomes	• What impact are the MHSTs and WSA having on mental health and emotional wellbeing outcomes for children and young people? • Are there any cost savings resulting from the MHSTs? • Has service utilisation been altered by the MHSTs? • How could the model be improved further?	• Outcome data pre and post intervention • Cost analysis • Referral data for more intensive CAMHS services • Interviews with MHST staff members • Interviews with MHST leads (service managers and commissioners) • Staff survey (MHST and Educational Setting)

Staff members

Survey with staff

A survey (see Appendix 1) was designed to explore how staff in the MHSTs and any other staff who work with the MHSTs (e.g. school/college staff) found the experience. The survey consisted of 8 Likert scale questions (a Likert scale is a psychometric scale which measures attitudes or opinions. It typically has statements that respondents have to indicate to what extent they agree with) and two open ended questions which aimed to understand staff's thoughts on and experiences with the MHSTs. In addition, there were two general questions asking what area staff worked in and their job role.

The survey was designed to be brief and to be completed in under 10 minutes, to increase the uptake amongst participants. Therefore, the survey did not include any further demographic questions.

This survey was sent via email to all staff that work in and with the MHSTs in both Nottingham City and Nottinghamshire.

Data from the Likert scale questions was analysed using descriptive statistics. Data from open ended questions was analysed thematically to identify common themes across all respondents.

The survey aimed to examine how successfully Functions 2 and 3 are being delivered by the MHSTs

Interviews with staff

Interviews were conducted with staff members who work in or with the MHSTs. All interviews were conducted online via Teams with a member of the evaluation team in a secure and confidential setting.

Online interviews, conducted by the team, were transcribed, coded and themes identified. Relevant quotations were extracted and analysed to identify themes throughout the qualitative data and contextual information was included to provide understanding of the roles and responsibilities of respondents. The themes that were identified across the data are thematically presented here, the direct voices of the participants are used to illustrate each theme.

The staff interviews aimed to examine how successfully Functions 2 and 3 are being delivered by the MHSTs.

Staff participants

The table below shows the numbers and categories of staff participating in the evaluation.

Table 3 Participants

Method of Data Collection	Number of Participants	Participant Group
Interview	7	MHST Staff
Interview	1	GPs
Interview	4	Service Managers/ ICB Commissioners
Survey	60	MHST Staff School/college Staff (See Figure 12 in Findings for breakdown)

Mental Health and Emotional Wellbeing Outcomes

Children and young people complete the Revised Children and Anxiety Depression Scale (RCADS), Children's Global Assessment Scale (CGAS) and/or the Strengths and Difficulties Questionnaire (SDQ) at the start of 1:1 or group intervention and again at the end. Not all children and young people engaging with the service will complete paired outcome measures as some will choose not to, and some may complete a pre measure but not a post measure, for example if dropping engagement prior to intervention completion. MHST clinicians use their clinical expertise to decide which outcome measures are most appropriate to use with the child or young person based on their presenting symptoms and the intervention they are delivering. Clinicians consider which outcome measures will best demonstrate the impact of the intervention, which is typical in practice across the UK.

Outcome measures are only used for interventions given by the MHSTs under Function 1 and therefore will examine the success of Function 1.

RCADS - (Chorpita et al., 2000) is a 47 item self-report questionnaire for children and young people aged 8-18 years. It also includes 6 sub-scales which can be used independently, or the 5 anxiety sub-scales can be used together to create a total anxiety score or the sum of all 6 sub scales can be used to create a total internalizing score. The sub-scales are: 1) Separation anxiety disorder 2) Generalised anxiety disorder 3) Social phobia 4) Panic disorder 5) Obsessive Compulsive disorder and 6) Low mood. Raw scores are converted into T scores. T scores of 65 and over represent a clinical disorder. An improvement would be indicated by a lower score.

CGAS - (Shaffer et al., 1983) is a rating of psychological and social functioning for children and young people aged 4-16 years. It is completed by clinicians when assessing a child. The child will be given a single score between 1-100. Higher scores represent higher functioning. An improvement would be indicated by an increase in score.

SDQ - (Goodman, 1997) is a 25-item questionnaire for children and young people aged from 2 – 17 years. The questionnaire comprises 5 sub-scales. These are: 1) Emotional symptoms 2) Conduct problems 3) Hyperactivity inattention 4) Peer relationships 5) Prosocial behaviour. Scores range from 0-40. An improvement would be indicated by a lower score at follow up.

Data was provided by Nottinghamshire Healthcare Trust for Nottinghamshire and Nottingham City Council for Nottingham City. Differences in the way the respective organisations collect data meant Nottingham City chose to randomly select a sub-sample of data to be used in the evaluation. In addition, Nottingham City requested that data for the sub-scales that make up the RCADS were to be used in the analysis as opposed to total RCADS score. The service felt that this better reflected the work

that they do. Nottinghamshire Healthcare Trust chose to share all available data and total RCADS scores were shared to be used in the analysis.

Data has been analysed separately for Nottinghamshire County and Nottingham City. Inferential statistics have been used to identify any significant changes in scores from the start to the end of treatment.

The final sample of data provided for Nottingham City and Nottinghamshire County on all measures was as follows:

Nottingham City

A sub sample was selected at random by Nottingham City Council from the total number of children and young people (n =1366) who had completed the measure at **both** pre and post intervention. The data collection period was from July 2019 to March 2024.

RCADS n = 60. The mean length of treatment for this sample was 143.91 days (sd = 74.8).

Nottinghamshire County

All samples are the total number of children and young people who received a 1:1 or group intervention from an MHST and had completed a measure at **both** Time 1 and Time 2. The data collection period was from February 2021 to April 2024.

RCADS n = 966. The mean length of treatment for this sample was 108.9 days (sd = 63.92)

CGAS n = 1305. The mean length of treatment for this sample was 97.5 days (sd = 50.2)

SDQ n = 9. The mean length of treatment was for this sample was 113.33 days (sd = 55).

Cost Analysis

Counterfactual scenario analysis has been used to conjecture the cost savings associated with the 1:1 and group interventions provided by the MHSTs under Function 1 of the national model. It must be noted that there will be further cost savings made as a result of the MHST's other Functions 2 and 3, but this analysis focuses on cost savings directly made through 1:1 and group interventions, as Function 1 is the only aspect of the MHST model which consistently produces quantitative paired outcome measures which are essential for the methodology used. Counterfactual scenario analysis can be applied to a cost benefit analysis to infer the hypothetical costs that would have occurred due to an inferred hypothetical scenario. It has been used in this evaluation in recognition of MHSTs being primarily an early intervention

and prevention service whereby we can only estimate the hypothetical costs that would have been incurred if the children and young people who access the service had not received an intervention under Function 1 of the MHSTs.

Whilst it is not possible to know exactly what would have happened to each child or young person's mental health and emotional wellbeing if they had not received a 1:1 or group intervention from the MHSTs, we can make estimates based on hypothetical costs that may have occurred if their mental health and emotional wellbeing needs had remained untreated. In the analysis, cost savings have only been applied to the sample of children and young people that were shown to make a recovery. Recovery is indicated from RCADS outcome data. Cost savings are assumed for the sample of children and young people that moved from the clinical range (a T score of 70 and above) into the normal range following treatment. As a T score of 70 and above is in the clinical range it has been assumed that if children and young people who are in this range did not receive an intervention from the MHST, they would have continued to deteriorate and require more intensive and therefore more costly treatment at a later point. It is also likely that waits to access this more intensive treatment would be longer, noting that MHSTs are an additional resource within the wider children and young people's mental health and emotional wellbeing pathway.

The cost analysis gives estimated cost savings throughout childhood (from the point of finishing the intervention until 18 years), and lifetime cost savings into adulthood, (from 18 years to retirement age), that are likely to occur because of the 1:1 or group intervention. These cost savings have been calculated separately for MHSTs in Nottingham City and Nottinghamshire County on account of the differences in population need, availability of alternative mental health and emotional wellbeing services within the wider system, nuances in MHST model delivery and variance in coverage at the time this analysis took place. Unit costs used have been taken from the Greater Manchester Combined Authority (GMCA) Research Team Unit Cost Data Base (version 2.3.1).

The GMCA Cost Data Base is a tool that constructs cost estimates based on multiple sources including government reports and academic research. All estimates are quality assured by the GMCA Research Team and have been subjected to a rigorous validation process.

The GMCA Cost Data Base classifies costs into three different groups depending on what kind of cost saving is being made. These are:

Fiscal costs – these cost savings are to public sector agencies (e.g. health, police, education) and come from public expenditure

Economic costs – these cost savings are to individuals (e.g. personal earnings), employers (e.g. profit, turnover) or the wider economy (e.g. growth of the economy).

Social costs – these cost savings are to society and come from benefits such as improved health and wellbeing, reduced pollution, increased safety etc

In this cost analysis different cost savings have been identified from the literature that would be made through receiving an early intervention in childhood that prevented further support being needed for mental health conditions. These costs are:

Cost savings incurred through childhood

- Mental Health – average annual cost of service provision for children and young people with a mental health condition. £325 per child/young person per year. Fiscal costs to the NHS ICB.
- Education – average annual cost incurred from persistent absence from school per child. £1057 per/young person per year - Fiscal costs to the Local Authority
- Youth offending - average cost of first-time offender in the first year following the offence (under 18 years). £4329 per child/young person - Fiscal costs to the criminal justice system

Lifetime cost savings

- Mental Health – average annual costs of service provision for people suffering from mental health conditions (excluding dementia). - £1163 per person per year. This is made up of: £1014 per person - fiscal costs to the NHS, £129 per person - fiscal costs to the Local Authority and £20 per person - fiscal costs to the criminal justice system.
- Mental Health – average annual cost of mental health conditions to the economy. £4755 per person per year - economic costs to HM Treasury
- Education – average annual cost of lifetime benefit of 1 GCSE grade improvement. This represents the average increase in lifetime earnings because of 1 GCSE grade improvement. £202.92 per person per year - economic costs to HM Treasury.
- Not in Education, Employment or Training (NEET) – average annual NEET cost (from 18-24 years) – £5662 per person per year – This is made up of £4280 per person - fiscal costs to Department of Work and Pensions (DWP) and £1382 per person – fiscal costs to HM Revenue and Customs (HMRC) (£1382).
- NEET – average annual NEET cost to economy (from 18-24 years). £11,969 per person per year – economic costs to HM Treasury

Cost of providing 1:1 and group interventions through the MHSTs

The cost of providing an intervention through the MHST has been estimated at being £121 per session. This is the estimated cost of providing CBT therapy through a CAMHS team. Costs for this estimate are derived from salary costs (including on

costs), working time plus a proportion to account for overheads and capital overheads. (Unit cost obtained from GMCA)

Ethics

Nottingham Trent University's School of Social Sciences Research Ethics Committee gave a favourable ethical opinion upon the completion of the ethical application in February 2023. Any further amendments to the ethics application were made and approved throughout the evaluation.

This research evaluation falls under the NHS Health Research Authority's definition of Service Evaluation and therefore did not require an NHS Research Ethics Committee review. The MHST evaluation meets the criteria for service evaluation as it:

- Was designed and conducted solely to define or judge current care or service
- Is designed to find out what improvements can be achieved within this service only
- Involves an intervention or service already in use
- Involves the analysis of existing data with the administration of interviews and surveys
- There is no allocation to intervention and does not involve the randomisation of service users to particular intervention groups

Approval was granted by Nottinghamshire Healthcare NHS Foundation Trust for the parts of the evaluation that relate to the MHSTs that are provided by the Trust including the obtainment and use of Trust data. Nottingham City Council approved the elements of the evaluation that relate to MHSTs that are provided by Nottingham City Council including the obtainment and use of Nottingham City Council data.

All secondary data that was provided by Nottinghamshire Healthcare Foundation Trust and Nottingham City Council was in anonymised form and had no identifiable information relating to individual service users or staff members. Appropriate information sharing and data protection processes were followed.

All participants who took part in any primary data collection (for example, staff survey, staff interviews and children and young people's survey) gave informed consent. Parental consent was also sought for children and young people under 18 years of age. As this evaluation explores mental health and emotional wellbeing support and mental health is largely recognised as a stigmatised subject within the UK, the evaluation team explained that all data collection and analysis would be confidential and that participants would be anonymised. The evaluation team were also clear that they had a duty of care and would need to break confidentiality if there was a disclosure indicating risk and/or safeguarding concerns to the individual and/or others.

The actions that would need to be taken should a disclosure be made were explained and all participants who took part accepted this.

3. Findings

Research Question: What impact are the MHSTs, including the Whole School Approach, having on mental health and emotional wellbeing outcomes for children and young people?

Measured outcomes

Children and young people complete the RCADS scale, the SDQ questionnaire and the CGAS scale at the start and end of interventions provided under Function 1 of the MHST model. These are either 1:1 or group interventions. Data is collected to enable clinicians to assess changes in their mental health state pre and post 1:1 or group intervention. (SDQ and CGAS data has only been provided for Nottinghamshire County MHSTs as City MHSTs do not use these measures). This data was provided separately for Nottingham City and Nottinghamshire and has therefore been analysed separately.

Nottingham City MHSTs

Data from the 5 sub-scales that make up the RCADS were provided for Nottingham City MHSTs by Nottingham City Council. These scales are 1) Separation Anxiety, 2) Generalised Anxiety, 3) Panic, 4) Social Phobia and 5) Obsessions/Compulsions. Data was provided for 65 children and young people that had received treatment from the City MHSTs between June 2022 and April 2024. This sample was selected at random from the total number of children and young people who had received treatment. The average (mean) duration of treatment was 143.91 days (sd = 74.8).

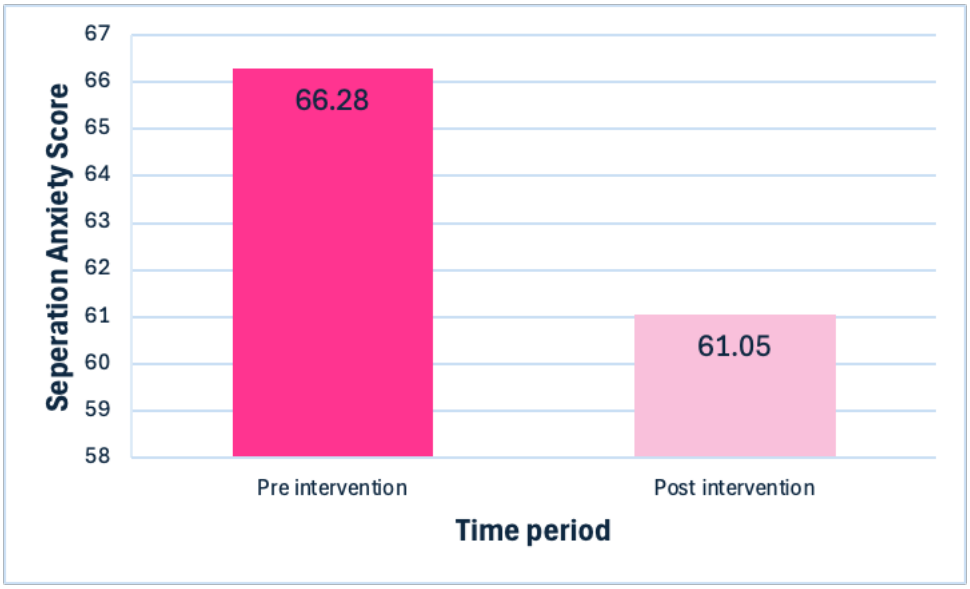
Table 4 Outcome measures collected pre and post 1:1 or group intervention

Outcome measure	Mean score pre intervention	Mean score post intervention
Separation Anxiety	66.28	61.05
Generalised Anxiety	55.57	47.46
Panic	69.77	62.37
Social Phobia	59.42	51.62
Obsessions/Compulsions	56.03	51.54

Separation anxiety

Analysis showed a significant improvement ($t(64) = 2.86$, $p = <.003$) in children and young people's scores for separation anxiety following their treatment from the MHST. This is shown in Figure 4.

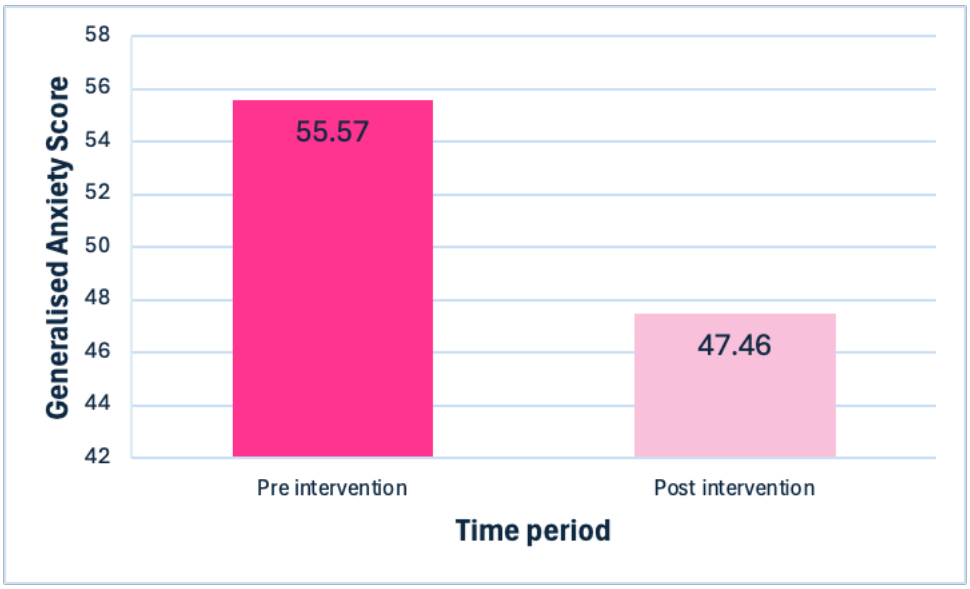
Figure 4 Mean separation anxiety scores before and after 1:1 or group intervention from the MHST



Generalised anxiety

The analysis of children and young people's scores showed a significant improvement ($t(64) = 5.12$, $p = <.001$) in generalised anxiety following their treatment from the MHST. This is shown in figure 5.

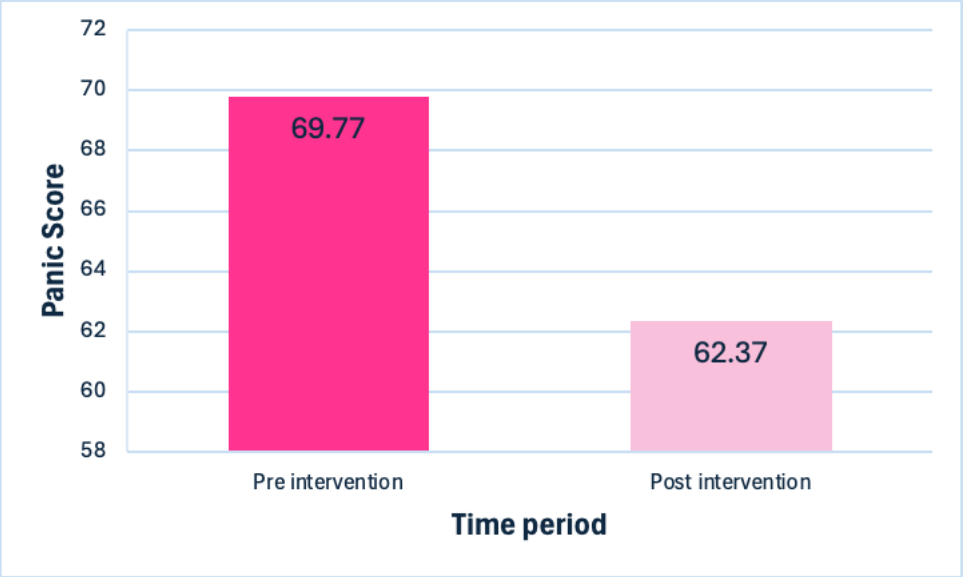
Figure 5 Mean generalised anxiety scores before and after 1:1 or group intervention from the MHST



Panic

Analysis showed a significant difference ($t(64) = 2.88$, $p = <.005$) in children and young people's panic scores following treatment from the MHST with scores being significantly lower post treatment.

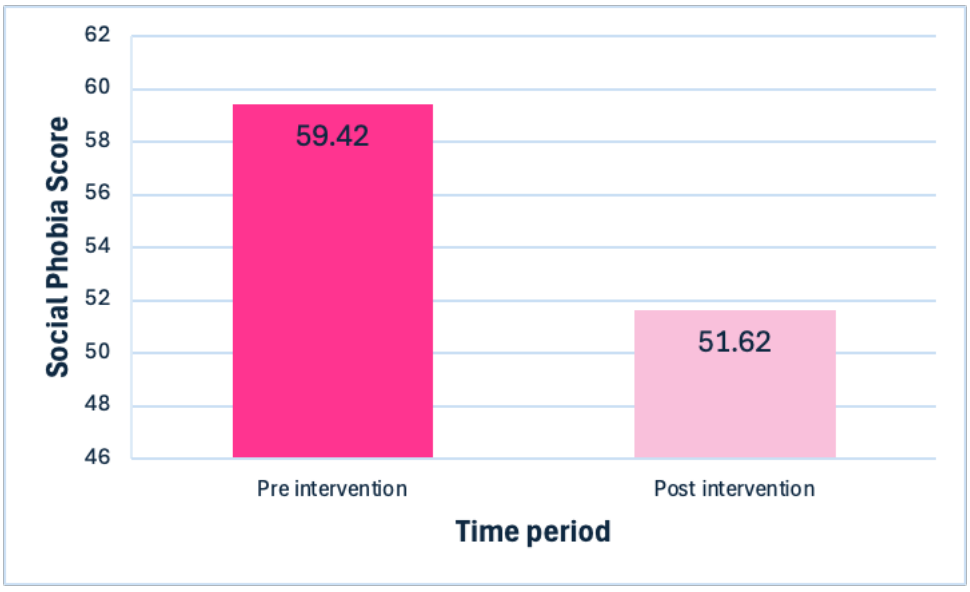
Figure 6 Mean panic scores before and after 1:1 or group intervention from the MHST



Social phobia

Analysis showed a significant improvement ($t(64) = 4.81$, $p = <.001$) in children and young people's scores for social phobia following their treatment from the MHST.

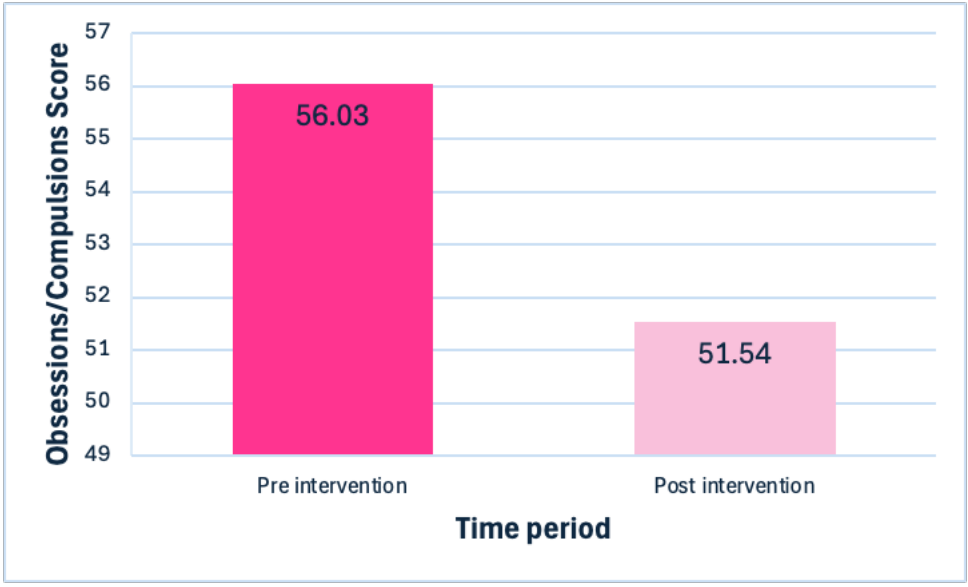
Figure 7 Mean social phobia scores before and after 1:1 or group intervention from the MHST



Obsessions and Compulsions

Analysis showed a significant difference (t (64) = 2.47, p = <.02) in children and young people's scores for obsessions and compulsions following treatment from the MHST with scores being significantly lower post treatment.

Figure 8 Mean obsessions/Compulsion scores before and after 1:1 or group intervention from the MHST



Summary

Overall, the data indicates that the scores of all 5 sub-scales of the RCADS were significantly improved (scoring lower) when comparing pre and post treatment measures. Children and young people who had received a 1:1 or group intervention under Function 1 of the MHST model went on to show statistically significant reductions in measures of generalised anxiety, social anxiety, social phobia, panic disorder and obsessive and compulsive behaviours. This suggests that the interventions provided by the MHSTs consistently help to improve the mental health status of children and young people.

Nottinghamshire MHSTs

The RCADS, CGAS and SDQ scores used to assess the impact of 1:1 or group interventions on children and young people accessing the MHST were provided by Nottinghamshire Healthcare Foundation Trust. This data was taken from children and young people receiving treatment between February 2024 and April 2024 and who completed pre and post outcome measures at the start and end of their treatment. As with the outcome measure data from children and young people accessing MHSTs in Nottingham City, not all children and young people accessing Function 1 of the MHST service will complete paired outcome measures. This data is therefore indicative of the impact of Function 1 of the service, but not definitive.

The final sample sizes were RCADs n = 966, (mean length of treatment = 108.9 days, sd = 63.92); CGAS n =1305 (mean length of treatment = 97.5 days, sd = 50.2) and SDQ n = 90 (mean length of treatment = 113.33 days, sd = 55.1). The mean scores pre and post intervention are shown in Table 5.

Table 5 Outcome measures collected pre and post 1:1 or group intervention

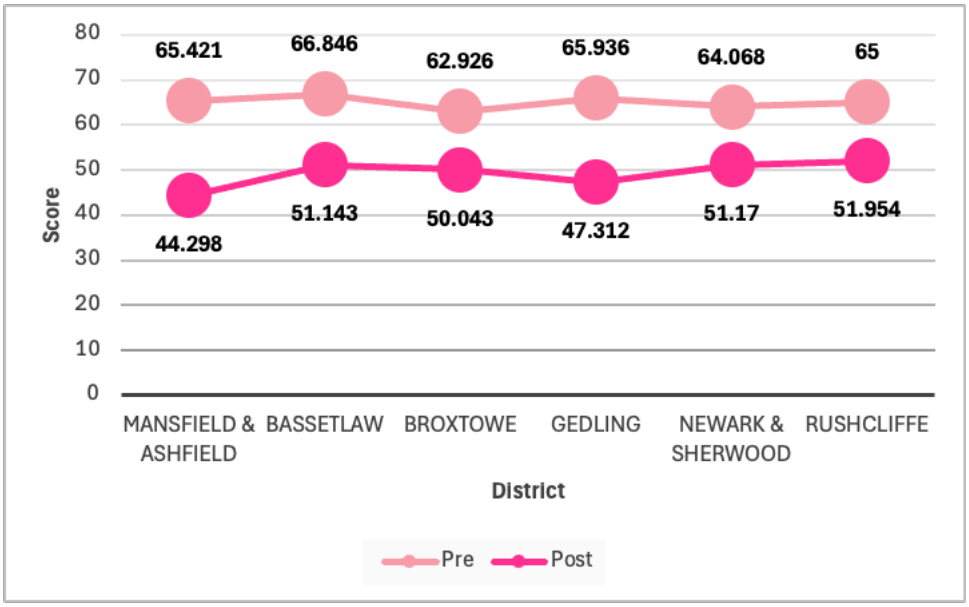
Outcome measure	Mean score pre intervention	Mean score post intervention
RCADS	65.47	49.05
CGAS	60.15	70.05
SDQ	18.66	17.06

These scores were analysed further using Analysis of Variance (ANOVA) to identify any statistically significant differences from pre to post 1:1 or group intervention and to examine if the district/borough in Nottinghamshire the MHST was situated in significantly affected the change in outcome score from pre to post intervention. ANOVA is a statistical test used to examine complex relationships among variables. It identifies significant differences in means across groups.

RCADS

Analysis showed a significant main effect in scores from pre to post intervention, $F(1,960) = 445.35$, $p < .001$, no significant main effect of the district the MHSTs operated in $F(5,960) = 1.1$, $p > .05$ but a significant interaction between the difference from pre to post intervention and the district $F(5,960) = 4.37$, $p < .001$. The data suggests that RCADS scores significantly improved (reduced) from pre to post intervention, and this reduction was greater in some districts in the County. This is illustrated in Figure 9 where the biggest reductions were seen in Mansfield & Ashfield and Gedling districts.

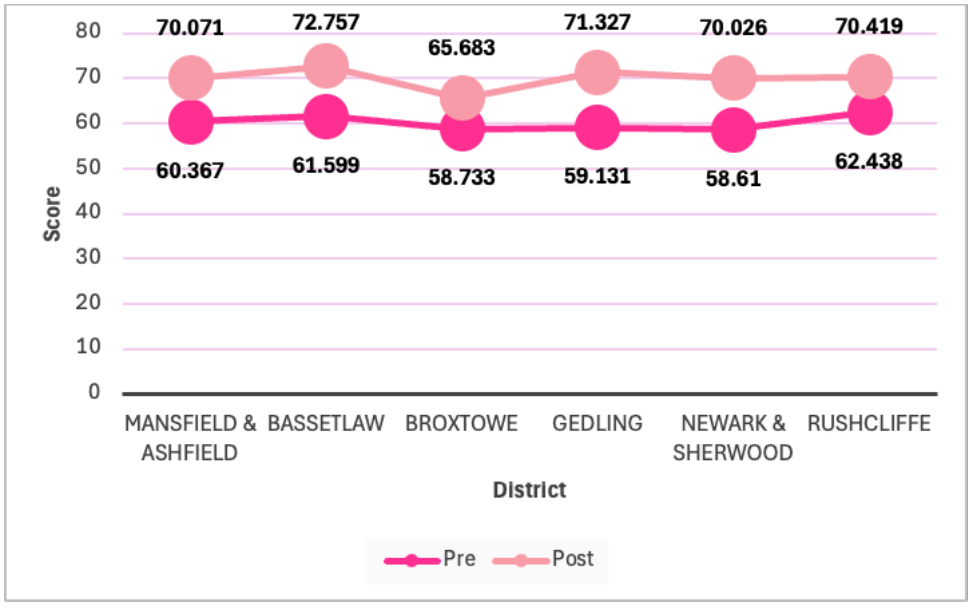
Figure 9 Mean RCADS scores pre and post 1:1 or group intervention from MHST



CGAS

The analysis of CGAS scores found a significant main effect from pre to post intervention F (1,1298) = 1179.96, p <.001, a significant main effect of the district the MHST was in F (5,1298) = 6.89, p <.001 and a significant interaction between the difference in scores from pre to post intervention and the district the MHST was in F (5,1298) = 7.99, p <.001. The data suggests that CGAS scores significantly improved (increased) from pre to post intervention, and this increase was greater in some districts in the County. This is illustrated in Figure 10 which shows the biggest increases were seen in Gedling and Newark & Sherwood districts.

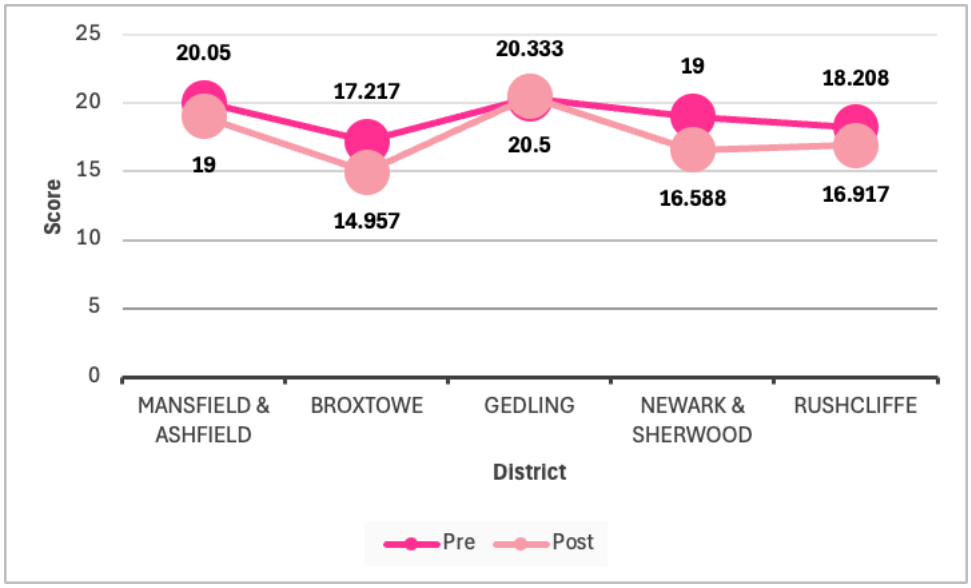
Figure 10 Mean CGAS score pre and post 1:1 or group intervention from MHST



SDQ

The analysis of SDQ scores showed a significant main effect from pre to post intervention $F(1,85) = 6.73$, $p < .01$, no significant main effect of the district the MHST was in $F(4,85) = 1.12$, $p > .05$ and no significant interaction between the difference in scores from pre to post intervention and the district of the MHST $F(4,85) = 0.63$, $p > .05$. This suggests that SDQ scores significantly improved (decreased) from pre to post intervention across Nottinghamshire, but this was not significantly different across districts. Overall, SDQ scores for Nottinghamshire are consistently significantly lower post treatment. Although there is some variation between districts, this is not considered statistically significant.

Figure 11 Mean SDQ score pre and post 1:1 or group intervention from MHST



Please note there was no SDQ data available for Bassetlaw therefore this district is excluded from SDQ outcome measure analysis.

Summary

The data suggests that RCADS, CGAS and SDQ scores were all significantly improved when comparing pre and post treatment. Children and young people who had received an intervention under Function 1 from the MHSTs went on to show statistically significant improvements in these measures. For RCADS and CGAS scores this effect was greater in some districts compared to others. Overall, the data suggests that the interventions provided by the MHSTs under Function 1 help improve mental health and emotional wellbeing outcomes in children and young people.

Service Utilisation

From the available data, only a small sample of children and young people across the city and county had contact with Community CAMHS services in the year prior to their referral into the MHSTs.

For children and young people receiving interventions (under Function 1) from Nottingham City MHSTs over the data collection period, the available data indicated that less than 1% had any previous contact with mental health services. This sample therefore did not have enough statistical power to complete any analysis on. Therefore, the below analysis relates only to children and young people accessing the MHST in Nottinghamshire County.

The anonymised data provided by Nottinghamshire Healthcare Foundation Trust was reviewed to identify any children and young people who had previous contact with Community CAMHS teams and to assess whether support from the MHST reduce the need for further support from (higher intensity) Community CAMHS teams. To examine this, we looked at each child's contacts with Community CAMHS teams (this includes all Community CAMHS teams, that are provided by Nottinghamshire Healthcare Foundation Trust). This was compared across the year prior to their referral to the MHST and the year post their discharge from the MHST. This sample (n = 38) had an average of 157.87 days spent (from referral to discharge) in the service. The mean age of the sample was 12.63 years (sd = 2.51, age range 4 -17 years).

Looking at this smaller sub sample, the analysis found that contact with other CAMHS teams significantly reduced post discharge from the MHST when comparing the year prior to their referral with the year post their discharge.

On average each child had 4.18 appointments with Community CAMHS in the year prior to their referral to the MHST, however in the year post discharge from the MHST this had reduced to an average of 0.95 appointments with Community CAMHS teams. Analysis showed this was a significant ($t(37) = 5.18$, $p = <.001$) reduction in contact with Community CAMHS.

Table 6 The mean number of appointments per child/young person with Community CAMHS teams in the year prior to and the year post their time in the MHST

Area	Average number of Community CAMHS appointments per CYP in year prior to referral to MHST	Average number of Community CAMHS appointments per CYP in year post discharge from MHST
Bassetlaw	4.33	0
Broxtowe	2	0
Gedling	4.13	1.5

Mansfield and Ashfield	3.75	1.38
Newark and Sherwood	2.5	0
Rushcliffe	5.08	1.08
Total	**4.18**	**0.95**

Summary

This suggests that for children and young people who had previously accessed Community CAMHS prior to accessing the MHST, the MHST appears to be a way to help reduce the need for further support from (higher intensity) Community CAMHS teams. This suggests the MHST are a successful early intervention service and may reduce the need for Community CAMHS for other children and young people who are at the lower threshold of need (the majority of those accessing MHSTs).

Research Question: What is staff experience of the MHSTs and delivering the WSA and to what extent has the WSA been delivered effectively?

Staff survey

Data collected from 60 staff members was analysed in order to produce a representative understanding of how staff who work in or with the MHSTs find the experience.

Figure 12 shows which areas of Nottingham and Nottinghamshire the respondents worked within, and Figure 12 illustrates the different job roles and associated responsibilities the survey respondents had.

Figure 12 Area respondents currently work in

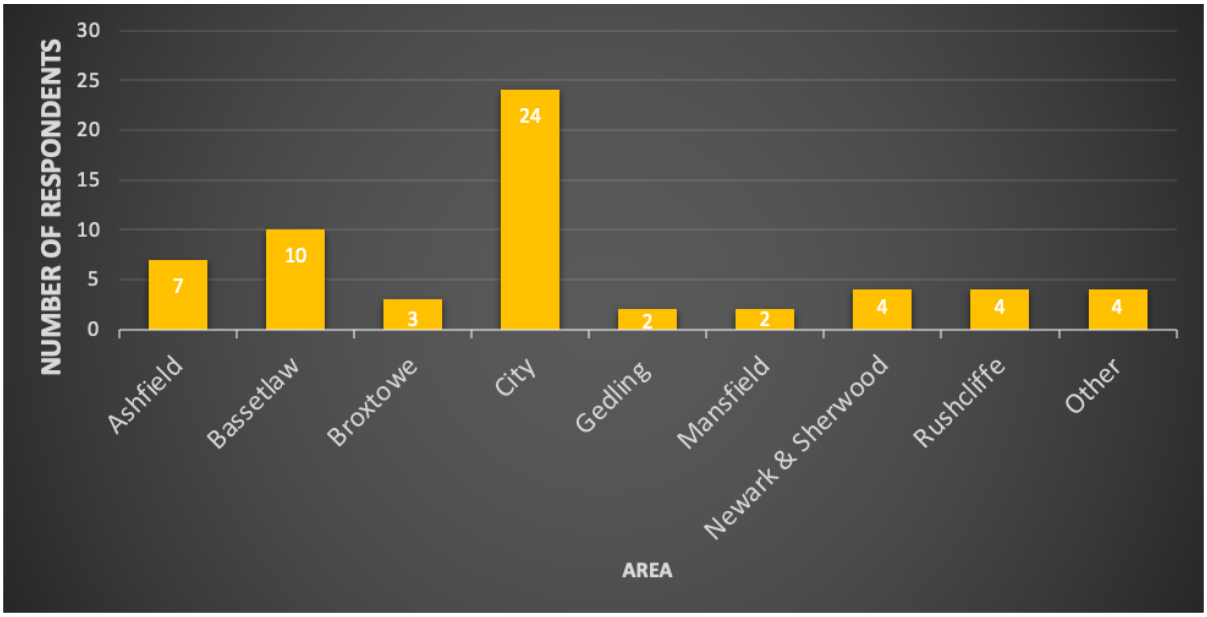
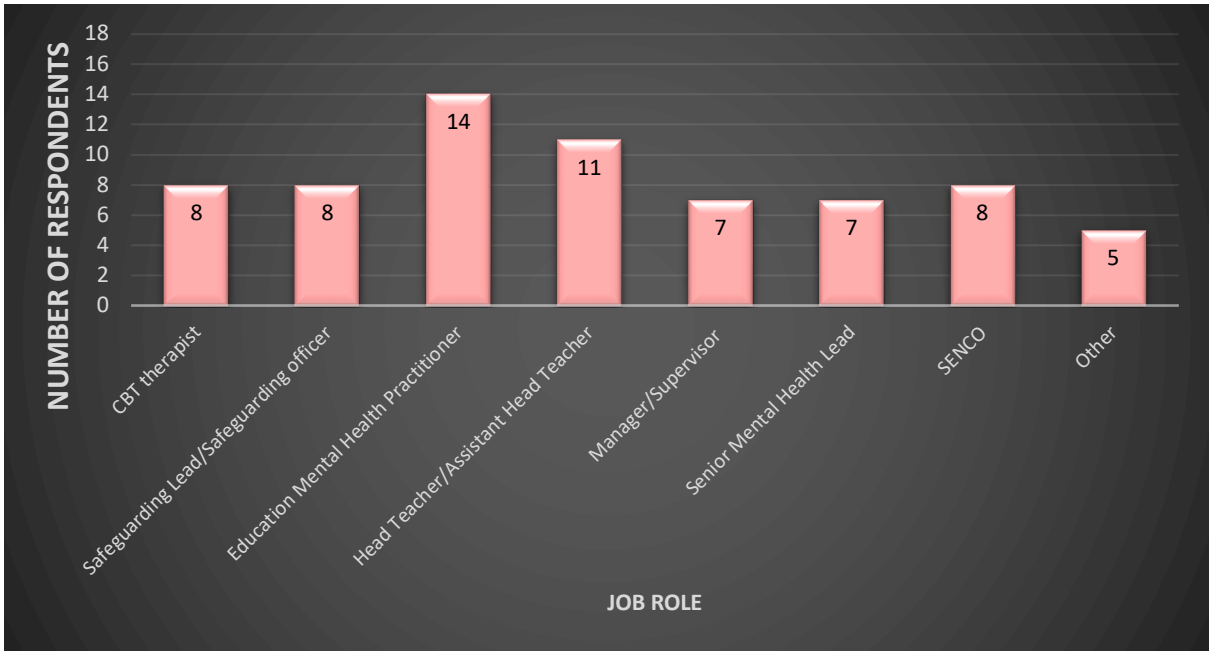


Figure 13 Job role of respondents

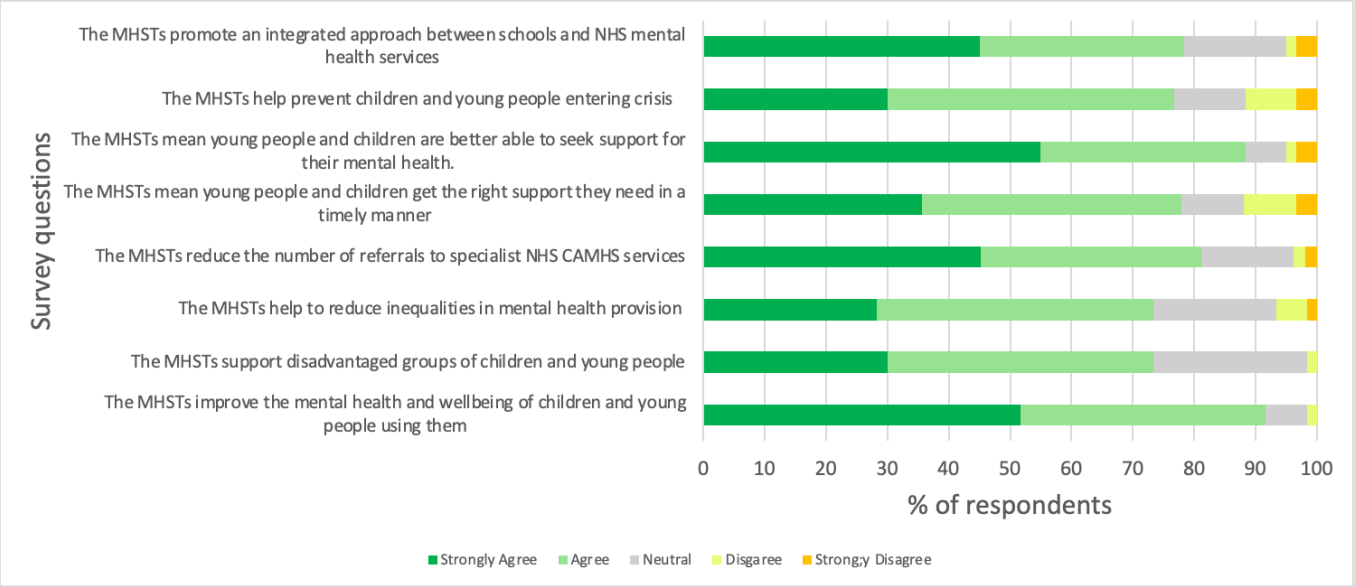


Please note some respondents had more than one job role stated so total figures exceed total sample size.

Staff views of the MHSTs

Figure 14 shows professionals' responses to the 8 Likert scale questions regarding their views of the MHSTs. The findings show that for all 8 questions the majority of professionals who responded gave a positive response ('Strongly Agree' or 'Agree').

Figure 14 Survey responses



Percentage of staff who gave a positive response

- **91.67%** of staff asked think that the MHSTs improve the mental health and emotional wellbeing of children and young people
- **73.33%** of staff asked feel that the MHSTs support disadvantaged groups of children and young people
- **73.33%** of staff asked think that the MHSTs help reduce inequalities in mental health and emotional wellbeing provision
- **81.13%** of staff asked believe that the MHSTs reduce the number of referrals to specialised/higher intensive CAMHS
- **88.33%** of staff asked think that the MHSTs mean young people and children are better able to seek support for their mental health and emotional wellbeing

- **76.67%** of staff asked think that the MHSTs help prevent children and young people entering crisis
- **78.33%** of staff asked feel that the MHSTs promote an integrated approach between schools/colleges and mental health and emotional wellbeing services
- **77.97%** of staff asked think that the MHSTs mean young people and children get the right support in a timely manner

Staff were asked ***"What do you believe to be critical to the success of the MHST you work in or with?"*** The responses were analysed thematically to identify the most common responses. The themes identified are shown in Figure 15 and Table 7

Figure 15 Critical success factors identified by staff

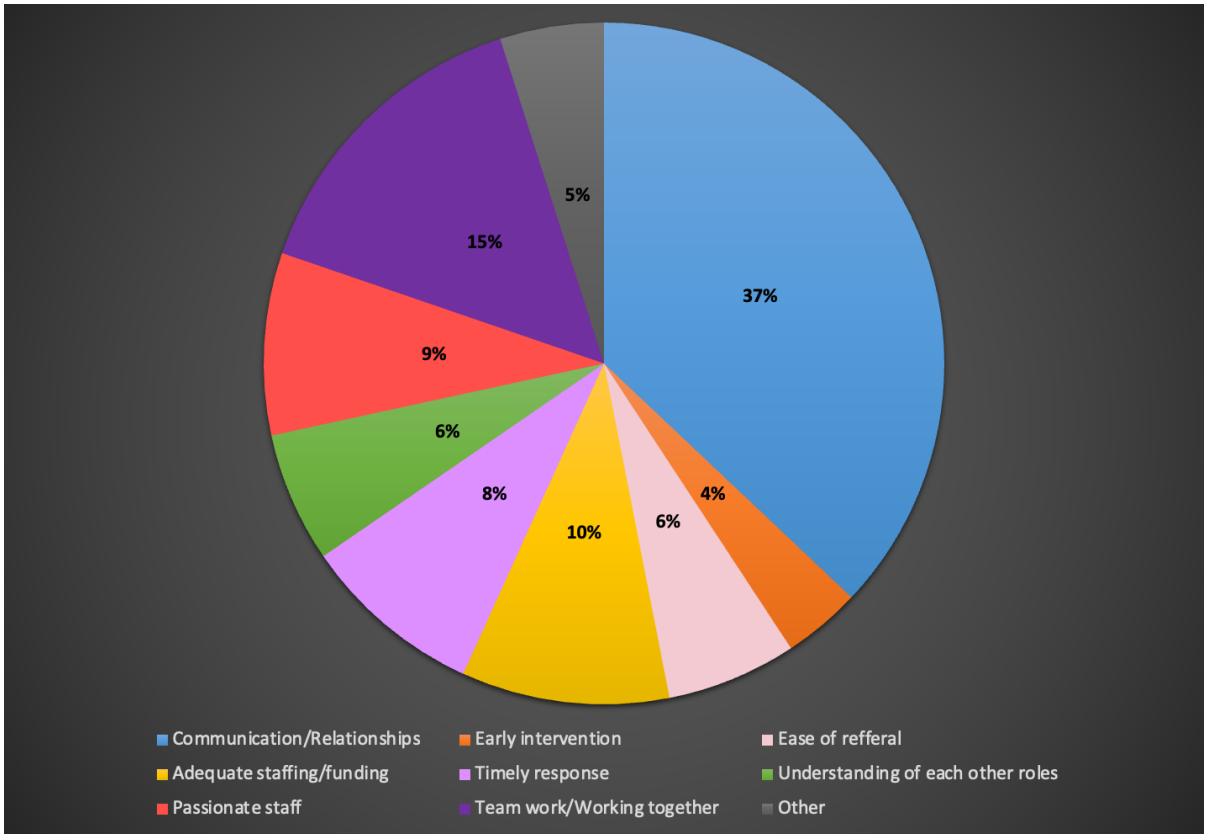


Table 7 Critical success factors identified

Theme	Description	Example quotes
Communication	A good relationship between the MHSTs and the school/college was identified as being important by staff	*'Communication between MHST and school is vital in me being able to support the family in the best possible way.'*
Teamwork	It was seen as important that all staff work together as a team	*'Everyone working together to ensure that all children and young people have access to the right support at the right time.'*
Adequate Staffing/Funding	Staff mentioned a lack of staff and resources in the MHSTs and felt this would be critical to further success of the MHSTs	*'It is a good idea however there isn't enough capacity to meet the demand.'*
Passionate staff	Staff need to be passionate about their role and the MHSTs	*'Passionate, skilled staff who care about young people and families they work with.'*
Timely response	It was seen as crucial by staff that the MHSTs give a timely response	*'Quick turn around for referrals being made so that early intervention can be achieved.'*
Understanding of each other's roles	Staff felt they needed to understand each	*'Understanding that the role of staff in school is very different to their role.'*

	other's roles for the teams to work	
Ease of referral	To be able to refer to the MHST quickly and easily was seen as important by staff	*'The provision offered is really accessible - easy to book in workshops, easy to make referrals'*
Early intervention	The ability for the MHSTs to provide early intervention to young people was seen as key by staff	*'Supporting students before they hit a crisis and need other agencies who have longer waiting lists.'*

Staff were also asked '***What has been the main barrier in the implementation and success of the MHST you work in or with?***' These responses were analysed to identify the most common themes. The themes that emerged from the data are shown in Figure 16 and Table 8.

Figure 16 Barriers identified

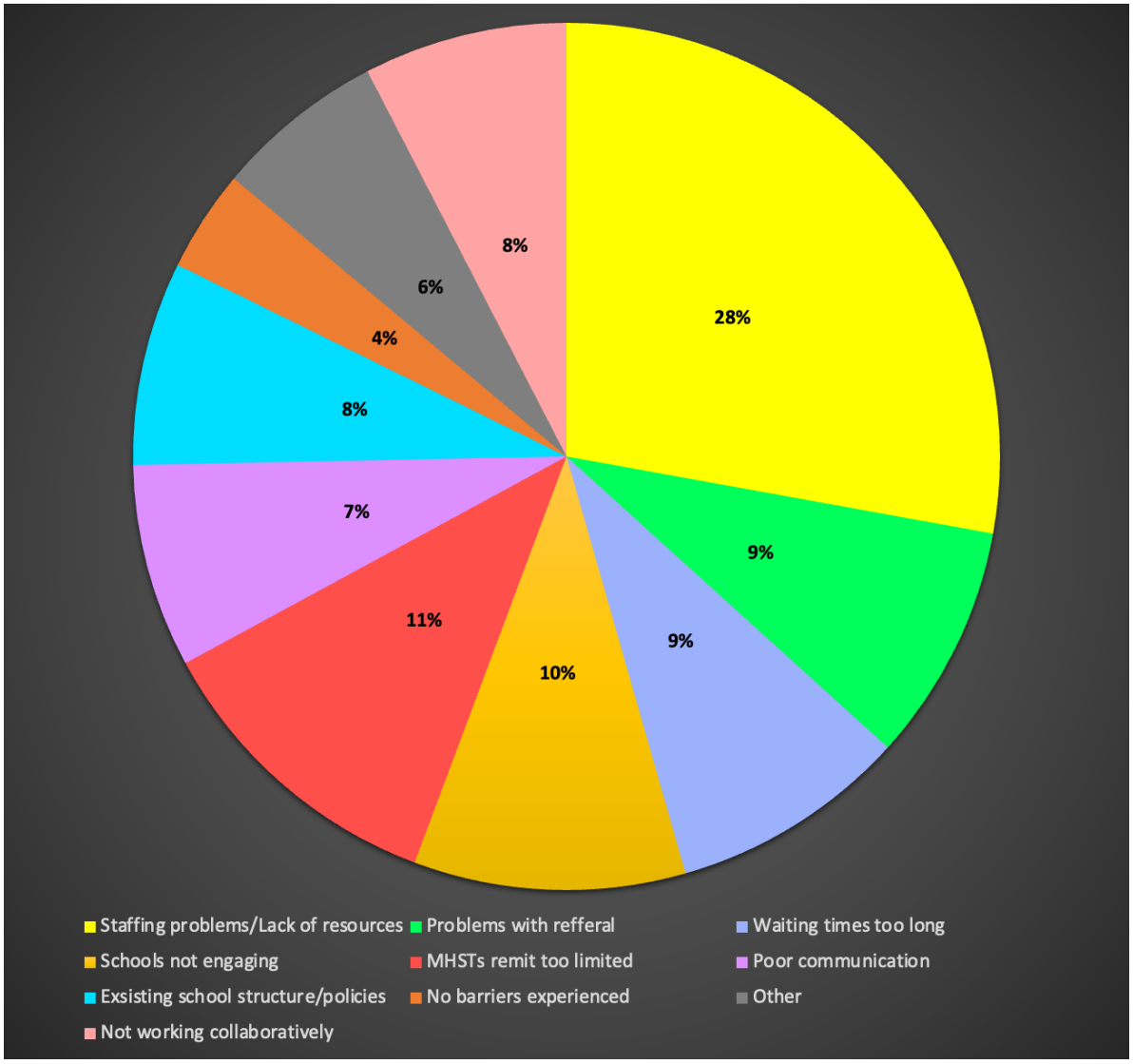


Table 8 Barriers identified

Theme	Description	Example quotes
Staffing problems/Lack of resources	Respondents felt that a lack of MHST staff and resources was a barrier to the success of the service as this led to the MHSTs	*'No pool of qualified EMHP's so when people leave it is hard to get replacements so often the MHST is understaffed'* *'Lack of capacity in comparison to the rapidly increasing demand.'*

	being unable to meet demand	
Schools/colleges not engaging	Schools/colleges not fully engaging with the MHSTs or lack of awareness	*'Lack of engagement from school leadership teams.'* *'Barriers to booking in WSA activities due to school staff not understanding the importance.'*
MHSTs remit being too limited	School/college staff expressed frustration that the MHSTs only provide low intensity support	*'The very prescriptive and tightly defined situations MHST will actually engage in and a lack of flexibility around this.'* *'The remit of need they are able to work with is quite small. Most referrals seem to be signposted elsewhere.'*
Problems with referral	Staff working in schools/colleges found the referral process to sometimes be difficult whereas MHST staff found they sometimes received inappropriate referrals	*'The process for sending in referrals is overly complicated.'* *'There can be referrals from school that wouldn't benefit from the level of intervention we offer.'*
Waiting times	Staff reported waiting times from referral to being seen were too long	*'Waiting for referrals to be processed and allocated - it would be good to have a set time frame i.e. within 3 weeks'*
Poor communication	Poor communication between MHSTs and schools was	*'Understanding that the role of staff in school is very different to their role.'*

	identified as a barrier	*'School are no longer informed if referral unsuccessful - not helpful when trying to support families to access support.'*
Existing school/college structure/policies	The current structure and set up of schools/colleges were seen to be detrimental to young peoples' mental health and emotional wellbeing	*'YPs who have mental health difficulties, especially secondary school aged, often present as angry. They display negative behaviours and unfortunately school polices are heavily weighted towards instilling punitive measures of behaviour correction.'* *'Schools increasingly rely on draconian behaviour policies to cope with the behaviour and distress of students which exacerbates the problem of anxiety and school avoidance.'*
Not working collaboratively	Schools/colleges and MHSTs finding it difficult to work together which was linked to a perceived lack of flexibility of MHSTs.	*'The link worker having their own set agenda without the flexibility to meet the needs of the pupils or school.'* *'The fact that because their role is so narrowly defined it is very difficult for them to become embedded in school life.'*

Summary of findings from the staff survey

The staff survey was able to highlight critical success factors for the MHSTs and the main barriers encountered while working in or with the MHSTs. Eight main critical success factors were found, with communication being the most salient, with 37% of staff citing this as critical for success. Six main barriers were identified. Within this staffing problems and lack of resources were believed to be the biggest barrier to success.

The survey also demonstrates that most staff who responded have positive views of the MHSTs with over 90% of staff believing they improve the mental health and emotional wellbeing of children and young people.

Qualitative Data: Staff Experiences

In addition to the survey, we also invited staff across Nottingham and Nottinghamshire to contribute their views through an interview with the evaluation team. This section of the report presents key findings from interviews with a range of staff connected to MHST's. Our mixed approach to data collection was designed to capture a range of views and experiences in order to provide a holistic picture of MHSTs in Nottingham and Nottinghamshire. The qualitative findings are presented thematically.

Theme 1: Remit of MHSTs

All staff participants were asked about the remit of MHSTs from their own understanding. There was a strong consensus regarding the core principles of MHSTs, with one participant clearly describing the many facets of an MHST:

> *'So, the MHSTs work as they are under a large umbrella. So, we're one large team, but we're separated into localities, which makes us much smaller teams. So, the whole ethos of our team is to provide mental health at the time that it's needed in a place that's convenient for the young people. So, within our team we have an Education Mental Health Practitioner, which are the bread and butter of the teams and are the backbone to the whole school approach. Whole School Approach means that we're trying to get into schools a parity with physical health, so destigmatising mental health and being at that point of need. We do school assemblies and things to get the message out and we work very closely with our school, so we have good relationships with the schools that enable us to go into school and almost not be a visitor, almost to be a face that's known and seen in school. We work quite closely with them and within our team and we have something called a Specialist Practitioner who has different skills to Education Mental Health Practitioners who are CBT, low intensity. Our specialist practitioners have a varied amount of skills that don't necessarily include CBT. So, they might do completely different work depending on what the need of the young person is or their parents, because obviously we work with parents as well as children and with schools and then we have the CBT practitioners who are therapists that can do the full blown CBT protocol. So instead of doing a low intensity, they do the more high intensity work where that's needed.'* [EMHP]

EMHPs also described how the remit of MHSTs was clearly taught during their training year:

> *'I think it's really emphasised at the beginning of the training to understand the purpose of the mental health support team, why the mental health support team was put in place, what the sort of aim is over the next sort of 3-4 years.'* [EMHP]

Frontline MHST staff also spoke of times when they recognise that their defined remit can prevent them from supporting children and young people who may need higher intensity support:

> *'If a child's at high risk of doing something to harm themselves then I wouldn't work with them, particularly because… I can't be that I'm not a crisis service, if they need me in the evening, I'm not there, I have a weekly appointment, I can't just say I'm going to come and see you. So that wouldn't help that person, they're better to be on a waiting list for somewhere and have CAMHS crisis to access than have me who can't help them because it's not within my remit.'* [Specialist Practitioner]

However, other frontline staff feel that they may be qualified to support past the point of low or mild to moderate intensity sessions that MHSTs were originally commissioned to offer:

> *'I think there's always that balance of like wanting to provide that really high-level care, also, being kind of like pushed back by Commissioners that actually no, like they're only allowed to offer this many sessions or not. So, I think it's a really hard, sometimes you feel quite stuck in the middle of it and like ethically you want to kind of do what you feel is right as a clinician'* [CBT therapist]

Managers and Leads were also interviewed when exploring the remit of MHSTs, with this group of staff often taking a wider goal-focused approach to their understanding of the support MHSTs can offer:

> *'So, my priority is making sure that we've got a diversity of practitioners and by a diversity, I mean, in, in every kind of way, I guess, by skills, by experience, knowledge, by profession and then also by background as well and protected characteristics...I consider a massive part of my role is to, you know, be creative in terms of what that service delivery looks like and how we can make it the absolute best through the service design. So, you know, introducing new ideas for service delivery in terms of things like how we take referrals and, and how we build relationships with schools.'* [Service Manager]

Theme 2: Referral Routes and Pathways

Referral routes play a vital role for the children and young people that MHSTs support, with the methods of referral developing and improving as more waves have been rolled out across the City and the County. The following theme draws on data from staff

participants to provide insight to the process of referral and support-seeking for children and young people.

Referrals can be made by several people, with the process being different for City and County. One participant from County states:

> *'…referrals get made by either teachers, young people or parents, no other professional can refer, which causes some confusion as we're the only service that is so limited on that. It goes to CAMHS SPA, the Single Point of Access, and then if they're under an MHST school, then they'll get passed on to us.'* [Specialist Practitioner]

In City referrals are also made in consultation with the schools themselves:

> *'… our referrals are done through consultation. So, we have 6 to 8 weekly consultations with schools. Which works in the cycle of our treatments which are 6 to 8 weeks. So, we typically will go into a consultation with schools, we will discuss referrals, priorities. And then as part of that, we'll also look at the bigger picture in the school and think about that Whole School Approach work as well. What the school needs are, what the needs might be at different times'* [Service Manager]

Getting referrals for children and young people who are suitable for the service can sometimes prove to be a challenge:

> *'This has failed sometimes because sometimes it's been declined at the SPA point and not passed on to us and it is suitable for us, and sometimes it gets passed on to us when it's not suitable just because they go to a school that we cover.'* [Specialist Practitioner]

> *'…schools do a lot of scattergun referrals, so they don't know who to refer to, they don't know the best services, they don't know what services are on offer, so they just refer to everyone and then it becomes really difficult because then everyone's getting these different referrals and they're like, well, who's going to deal with this?*" [CBT therapist]

However, staff overall noted a positive improvement in the referral system over time, especially now that they have an EMHP within the SPA team, overseeing all referrals:

> *'… the person that's in SPA now was or is an Education Mental Health Practitioner and she's gone over to SPA and because she's been working on the ground and has a good understanding of SPs, CBT's and the MHSTs, they're far better now than they've ever been. So, as we're evolving and school are getting to knowing what to refer to us and the consultations certainly help*

them with that, so we're now getting to where we're streamlining, whereas before, not so much.' [EMHP]

Referrals also follow the structure of the academic year, with staff recognising that referral rates ebb and flow depending on the school/college holidays:

'I think September is always a little bit quieter and then it comes to October and it's almost like the floodgates open. So, I would say it does feel manageable, but there has been a noticeable kind of ramp up of cases, it's almost, as I say, it's almost like the floodgates have opened, schools have come back, they've had a couple of weeks to settle down and now they're starting to refer.' [CBT therapist]

Theme 3: MHST Location

MHSTs work across school and colleges in Nottingham City and Nottinghamshire. In interviews with frontline staff the evaluation team explored the similarities and differences between the teams and areas. Many staff interviewed were in agreement that each MHST is organised differently in response to the needs of the children and young people in the area:

'…every MHST is kind of individual to the need in the area. So…all MHSTS are designed within that area on the need of that area, so, they all have like the same staff and whatnot but like, there's some areas that have like 2 support workers and two CBT therapists because the need is higher, so I guess we adapt staff around that' [CBT therapist]

Participants also commented on the experiences of Nottingham City compared to Nottinghamshire County MHSTs, suggesting that there are differences in how the MHSTs are run based on which Provider they are delivered by:

'…whereas with the City team, because Nottingham City also have their own mental health support team, but they're linked in with the council. So, I'm not entirely sure about their process, so maybe they have a completely different process because they're not NHS.' [EMHP]

Multiagency working often takes place within MHSTs, to best support children and young people in a holistic way. Staff interviewed explored this in relation to how they tailor the support in response to the need presented:

'…always like multi agency because you've got different practitioners working together with different training and different backgrounds. So, it means it's not consistent across the board, so within the Notts Healthcare MHST everyone will work differently, so it depends what your background is and where you come from.' [Specialist Practitioner]

Similarly, staff that had worked in multiple MHSTs had noticed differences in demand depending upon the socio-economic demographic of the area,

> *'it's different in different areas, because I think there's still a lot of stigma around mental health, and particularly in the area that I work in, the feedback that I sometimes hear from the EMHPs is because it's quite an affluent area, they don't want anything attached to mental health, so unless their kid is really high need and they think, well, actually we need some support, they kind of push back on mental health, being labelled or anything like that.*' [CBT therapist]

Overall, MHSTs have a strong ability to adapt to demand and offer holistic support to the children and young people who are accessing them. This is easily summed up with one participant sharing:

> '*…we will look for expertise in a certain area if we don't have it, we'll, like consult and get supervision around that if needed to just adapt into the individual need in the area, really, I don't think any MHST team is the same like they all tend to work differently depending on what's it's like*' [CBT therapist]

Theme 4: Access to support

The evaluation team explored who was accessing the support of the MHSTs. Many staff noted that they support a wide range of children, young people, teachers, and carers, aiming to improve their mental health and emotional wellbeing:

> *'I guess it's around kind of it being kind of a low intensity presentation. So obviously if there's a lot of complexity involved or they've already accessed like Tier 2 services [historic label for mild to moderate services], then we might be considering we'll actually use this avenue of support. So, anxiety, low mood, those kinds of presentations, parenting too if it's younger children, it's around kind of parenting, parent led kind of groups or individual work'* [CBT therapist]

> *'…the parent groups are really popular, really popular'* [EMHP]

Both frontline staff and Managers also recognised that there are a higher proportion of children and young people with neurodiversity, when compared with the general population,

> *'I guess our biggest uptake is the neurodiversity and anxiety. So, we do a workshop that looks at neurodiversity with the pure focus of anxiety on it, which is one of the biggest, and parents get a lot from that and they tell us they get a lot from that'* [EMHP]

> *'…we work with quite a high proportion of neurodiverse people...'Predominantly low mood and anxiety are the two predominant presentations that we would see and that, that is, you know, mixed with perhaps a range of other what we*

would call behaviours, so, for example, poor attendance, things like emotional dysregulation.' [Service Manager]

Participants raised the change in needs over the time they have worked with children and young people, seeing the level of need as being more complex, not just within MHSTs but across all mental health and emotional wellbeing services. It was also noted that MHSTs and SPA were facing a rise in referrals around neurodiversity, where neurodiversity was the primary support need, and were not the appropriate services to manage the need. MHSTs were regarded as able to fill the gap of support between targeted and specialist CAMHS:

'I think there is a little bit of a gap there and then we [specialist practitioners within MHSTs] reach those kids that are needing that one-to-one intervention and I suppose those kids that would usually maybe fall through the gap where they're not quite meeting that threshold, and because we have CBT, we would probably fit in getting those kids that wouldn't usually have support until it got to the more intensive CAMHS services [like Targeted CAMHS or Community CAMHS], but like there may be too high intensity for an EMHP to pick up, but they're not high enough for CAMHS [Targeted and Community] to pick up. So, then they're kind of like stuck with us [specialist CBT practitioners], but not all MHSTs have that.' [CBT therapist]

Despite all staff commenting on the successful support offered by MHSTs, it was also stated that:

'…it's hard because like the whole point of the MHST is to kind of get prevention for those kids before they get to a point of needing to go to CAMHS [specialised/community CAMHS], but it's sometimes quite, I think, a lot of them have worked in a few different MHSTs now...and I think it's a real challenge still to get those kids, or to identify those kids because school staff are so overrun and so overwhelmed that they're picking those kids, that is when they start to show behavioural difficulties or mental health difficulties that then they're like, oh, MHST, but sometimes those kids are too far along the spectrum of need.' [CBT therapist]

The focus on supporting children and young people with low intensity presentations is central to the MHST remit, however, staff felt it was also vital to prioritise prevention of mental ill health through offering support to those who may be going under the radar:

'if you're going into school and you said to a teacher "which pupils do you feel need some additional work", they would off the head straight away be able to say, "they will all score significantly", and then you'll say, "well, what about those that are quiet that need a little bit of additional, but they sit at the back of the class, they never cause a fuss and they're really well behaved, they're the ones

that we want to support to keep well". So, we also have that remit there, that part of our role is health promotion and to not let that that slip.' [Specialist Practitioner]

Theme 5: Training Routes

When MHSTs were commissioned the new support role of Education Mental Health Practitioner (EMHP) was developed. This required a new training programme, in the form of a one-year Postgraduate Diploma, that qualified workers to support children and young people with evidence-based therapies:

'… all of our education mental health practitioners come in as trainees, so they come in as, in what we call recruit to train posts and they have a post, they do a postgraduate course, which is a year's training course in becoming an Education Mental Health Practitioner. So, they all have training on evidence based psychological therapies, predominantly CBT based. Because as I said, we follow the evidence base, they cover things like low mood, they cover anxiety and worry and interventions for that. So, things like behaviour activation, graded exposure, sort of things that you would, you would do within Cognitive Behavioural Therapy, but a very early and low intensity level.' [Service Manager]

All EMHPs interviewed felt that universities they received their training from taught them what was needed to be able to take on the role, though they reflected on it being an intense experience:

'…training in university is quite intense. It's a very short course. It's one year, there is a lot that they shoehorn in within that one year, a lot.' [EMHP]

Managers recognised that though they felt the EMHPs were confident practitioners, they may need some extra support:

'…with their training, they're very capable, but the confidence isn't there. So, there must be something within the training that could be improved' [Specialist Practitioner]

Staff gave recommendations to help develop the training, through extending the timing of the course:

'It's the pressure that you put in and we don't need to be under this pressure, you know, besides doing this we're learning new techniques in practice, we're only here two days a week and then the other three days we're at work and you know, we're trying to get to grips with what you're teaching us. So, it was very difficult, I think it should be longer, I think it could be a two-year course, but it did do what it needed to do. Sometimes now I look back on to those days and I wish that it had been a slower, a slower pace to allow you to make your mistakes

and come back and kind of say, well, you know, we did this piece of work by so and so' [EMHP]

Managers noted how they wished to develop a stable workforce and issues with retention, particularly of EMHPs, affect whether this can be achieved. One manager saw an issue with the model of training:

'They don't tie anybody into their EMHP training…somebody who is 2 months of qualifying has just decided that they don't want to do it anymore…£11k of training and they don't have to pay anything back, but I can't re access the money for that place' [Operational Team Lead]

Further recommendations suggested by staff were to introduce a focus in university training on supporting children and young people who are neurodivergent, as EMHPs recognise that this constitutes most of their caseloads:

'I think there definitely could have been further training around kind of adapting the intervention to children with additional needs. So, specifically neurodiverse children, but for example, we were trained on helping parents manage challenging behaviour. So, with that challenging behaviour intervention, it doesn't necessarily take into account that actually a lot of neurodiverse children display certain behaviours that might be typically seen as kind of challenging to a neurotypical individual, but actually, it's because there's a need that they are communicating. So, I think, definitely in terms of training, I think there should have been, in my opinion, kind of more training and kind of coverage around how to adapt certain interventions to neurodiverse children. There was training, but I think there should have been more coverage.' [EMHP]

Staff who had previous experience in mental health and emotional wellbeing services also felt the training was idealistic in nature, and worried that it would not be what happened in real life:

'…they allowed me to go to uni and I never thought that would happen… and that was great, but it was also very idealistic. So, as you can see by my face, I've been around the block a bit... and so the stuff that we were learning, it was quite idealistic and you, kind of, in the back of your mind, you knew that what they were teaching was correct and the right way to teach it, but you knew when that front door opened it never looked entirely like that. There were elements that would, but there were elements that weren't and that kind of messed a lot with your mind as well, you know, 'this is what uni said I should be doing', but I can't do that because that's not presented in its pure form and so that was a little bit tricky.' [EMHP]

Theme 6: Benefits and Successes

MHST staff raised several examples of successes and their view of the benefits of this new approach to the mental health and emotional wellbeing of children and young people, during the one-hour interviews with the evaluation team. The benefit raised most often was the MHST's ability to fill the gap left when children and young people are assessed as too low risk for more intensive services such as Targeted CAMHS or Community CAMHS:

> '*…for those who aren't able who aren't high enough [need] to reach CAMHS, but they are still struggling with anxiety and like [MHSTs are still] impacting them positively because you're providing them the strategy that they can use to then kind of manage their own anxiety in class…I find that it's been helpful bridging that gap for the children, young people who aren't necessarily high enough [need] for, let's say, specialist [services], for example, to be escalated up, but it's a good stepping stone for them.'* [EMHP]

> *'I think it's just so important to bridge that gap, to be a safe space for young people to sort of go to as well as sort of families and parents that struggle as well, you know.*' [EMHP]

Short and manageable wait times are another vital aspect of success for the MHSTs:

> '*So yeah, I think if they weren't here, Community CAMHS would have had really, really long waiting lists and would be quite overwhelmed and some of these young people might not have been able to access support.'* [Commissioner]

Alongside this, staff interviewed often mentioned the support they received from their team members, recognising that they each have a specialism enabling them to work together in the best interest of the children and young people they support:

> *'…thinking about adaptation and kind of considering things like, for example, sensory issues or communication. So that's one thing that we as a team that's really good that we offer and a lot of our specialist practitioners as well because they are specialised in a certain area, they can aid more with that kind of aspect of it.*' [EMHP]

> *'…it's a good place to be. It's a good place to work…there's so many different sorts of people with different skills and experience. I think it makes us really quite strong.*' [EMHP]

Though staff sometimes felt their feedback did not truly represent the successes of the MHSTs, they often spoke about the experiences shared by children and young people:

> *'I found that it's had a positive impact and not only just helping them manage their anxiety, but also kind of creating that sense of "oh, so, it's not just me that*

feels like this?". So, it can feel quite reassuring for them and especially with young people who might be going through a lot, a lot and they're like, 'oh, OK, it's just me. I'm the only person that feels like this.' And then just letting them know that actually it is pretty common.' [EMHP]

'I see with the children I work with; I make a difference...there's a small difference, but we don't capture a large amount of young people.' [Specialist Practitioner]

'…at the end of our intervention, so at the end of like eight weeks, you're saying, "have you improved?" and you can see whether the young person can relay the information that you've shared with them and skills, and they say "I've had some huge successes' [Specialist Practitioner]

'We do make real big changes and you can see it even within those 6 to 8 weeks…I think it's a really good service. I like it, MHST, I'm passionate about it and like I said, I've worked for another similar service and the MHST is a really nice friendly service with lots and lots of resources.' [Specialist Practitioner]

Theme 7: Challenges

Though there are an overwhelming number of successes for the MHSTs, participants did raise a number of challenges that they are currently facing.

One challenge the MHSTs are currently facing is the difference between uptake of support between schools/colleges. Many staff interviewed commented on the difficulties in engaging some schools/colleges and developing their understanding of the remit of MHSTs:

'I find some schools are really good with integrating us, like, I know there's a secondary school who we can share a counselling room with the school counsellors. So, there's specific days where we kind of have a rota, so one day it's an EMHP, the other day it's the school counsellor, so that's really good. But then you've got other schools where they, you know, they're not really aware of kind of the support that we offer.' [EMHP]

'…there are challenges sometimes when schools are reluctant to sort of give you time to take children out of class or to, I guess, just come in and deliver different sort of workshops and assemblies and whatnot because sometimes they feel like their curriculum is more important, which is obviously very important but so is children's mental health. So yeah, that can be difficult when you've got schools that maybe have walls that you kind of have to try to bring down, but on the whole, our relationships with our schools is brilliant.' [EMHP]

'…some schools don't want to do the audit or are sporadic with the audit because they've got so much other stuff to do, which I completely understand,

and then you will get bits coming through. But because we're only an eight-week service, what we don't do is have children on a waiting list for eight weeks. We're supposed to be easy, accessible to be able to join a group, so sometimes there is a little bit chicken and egg situation, if that makes sense. Sometimes it's a bit tricky to get those groups up and running.' [EMHP]

'I think there's still, there's still a level of need out there, but I think also it's trying to get school staff to understand about what our remit is, and so we still get lots of very complicated cases or cases where things have been ongoing for a very long time and actually we know that, you know, eight weeks, twelve weeks is probably not going to make much of an impact, they need a much longer piece of work. Therefore, they should go to community CAMHS, for example.' [CBT therapist]

Similarly, some children, young people and their families/carers can be worried about engaging with MHSTs due to the stigma of CAMHS in general:

'I think a challenge would be the stigma around CAMHS and CAMHS has sort of had quite a lot of negative press in the past. So, it's kind of trying to overcome that and for children and families to sort of put their trust in us again. So yeah, that's definitely an aspect. Another aspect would be schools that don't engage, we want to really ideally be in every school at some point, but that is, it's quite a big aim, so we'll sort of work towards that.' [EMHP]

'Some parents don't like it, so there's certainly when there's difficult balance between parents. Like mum generally would want them to access and dad doesn't. There is stigma. I guess if because parents and young people have to consent to the referral, so if there's stigma, we wouldn't necessarily see it so much because they wouldn't consent in the first place.' [Specialist Practitioner]

'MHSTs are kind of like optional support, aren't they? Like whether we can provide this preventative work, this early intervention, but I guess the buy in can be quite difficult, especially for families depending on what area you come from, and yeah, so I think there could be that difficulty with engagement.' [CBT therapist]

When working with schools and colleges, staff also noted that prevention work can sometimes be a challenge as it is difficult to recognise children and young people before their mental wellness begins to deteriorate:

'*…a big challenge is that like identifying those kids that are at that really early intervention level, I think that's not always kind of done in the right way and I think there can be some challenges in terms of like once kids sit with us, a lot of services can be like, wash your hands and be like, well, they're with MHST*

> *so it's fine whereas actually, we probably might not be the right service for that young person, but once we've got them, it can then be hard to kind of get them the right support.*' [CBT therapist]

A further challenge raised by staff interviewed is the retention of EMHPs. EMHP's shared:

> *'…out of the four of us, we qualified in January, by March, 3 out of 4 of us, three of them had left…*' [EMHP]

> *'I'm not so much sure about the CBT therapist I know, definitely for EMHP, I think it does affect retention and I suppose that's why I went for the CBT role, because that is a progression.'* [CBT therapist]

Retention of trained staff is a recognised challenge for service leads, who report that trained EMHP's do not always stay in post. In the early stages of MHSTs the EMHP role attracted psychology graduates, some who used the post as a 'stepping stone to doing something else':

> *'Whereas now we are able to recruit people who represent the local culture and are more diverse, where the kids can see somebody who looks like them…and those people who are more local, more settled in the area, are better recruited and stay'* [Operational Team Lead]

A further challenge raised was difficulty in requesting feedback from children and young people:

> *'I don't think we get a very good return rate on our feedback forms to be completely honest…I try and ask young people to do it, but it's really hard because if I sit there in a session and ask them to fill out a feedback form, I'm not sure how honest they might be. There's that expectation that I'm sat there, kind of watching them, or even if I try not to watch them, you know, you try and busy yourself doing something, you're still in the same room.*' [CBT therapist]

Finally, awareness raising of the service offer amongst all who have a remit for supporting children and young people is still needed. An external clinical professional who has an interest in working more closely with MHSTs noted that the head teachers they are engaging with had never heard of MHSTs or the support they could offer until they had raised it:

> *'…when I spoke to a local school head teacher, they didn't know what they were either. And she had to go and make inquiries to get back to me about what she knew about it or what her, what her school knew about it.'* [GP]

Summary of findings from interviews with staff

Overall, there was a confident and clear understanding of the **remit of MHSTs** across all staff interviewed, however it was suggested the understanding of the MHST remit is not fully understood by all staff within education settings which can lead to confusion and inappropriate referrals being made. Some MHST staff feel that they have built up enough experience and qualifications to broaden what they are able to offer in terms of support, encompassing more than mild to moderate or low-level early intervention, but are held back by the limitations of what they are commissioned to deliver.

Staff felt that the **referral systems** worked well although these processes are different for City and County, and there are times when schools/colleges misunderstand the role of MHSTs and made inappropriate referrals. Staff across City and County also recognised that they have seen the referral processes evolve and feel that, for the County process, having an EMHP sat within the SPA team has made a marked improvement to referrals being accurately triaged to the most appropriate service. For the City, the consultation process to referrals has been positive in ensuring equal access to all education settings within the locality.

MHST locations vary operationally as they are organised differently according to locality and aim to tailor their response to the needs of children, young people, families, carers and school/college communities in their locality. Where expertise beyond the remit of MHST staff is required, MHST staff will consult and draw in multi-agency support.

Access to support for children and young people who are likely to benefit from early mental health and emotional wellbeing intervention was prioritised by staff. The increase in need related to SEND and neurodiversity were mentioned often, with staff wanting to provide an appropriate offer for neurodiverse children and young people where they felt that they could.

Training routes and courses for EMHPs were felt to be evidence based and thorough in terms of content and the amount of information learnt within the course duration. Staff feel that there was much more they would have benefitted from learning and also identified areas the training could be improved, both in terms of time taken to teach information and skills, and for this to be absorbed and applied, and in the content, for example understanding of the need to and skills to make the approach more inclusive to a wider range of children and young people. The current model can negatively influence staff retention if EMHP's are looking for progression but need to move to another role to be able to progress.

Overall, staff identify a wide range of **benefits and successes** with MHSTs, for children and young people, their parents and carers, wider and college communities and the capacity of other mental health and emotional wellbeing services. They feel that MHSTs are a positive place to work, enjoy being part of a team and interacting

with other stakeholders and services. They hope to see MHSTs go from strength to strength.

Challenges raised mostly relate to the developing relationship between MHST's and schools and colleges. Whilst engagement from some is strong and school/college staff are aware of the MHST offer and refer appropriately, school and college staff from other settings are more difficult to persuade to engage to take up the offer. The timing of support is also a challenge, staff would prefer to work with a young person at an earlier stage of need, before their mental health and emotional wellbeing deteriorates so that what they provide is true early intervention. They are also keen to work effectively with neurodivergent children and young people, suggesting the need to adapt the provision to meet additional needs. The role that stigma related to mental ill health plays was also highlighted, with efforts made to increase understanding amongst children, young people, parents, carers and the wider school and college community.

Research Question: What is the cost effectiveness of the MHSTs?

Cost Analysis

Counterfactual scenario analysis has been used to estimate costs that would have incurred if children and young people accessing Function 1 of the MHST model had not received early intervention from the MHSTs.

From RCADS data we have identified which children and young people have made a clinical improvement in their scores following treatment from the teams. To determine recovery the clinical cut off scores from the RCADs have been used. Cost savings are not assumed for the sample of children and young people who remain in the clinical range following treatment, children and young people who moved to the borderline range or children and young people who were not in the clinical range to begin with.

These costs are in two parts; cost savings throughout childhood and lifetime cost savings.

Childhood costs savings have been calculated based on

1) **Cost of service provision for children and young people with a mental health condition**. It is assumed that if children and young people had not made a recovery, they would have needed a future treatment within CAMHS. The type of CAMHS support they would have needed would be varied so the average annual cost of service provision per child/ young person has been used.

£325 per child/young person per year. Fiscal costs to the NHS.

2) **Costs of persistent school absence**. Evidence suggests that children and young people with mental health conditions are more likely to miss school than children and

young people who have no mental health conditions (NHS Digital, 2022). This data shows that in children and young people aged 7 -16 years, children/young people with a mental health condition are almost 4 times more likely than children/young people with no mental health condition to have missed more than 15 days of school. Therefore, costs associated with absence from school have been applied.

£1057 per child/young person per year - Fiscal costs to the Local Authority.

3) **Cost of youth offending**. Poor mental health is linked to offending behaviour in childhood with the occurrence of mental health conditions being higher in children and young people within the youth justice system than within the general population. It has been found that 72% of children/young people sentenced within the youth justice system have mental health conditions. (HM Inspectorate of Education, 2020). The costs that are associated with this have been applied.

£4329 per child/young person in the first year following the offence- Fiscal costs to the criminal justice system

Annual costs savings in adulthood have been calculated based on:

1) **Cost of providing mental health treatment to adults.** It has been shown that childhood mental health conditions are linked to increased likelihood of adult mental health conditions (Mulraney et al., 2021). Furthermore 50% of adult mental health conditions are believed to start before 14 years of age (Kessler et al.,2005) meaning any early intervention in childhood has the potential to limit mental health conditions in adulthood. Therefore, costs associated with mental health treatment in adulthood have been applied.

£1163 per person per year - fiscal costs to the NHS, Local Authority and the criminal justice system

£4755 per person per year - economic costs to HM Treasury

2) **Cost savings associated with the lifetime benefit of achieving 1 grade improvement at GCSE**. The effects of mental health conditions on education such as persistent absence (NHS Digital, 2022) have the potential to result in reduced attainment at GCSE level. Specifically, research (Smith et al., 2021) shows that mental health conditions at 11-14 years are related to lower attainment of GCSEs. Therefore, associated cost savings have been applied.

£202.92 per person per year - economic costs to HM Treasury

3) **NEET costs** – There is a strong link between experiencing a mental health condition and being NEET (Gariepy et al.,2021; Knapp et al.,2016). Therefore. costs associated with adults aged 18-24 years who are NEET have been applied.

£5662 per person per year –fiscal costs to DWP and HMRC
£11,969 per person per year – economic costs to HM Treasury

As the MHSTs do not capture paired outcome data for all children and young people that they treat, for the samples that were provided (MHSTs County n = 966; MHSTs City n = 65) the percentages of children and young people that moved out of the clinical category into the normal category were identified. Cost savings have been calculated based on the average number of children and young people the MHSTs provide a 1:1 or group intervention to in a year (Data provided by the MHSTs suggested MHSTs in the County treated on average 952.5 children/young people in a year, whilst MHSTs in the City treated on average 439.33 children/young people a year). The percentage of children and young people who made a clinical improvement in their RCADS scores has been used. From this it has been calculated what the average annual savings would be.

For ease of understanding this saving has then been averaged across the total number of children and young people that the teams treat so that the cost savings can be seen as being per child. This means the saving is the saving incurred for **every child** the team treats under Function 1 of the MHST model. This therefore considers that some children and young people do not make clinical improvements in their mental health. This is shown in Table 9.

Table 9 Summary of cost savings identified in City and County MHSTs

Childhood cost savings	Frequency of saving	Average cost saving **per child/young person** who received an intervention	Agency making the saving
MHSTs Nottingham City			
CAMHS provision	Per year	**£205.01**	NHS
Education (persistent absence)	Per year	**£666.76**	Local Authority
Youth offending	1 year	**£2730.74**	Criminal Justice System
Total cost savings	Initial Yearly	**£3602.51** **£871.77**	All agencies
MHSTs Nottinghamshire County			
CAMHS provision	Per year	**£89.38**	NHS
Education (persistent absence)	Per year	**£290.68**	Local Authority
Youth offending	1 year	**£1190.49**	Criminal Justice System

Total cost savings	Initial Yearly	**£1570.55** **£380.06**	All agencies

Lifetime cost savings	Frequency	Average cost saving **per child** who received an intervention	Agency making the saving
MHSTs Nottingham City			
Adult mental health provision	Per year	**£3733.08**	NHS Local Authority Criminal Justice System
Lifetime benefit of 1 GCSE grade improvement	Per year	**£128**	Local Authority
Costs of being NEET	Per year from 18-24 years of age	**£3571.6**	DWP HMRC HM Treasury
Total cost savings	Yearly (18-24 years) Yearly	**£7432.68** **£3861.08**	All agencies
MHSTs Nottinghamshire County			
Adult mental health provision	Per year	**£1627.47**	NHS Local Authority Criminal Justice System
Lifetime benefit of 1 GCSE grade improvement	Per year	**£55.8**	Local Authority
Costs of being NEET	Per year from 18-24 years of age	**£1557.06**	DWP HMRC HM Treasury
Total cost savings	Yearly (18-24 years) Yearly	**£3240.33** **£1683.27**	All agencies

Table 10 The cost of providing 1:1 or group interventions through MHSTs

Cost of providing an intervention through MHST	Frequency	Average cost **per session**	Average cost **per child** who receives an intervention (8 sessions)	Agency bearing cost
MHSTs				

Nottingham City And Nottinghamshire County				
MHST intervention provided by MHST staff (under Function 1 of the MHST model)	Once	£120	**£960**	NHS

Summary

The cost analysis looked at both the immediate cost savings through childhood incurred because of a successful mental health intervention from an MHST and the lifetime cost savings due to receiving a successful mental health intervention in childhood. A successful mental health intervention was identified in children and young people who had moved from the clinical to the normal range on a mental health outcome measure (RCADS) following their 1:1 or group intervention. Cost savings were then averaged out across the average number of children and young people who received these interventions annually. This was to provide an average cost saving per child. The cost saving would apply in the years following the time the child/young person received their intervention if they remained in recovery.

It was found that for Nottingham City for every child/young person the MHST provides a 1:1 or group intervention to an initial saving of £3,602.51 is made and then an additional saving of £871.77 each year through childhood. Lifetime savings are £7,432.68 per child/young person per year in adulthood from 18 to 24 years and then £3861.08 per child/young person per year till retirement age.

For Nottinghamshire County a saving of £1,570.55 per child/young person treated is made and then an additional yearly saving of £380.06 is made through childhood. A lifetime saving of £3,240.33 per child/young person treated is made ever year from 18-24 years and then an annual saving of £1683.27 is made

The cost of providing a 1:1 or group intervention is estimated to be £960 for both City and County and therefore is offset by the immediate total cost savings. If focusing only on NHS cost savings as this the agency bearing the cost of providing the MHST, the cost to the NHS will be offset within 5 years in Nottingham City and within 9 years in Nottinghamshire County and NHS cost savings continue to be seen, increasing in adulthood due to the higher cost of Adult Mental Health provision.

The methodology has some limitations, the cost analysis infers savings for children and young people who indicated recovery at their second testing however it is not known if any children and young people then went on to relapse or develop further needs meaning they needed further treatment at an increased cost. In addition, the analysis does not assume cost savings for children and young people who made improvements in their RCADS score but who did not move from clinical to normal

range. It is likely some cost benefits may be seen for these children/young people however by not including these children and young people it means the analysis has been more cautious in its approach. The cost savings only take into account children and young people who received an intervention from Function 1 of the MHST model, however Function 2 of the model which covers WSA work, e.g. assemblies in schools, work with schools and colleges to change responses to children and young people's behaviour, workshops delivered to parents/carers, etc., will also have the potential to yield cost savings. Again, meaning the cost savings shown here may be an underestimation of the potential savings the MHSTs can lead to. Cost savings are also likely to be seen from Function 3 of the MHST model. Signposting, advice and pathway development could make cost savings if they reduce children and young people being passed around the mental health system and therefore reduce numbers of assessments needed, referrals processed, waiting times etc. This would be a large saving but it would be difficult to evidence this. Finally, these cost savings are based on current data regarding average numbers of children and young people who receive an intervention therefore cost savings will change if numbers of children and young people accessing the service increase, and if MHST coverage increases. This means these cost savings are related to the current waves of MHSTs which at the time of conducting the evaluation was five MHSTs in City and nine MHSTs in County

Research Question: How are the main principles of the WSA contributing to changes in mental health and emotional wellbeing outcomes?

The WSA is a central remit for the MHSTs and encourages a positive mental wellbeing culture within schools and colleges. The WSA relates to Function 2 of the MHST model. Interviews with MHST staff explored their experience of the WSA and its impact on mental health and emotional wellbeing.

Data shows the number of children and young people the WSA is able to reach, demonstrating the potential impact of this approach.

Table 11 WSA Activity in Nottinghamshire MHSTs (2024)

District	Hours spent on WSA work	Children and Young People reached
Gedling	258	3785
Rushcliffe	368	6795
Bassetlaw	166	2186
Broxtowe	347	8708
Newark and Sherwood	222.	3031
Mansfield and Ashfield	341	4430
Nottinghamshire Total	**1702**	**28,935**

Table 12 WSA Activity in Nottingham City MHSTs (2022-2023)

	Number of WSA interventions	Number of schools reached	Children and Young People reached
Nottingham City	**480**	**143**	**19,788**

One participant shared how they deliver the whole school approach:

> '*I guess my day-to-day looks like seeing children and young people from mild to moderate mental health needs and that's half of what our job role is. And then the second half is Whole School Approach work, so we go into schools, and we deliver assemblies and workshops and training on mental health, and we each have allocated schools. So, I have seven schools in [Nottinghamshire district], and they're called my link schools, and I meet with the school's family and just sort of check in. How are things? What are your key sort of themes that are cropping up and what can I sort of put in place to help support you a bit better?'* [EMHP]

Some staff recognised that though they work hard and can offer excellent support, what the school/college is willing to accept and engage with really makes the difference:

> *'It can be very much a cultural thing, so some schools will very much buy into anything we've got, they want, yeah, you know, they know that we're well trained, they know that we're good at delivering, they know what we do and they will want everything that you can give them, everything, which is great and I absolutely love working with those schools, they are a delight to work with because, you know, you know that each and every one of those kids, they hold, which is great, whereas other schools, well, "you're not taking them out of lesson time, are you?'* [EMHP]

Amongst several mental health and emotional wellbeing support options that children and young people are able to access, MHST staff feel that the Whole School Approach offers a unique opportunity to those needing support:

> *'The whole school approach is what makes us stand out entirely'* [Specialist Practitioner]

At the heart of the Whole School Approach is a desire to shift the culture of schools and colleges to becoming a mentally healthy place to be for all children and young

people. It was felt that that MHST's may need to adapt their current methods in order to successfully achieve this:

> *'I think there's something bigger there and more national that when we're thinking about that side of our service how can we reframe that Whole School Approach, cause at the minute it's psychoeducation. A lot of it is with the children it's workshops, assemblies, which is great, as I've said, absolutely needed. But where is the, where is the ... getting into the heart of that school and making it a mentally healthy place to be.'* [Service Manager]

It is important to recognise that this is a long-term goal that needs a holistic approach and time to achieve, a goal that is not possible for MHSTs to achieve alone. A clear example was given of the challenges relating to school regimes and structures, in particular, the different challenges between the organisation of primary and secondary education:

> '*…schools are absolutely open to mental health support…our primary schools…a lot of them are working towards less sanctions, less behaviourist approaches, more relational. They're set up to do that anyway, by structure and design, you've got a child who goes in to the same person every day. Same teacher, same faces, same classroom. Our secondary schools? Absolutely not… they will welcome us to go and do training but by design they're not mentally healthy places to be. So, it's not that they're not embracing work and understanding of mental health and trying to get kids support. It's not that, it's that the system that these kids are in and the environment they're in is not a mentally healthy place to be. And that's to do with wider systemic structural issues within the education system not to do with the mental health support, if that makes sense?'* [Service Manager]

The WSA extends to staff working within schools and colleges too. The extra resource that is offered benefits staff mental wellbeing as well as that of children and young people. It was regarded as important that the WSA looks at the impact of the culture of school/college on staff as well as children and young people:

> *'As well as doing direct work with children and young people the MHST's will do work to support staff mental health. They'll do staff training, they'll do assemblies, they'll do wider pieces of work which are much more about … thinking about things you can do in school that will benefit everyone…it's great that we're able to offer schools extra resource because they need it…if staff feel ok within themselves then they'll be able to support young people better'* [Commissioner]

> *'In our jobs we have supervision, managerial, clinical support and if anything traumatic happens we get a debrief, teachers don't have any of that…what they*

don't realise is how much they hold in their jobs…it's not really normal to sit in your dressing gown on a Saturday morning doing marking, you need to have a bit of time off and really call it out…there is quite an unhealthy work life balance' [Operational Team Lead]

The Managers quoted here all emphasised the need for health, education and other welfare services to work more closely and also the benefits for all that can be gained from a multi-agency, joined up approach to addressing mental health and emotional wellbeing:

'The work that can be done around the Whole School Approach is going to be really important in terms of preventing young people from becoming unwell in the first place… there are benefits to a system enabling health and education partners to work more closely together…if we're going to improve children and young people's mental health the solution doesn't just lie with the NHS, it needs everybody involved, the MHST model is a good vehicle for us to do that' [Commissioner]

Throughout this evaluation it has been found that Commissioners and Leaders within the MHSTs -

- Regard positively that a whole additional level of the children and young people's mental health and emotional wellbeing workforce has been developed, with a sole focus on prevention and early intervention.
- Appreciate that funding was ringfenced for MHSTs and is additional to other services.
- Value that the Leads in the City were 'already embedded into the system', having their own contacts and established relationships with a range of stakeholders.
- Aim for a 'robust referral approach' within schools/colleges and further engagement with the WSA.
- Benefit from a Strategic Partnership Group for Children and Young People's Mental Health and Emotional Wellbeing being developed with strategic leadership from across the City and County, to engage a range of stakeholders and to strengthen collaborative working.
- See that MHST success is predicated on strong relationships with the Senior Mental Health Lead in schools/colleges. They recognise that the Senior Mental Health Lead may have multiple roles, such as SENCO and Safeguarding Lead which is useful for a holistic approach, but this also stretches their capacity and staff turnover is high.
- Identify a tension between the Whole School Approach and MHST targets associated with access to mental health and emotional wellbeing services, e.g. the need to maintain the focus on WSA whilst also being concerned with

numbers of referrals and paired outcomes data. The WSA is crucial in driving a mentally healthy culture for children, young people and the staff that work within schools and colleges.

- Value the tailored intervention that has at times been provided to children and young people with special educational needs and disabilities, children and young people with cultural, religious and language needs and support the broadening of this approach, recognising that children and young people with special educational needs and disabilities 'have a higher likelihood of struggling with their mental health'.

Future Development of MHSTs

Commissioners and Leaders within the MHSTs -

- Would like every school/college, including special schools, alternative provisions and independent schools, to have an MHST, it has been a challenge not to have full coverage, particularly in Nottinghamshire, *'it is not an equitable offer at the moment, the funding just isn't there to make it so…we are going to keep bidding for funding'*. At the time of writing, commissioners were waiting for a national steer about future opportunities to bid for funding and wished to focus further on areas of highest prevalence, greatest access to other mental health and emotional wellbeing services and greatest deprivation.
- Wish to act on feedback gathered from children and young people to make schools and colleges more mentally healthy places to be.
- Would value improved communication between MHST's and schools/colleges and consistent cascading or filtering down of information about MHST's to all colleagues within schools and colleges that interact with children and young people.
- Are taking steps to build stronger relationships with other Local Authorities, NHS Trusts and Commissioners, in order to share learning.
- Wish to explore further the relevance of the organisational location of the Whole School Approach Lead, in the City the WSA Lead is part of the MHST, funded through MHST monies and hosted within the core MHST. In the County the WSA Lead is a separate local authority funded post, within the education directorate of the County Council. The WSA Lead in the County links in with the County MHST team leads on an operational level, but the strategic oversight of the WSA Lead and MHST's working arrangements is currently unclear.

Success

We end this section of the evaluation with an illustration of what a tangible successful outcome for a young person accessing MHST support in Nottingham or Nottinghamshire might look like, from the perspective of a service commissioner:

'An outcome of referral would be that the young person successfully completed the sessions, is now equipped to manage their own mental health going forward and no longer requires [support]. But equally it is successful if that referral in and the work done then uncovered some more specialist needs and that young person got to access the more specialist services as quickly as possible. The third successful outcome would be that the young person's needs were met in a holistic way…whatever they were presenting with…and that school would be aware of the things that they could do to support the young person' [Commissioner]

Feedback from Children and Young People

Throughout the evaluation several attempts were made to get feedback from children and young people who had used MHSTs, via an online survey. Unfortunately, despite our best efforts we did not gain enough feedback to complete any large-scale analysis. Instead, we have collated some of the quotes from the children and young people who did complete the study and present them here. We also present a case study of a young person who had support from Nottingham City MHSTs.

Case study

Megan is 12 years old and she presented to MHSTs with anxiety and low mood. Her RCADS scores were within the clinical threshold

Background Megan's mental health was having a significant impact on her life and she was using self-harm to cope. Megan had lost approximately one and a half stone in weight due to her poor appetite and was prescribed sleeping tablets due to her inability to sleep. Megan was also avoiding attending school wherever possible, with Mum allowing her to take days off when she was struggling. Typically, Megan would take between 1 and 2 days a week off school as a minimum.

Family Mum would keep Megan off school whenever she was anxious, as Mum wanted to protect Megan from feeling any worse. Megan and her Mum completed psychoeducation on fight or flight and on habituation. It was explored how keeping Megan off from school was working to maintain Megan's anxiety, rather than protecting her from it. Graded exposure was completed to increase Megan's attendance at school. Mum stated that learning about habituation and being involved in the process helped her understand how she can support Megan and the importance of her attending school rather than avoiding it.

Intervention 8 sessions. An intervention called behavioural activation was used which explores a young person's values and supports them to live their lives according to these. Megan was supported to plan and schedule activities in that would boost her mood and bring her a sense of achievement, closeness to others and enjoyment. Part of Megan's scheduling involved her planning to go into school, rather than to avoid it due to her low mood. Ways were explored in which school could be more enjoyable for her and how she could increase her engagement with education to bring her a sense of achievement

Outcome Megan was no longer avoiding specific lessons at school and was only taking days off if she was physically unwell. School had commented on the significant improvements they had seen with both her behaviour and attendance within school. Megan no longer self-harmed and had stopped losing weight. She did not require sleeping tablets and was going out with her friends more. Megan's RCADS also showed that she was no longer clinically significant in any of the difficulties measured. Her total anxiety score had reduced from 71 to 41 and her total anxiety and depression score reduced from 76 to 43

Feedback from survey with children and young people

Reflections from Research Questions

Overall reflections when looking at the data collected and analysed as part of the evaluation of MHSTs:

- Data collected from outcome measures taken at the start and end of treatment found:
  In Nottingham City children and young people showed significant improvement on RCADS measures following treatment.
  In Nottinghamshire County children and young people showed significant improvement on RCADS, CGAS and SDQ measures following treatment.

- Data collected from the staff survey suggests **critical success factors** for MHSTs are:
  - Communication
  - Teamwork
  - Adequate staffing and funding
  - Passionate staff
  - MHSTs giving a timely response
  - Staff understanding each other's roles
  - Ease of referral to MHSTs
  - MHSTs providing an early intervention

- Data collected from the staff survey suggests the main **barriers to success** in MHSTs are:
  - Staffing problems/lack of funding
  - Schools/colleges not engaging
  - MHSTs remit being too limited – cannot provide intensive support
  - Problems with referral and waiting times
  - Poor communication and MHSTs and schools/colleges not working in collaboration
  - Existing school and college structures/policies not supporting positive mental health and emotional wellbeing

- Overall data from the staff survey showed that **92%** of staff asked thought that the MHSTs improve the mental health and wellbeing of children and young people and **81%** of staff asked felt that the MHSTs reduce the number of referrals to other services within CAMHS.

- Cost analysis supports the continuation of MHSTs and supports an increase in MHSTs. The analysis showed the potential the MHSTs have to save money to mental health services if early intervention can stop further referrals to higher tier services within CAMHS. Furthermore, if early intervention can prevent continued mental health conditions in adulthood cost savings will be made to Adult Mental Health Services. MHSTs also have the potential to save money for the Local Authority and the Economy due to better mental health in childhood being linked to improved attendance at school and educational attainment. There are also cost savings for the criminal justice system and society due to childhood mental health conditions being linked to youth offending and unemployment in adulthood.

4. Limitations

This evaluation focused on the implementation of Mental Health Support Teams in two localities, Nottingham City and Nottinghamshire County. Both services are commissioned and funded by NHS Nottingham and Nottinghamshire Integrated Care Board. Efforts were made to include a wide range of stakeholders, including Commissioners, Strategic Leads, Operational Leads and staff undertaking direct work with children and young people and service users. There were challenges involved in encouraging participation from some, for example, service user groups are less well represented in the data collected.

The cost analysis infers cost savings for children and young people who indicated recovery at their second testing however it is not known if any children and young people then went on to relapse or develop further needs meaning they needed further

treatment at an increased cost. The cost analysis only takes into account children and young people who received an intervention from Function 1 of the MHST model, however Function 2 of the model which covers WSA work, e.g. assemblies in schools, work with schools to change responses to children and young people's behaviour, workshops delivered to parents/carers, etc., will also have the potential to yield cost savings. This means that the cost savings found here may be an underestimation of the potential savings the MHSTs can lead to. Cost savings are also likely to be seen from Function 3 of the MHST model. Signposting, advice and pathway development could lead to cost savings if they lessen children and young people journeying through several mental health services, struggling to find appropriate and consistent support, and therefore reduce numbers of assessments needed, referrals processed, waiting times. This would be a large saving, but it would be difficult to evidence.

Finally, the cost analysis is based on current data regarding average numbers of children and young people who receive an intervention (under Function 1) therefore cost savings will change if numbers of children and young people accessing the service increase, and if MHST coverage increases. This means these cost savings are related to the current waves of MHSTs which at the time of conducting the evaluation was five MHSTs in City and nine MHSTs in County.

5. Recommendations

Research Question: How could the model be improved further?

Based on the evaluation findings the following **recommendations** have been made:

- For MHST coverage to expand to 100% across Nottingham City and Nottinghamshire County. This includes provision being made available to special schools, alternative provisions and independent schools. According to NHS England, current coverage in Nottingham City is c.76% when accounting for primary schools, secondary schools, colleges and special schools, in some areas of Nottinghamshire the provision of MHSTs is still relatively low (c.44% across whole of the County). However, this only accounts for primary schools, secondary schools, special schools and colleges, and does not recognise the needs of alternative provisions or independent schools despite operational guidance recognising best practice as covering these settings too. Additional funding is required to build provision up to 100% coverage according to NHS England's definition, and further funding will be required from alternative sources to ensure alternative provisions and independent schools also have equitable access to the MHST offer.

- Waiting times emerged as a key theme. It is recommended that MHSTs should have increased staff capacity to allow more children and young people to access the offer at one time and reduce waiting times. In addition, waiting times

should be made clearer, demystifying the processes and criteria for different services. Commissioners should look to publish waiting times for each service and a set timeframe for responding to referrals should be made clear to all schools and colleges.

- A standard operating procedure for referrals should be in place including post triage and letting children and young people, families/carers and referrers know the outcome of the referral.
- Learning should be shared between Nottingham City and Nottinghamshire County. For example, they have different operational processes for certain elements of the MHST model, such as the different referral processes, could this be aligned, based on feedback of what process works best? In addition, as Nottingham City is one of the few areas in England to have a Local Authority delivering the MHST model, the success of Nottingham City could be used to inform learning.
- Alongside deprivation data other sources such as prevalence data and access data should be considered when determining which localities should be prioritised for MHSTs as the expansion rolls out.
- To support MHST staff to further develop their skills and gain relevant experience to work with children and young people with additional health and care needs. The MHSTs should aim to work more closely and in an integrated way with neurodevelopment services such as Partnership for Inclusion of Neurodiversity in Schools (PINS) teams. Need is increasingly complex, and anecdotal feedback suggests that often mental health and emotional wellbeing needs cannot be separated from neurodevelopmental needs, SEND needs and/or emotional wellbeing difficulties occurring as a result of the school environment.
- Training for EMHP's, provided by universities, should cover how to adapt the interventions to address children with additional needs as many children referred to MHST's have needs that overlap with mental health and emotional wellbeing needs, such as identifying as neurodivergent. Consideration should also be given to how to retain a trained workforce as unlike in some other professions EMHPs are not obligated to work in the role for a required period following completion of training.
- All MHSTs to have specialist CBT practitioners to enable the teams to be able to provide higher level therapy if needed
- There is need for improved promotion of the MHSTs from education and health leads to increase awareness of the MHST offer. In particular, schools and

colleges who are reluctant to take up the offer should receive more promotion. This will help to strengthen the relationship between school/college colleagues and MHST staff which is crucial to the success of the MHSTs and will help to embed the Whole School Approach, shown to benefit young people, parents, carers school and college staff and the wider school/college community.

- For schools and colleges to be aware of how their structure and policies can negatively impact on children and young people's mental health and emotional wellbeing and to continue to consider their role in improving the school/college environment to make it mentally healthy.

- For the initiatives around multiagency working to continue to be developed, at a strategic, operational and delivery level. Bringing key stakeholders together to share good practice, for the benefit of children and young people, will serve to positively impact child-centred practice. This should be promoted beyond MHST level, and MHST staff should be expected to engage in multiagency working for the benefit of children and young people not on their caseload, as well as those they work with directly. Capacity should be freed up to allow this to be a consistent part of the role of MHST staff.

6. Conclusions

A growing number of children and young people nationally are experiencing mental health and emotional wellbeing challenges and require effective support. It is important to be able to evidence what works well and to identify where there are barriers or challenges to providing support. From the findings outlined in this evaluation report it is recommended that there is 100% coverage of MHSTs in schools and colleges across Nottingham and Nottinghamshire.

7. Acknowledgements

The evaluation team would like to thank the following for their valuable contributions:

- All staff members who gave their time to take part in interviews or complete the survey
- Nottinghamshire Healthcare NHS Foundation Trust and Nottingham City Council for providing secondary data to support the evaluation
- Nottingham and Nottinghamshire ICB for funding the evaluation
- Aislinn Forrest for her help with reviewing the final evaluation report
- Dr Verusca Calabria and Professor Pam Alldred as acting as advisors for the evaluation

8. References

Bailey, D., & Mutale, G. (2022). Social work's contribution to integrated primary health care teams in the UK for older adults with complex needs, *Journal of Integrated Care, 30(3*), 263-275

Bailey, D., & Mutale, G. J. (2020). Can a case lead approach deliver the "craft and graft" of integration? *Journal of Integrated Care*. ISSN 1476-9018

Bailey, D., De Motte, C., Nomikos, L., & Mutale, G. (2020). *Evaluation of the You Know Your Mind Project*. Research report for external body. Nottingham: Nottingham Trent University.

Bansal, N., Karlsen, S., Sashidharan, S. P., Cohen, R., Chew-Graham, C. A., & Malpass, A. (2022). Understanding ethnic inequalities in mental healthcare in the UK: A meta-ethnography. *PLoS medicine*, *19*(12), e1004139. https://doi.org/10.1371/journal.pmed.1004139

British Psychological Society., 2019. *Mental health support teams: how to maximise the impact of the new workforce for children and young people* [online]. Leicester: British Psychological Society. Available at: https://www.bps.org.uk/guideline/mental-health-support-teams-how-maximise-impact-new-workforce-children-and-young-people [Accessed 19 July 2021].

Children's Commissioner (2024). Children's mental health services 2022-23. Research Report. Available at: https://www.childrenscommissioner.gov.uk/resource/childrens-mental-health-services-2022-23/ [Accessed 22 October 2024]

Chorpita, B. F., Yim, L. M., Moffitt, C. E., Umemoto L. A., & Francis, S. E. (2000). Assessment of symptoms of DSM-IV anxiety and depression in children: A Revised Child Anxiety and Depression Scale. *Behaviour Research and Therapy, 38*, 835-855.

Great Britain. Department of Health and Department for Education., 2017. *Transforming children and young people's mental health provision: a green paper* [online]. London: HMSO. (Cm. 9525). Available at: https://assets.publishing.service.gov.uk/media/5a823518e5274a2e87dc1b56/Transforming_children_and_young_people_s_mental_health_provision.pdf [Accessed 19 July 2021].

Gariépy, G., Danna, S. M., Hawke, L., Henderson, J., & Iyer, S. N. (2022). The mental health of young people who are not in education, employment, or training: a systematic review and meta-analysis. *Social psychiatry and psychiatric epidemiology*, *57*(6), 1107–1121. https://doi.org/10.1007/s00127-021-02212-8

Goodman R (1997) The Strengths and Difficulties Questionnaire: A Research Note. *Journal of Child Psychology and Psychiatry, 38*, 581-586

Greater Manchester Combined Authority (GMCA) Cost Calculator Available at: https://www.greatermanchester-ca.gov.uk/what-we-do/research/research-cost-benefit-analysis/

HM Inspectorate of Education (2020). Available at: https://www.justiceinspectorates.gov.uk/hmiprobation/research/the-evidence-base-youth-offending-services/specific-areas-of-delivery/mental-health/ [Accessed 24 October 2024]

Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., Walters, E.E. (2005). Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*(6). 593-602. doi:10.1001/archpsyc.62.6.593.

Knapp et al. 2016). Youth Mental Health: New Economic Evidence. Available at: https://www.pssru.ac.uk/pub/5160.pdf {accessed 23 July 2025]

Mulraney, M., Coghill, D., Bishop, C., Mehmed, Y., Sciberras, E., Sawyer, M., Efron, D., Hiscock, H. (2021). A systematic review of the persistence of childhood mental health problems into adulthood. *Neuroscience and Biobehavioural reviews, 129,* 182-205

Mutale, G. J., De Motte, C., & Bailey, D. (2020). Using a mixed methods approach to examine the effectiveness of inpatient rehabilitation services following a programme of planned bed closures. *Journal of Psychosocial Rehabilitation and Mental Health*, *7,* 55-65

NHS Digital (2022). Mental Health of Children and Young People in England 2022 - wave 3 follow up to the 2017 survey. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2022-follow-up-to-the-2017-survey/data-sets [Accessed 21 May 2024]

NHS England, n.d. *Mental health support teams for children and young people in education: A manual* [online]. England: NHS England. Available at: https://www.transformationpartners.nhs.uk/wp-content/uploads/2015/10/Mental_Health_Support_Teams_for_Children_and_Young_People_in_Education_The_Manual_October_19_FINAL.pdf [Accessed 16 August 2024].

NICE, 2022. *Social, emotional and mental wellbeing in primary and secondary education* [online]. Manchester: NICE. Available at: https://www.nice.org.uk/guidance/ng223 [Accessed 15 August 2024].

ONS. Explore local statistics. Nottingham. Available at: https://explore-local-statistics.beta.ons.gov.uk/areas/E06000018-nottingham. [Accessed 22 October 2024]

ONS. Explore local statistics. Nottingham. Available at: https://explore-local-statistics.beta.ons.gov.uk/areas/E10000024-nottinghamshire. [Accessed 22 October 2024]

Public Health England, 2021. *Promoting children and young people's mental health and wellbeing: A whole school or college approach* [online]. London: Public Health England. Available at: https://assets.publishing.service.gov.uk/media/614cc965d3bf7f718518029c/Promoting_children_and_young_people_s_mental_health_and_wellbeing.pdf [Accessed 16 August 2024].

Procter, T., Banerjee, R., Roberts, L., Macdonald, I., Randell, B., 2021. *The Whole School Approach within Mental Health Support Teams: Best practice review* [online]. Kent: NIHR Applied Research Collaboration Kent, Surrey and Sussex. Available at: https://arc-kss.nihr.ac.uk/document-download/160-best-practice-review-of-whole-school-approach-wsa-within-mhsts-in-the-south-east-and-east-of-england-summary-of-the-evaluation-report/file [Accessed 21 August 2024].

Procter, T., Roberts, L., Macdonald, I., Morgan-Clare, A., Randell, B., and Banerjee, R.,2021. *Best practice review of Whole School Approach (WSA) within MHSTs in the South-East and East of England: Evaluation Report* [online].

Public Health England (2020a). Local Authority Health Profile. Ashfield. Available at: https://fingertips.phe.org.uk/static-reports/health-profiles/2019/E07000170.html?area-name=Ashfield [Accessed 22 October 2024]

Public Health England (2020b). Local Authority Health Profile. Mansfield. Available at: https://fingertips.phe.org.uk/static-reports/health-profiles/2019/E07000174.html?area-name=Mansfield [Accessed 22 October 2024]

Public Health England (2020c). Local Authority Health Profile. Rushcliffe. Available at: https://fingertips.phe.org.uk/static-reports/health-profiles/2019/E07000176.html?area-name=Rushcliffe [Accessed 22 October 2024]

Public Health England (2020d). Local Authority Health Profile. Nottingham. Available at: https://fingertips.phe.org.uk/static-reports/health-profiles/2019/E06000018.html?area-name=Nottingham [Accessed 22 October 2024]

Public Health England (2016). Psyhcosis data report. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/774680/Psychosis_data_report.pdf [Accessed 23 July 2025]

Schlack, R., Peerenboom, N., Neuperdt, L., Junker, S., & Beyer, A. K. (2021). The effects of mental health problems in childhood and adolescence in young adults: Results of the KiGGS cohort. *Journal of health monitoring*, *6*(4), 3–19. https://doi.org/10.25646/8863

Shaffer, D., Gould, M.S., Brasic, J., Ambrosini, P., Fisher, P., Bird, H., & Aluwahlia, S. (1983). A Children's Global Assessment Scale (CGAS). *Archives of General Psychiatry*, 40, 1228-1231.

Smith, N.R, Marshall L, Albakri M, et al. (2021). Adolescent mental health difficulties and educational attainment: findings from the UK household longitudinal study. *BMJ Open*;**11**:e046792. doi:10.1136/ bmjopen-2020-046792

Wolpert et al. (2019). Thrive Framework for System Change. Available from: https://implementingthrive.org/wp-content/uploads/2024/08/THRIVE-Framework-for-system-change-2019NEW-2.pdf

Appendices

Appendix 1 Staff Survey

Mental Health Support Teams Evaluation

Participant Information Sheet- Staff Survey

What is the purpose of the evaluation?

The purpose of our evaluation is to evidence the effectiveness of the Mental Health Support Teams (MHSTs) currently operating in schools across Nottingham and Nottinghamshire. The MHSTs are a collaborative service working with schools to provide early mental health interventions to support children and young people. This evaluation aims to understand how the MHSTs benefit the mental health of the children and young people who use them and the experience of staff who work in the MHSTs and the school setting. The evaluation will aim to understand how the Whole School Approach is implemented and how effective this approach is. The evaluation also aims to establish the cost effectiveness of the MHSTs.

The research is being conducted by Nottingham Trent University who are not involved in the development and delivery of the MHSTs

We would like you to contribute to the evaluation by completing a short questionnaire about the MHSTs and their delivery. Please read the information below to decide whether to take part.

What are the benefits of contributing?

By helping us evaluate the MHSTs you will help shape the future development of the teams. With your input, we will be able to identify the benefits and limitations of the MHSTs

What does the process involve?

The questionnaire should take around 10 minutes to complete. You can leave any questions you do not wish to answer blank. Some of the questions are in scale format others require a written response.

What if I want to withdraw from this evaluation?

You can leave the questionnaire at any time. You can also change your mind about taking part in the evaluation and may withdraw your data from the evaluation within 2 weeks of taking part. You can do this by contacting the evaluation team directly with your unique identifier.

Your withdrawal from the evaluation will have no effect on your employment with your current organisation

Will my contribution be kept confidential?

The evaluation team will keep all information about you and your participation confidential.

If you share with us any information relating to safeguarding issues we will need to share this with a professional in the MHSTs, in accordance with safeguarding procedures.

Please remember that the information you provide is confidential and anything you say in the survey will have no effect on your employment.

Your survey response will be stored anonymously in a password-protected file and only the NTU evaluation team will have access to these files.

The findings of the evaluation will be used to produce an evaluation report for Nottingham City and Nottinghamshire County Council. Nothing identifiable to you will be used in the report.

What will I have to do?

If you are happy to take part, we will ask you to sign a consent form to state that you:

- have read all the information about the project
- understand what you will be expected of you
- agree to take part

If you have any questions please either before or after taking part then you can contact any member of the evaluation team:

Professor Geraldine Brady (Principal Investigator) geraldine.brady@ntu.ac.uk

Dr Gabriella Mutale (Research Fellow) gabriella.mutale@ntu.ac.uk

Bailey Foster (Research Assistant) bailey.foster02@ntu.ac.uk

Ticking ALL statements below indicates that you have read the information provided and have decided to take part.

	Consent Statement	**Tick to Consent**
1.	I have read and understood the participant information sheet	
2.	I understand that my participation is voluntary, and that I am free to withdraw my data by leaving the questionnaire at any point.	
3.	I understand that my data will be kept confidential, unless I disclose harm to myself or others	
4.	I agree for my anonymised data to be analysed by the evaluation team, and used in the writing up of this research	
5.	I understand that I am free to withdraw my data up to two weeks after the completion of the questionnaire by providing my unique identifier.	
	Please provide a unique identifier here. This can be a number or a word or combination of both. Do not give your name. Unique identifier: ……	

You may withdraw from the study within 2 weeks of taking part by contacting Principal Investigator Geraldine Brady directly:
Email: geraldine.brady@ntu.ac.uk
Phone: 0115 8482145
Address: Nottingham Trent University, 50 Shakespeare Street, NG1 4FQ

Survey

Which area of Nottinghamshire do you currently work in?

- Ashfield
- Bassetlaw
- Broxtowe
- Gedling
- Mansfield
- Newark & Sherwood
- Rushcliffe
- Nottingham City

What is your job role?

Can you briefly describe your role?

The MHSTs improve the mental health and wellbeing of children and young people using them

Strongly Agree

Agree

Neutral

Disagree

Strongly Disagree

The MHSTs support disadvantaged groups of children and young people

Strongly Agree

Agree

Neutral

Disagree

Strongly Disagree

The MHSTs help to reduce inequalities in mental health provision

Strongly Agree

Agree

Neutral

Disagree

Strongly Disagree

The MHSTs reduce the number of referrals to specialist NHS CAMHS services

Strongly Agree

Agree

Neutral

Disagree

Strongly Disagree

The MHSTs mean young people and children get the right support they need in a timely manner

Strongly Agree

Agree

Neutral

Disagree

Strongly Disagree

The MHSTs promote an integrated approach between schools and NHS mental health services

Strongly Agree

Agree

Neutral

Disagree

Strongly Disagree

The MHSTs mean young people and children are better able to seek support for their mental health.

Strongly Agree

Agree

Neutral

Disagree

Strongly Disagree

The MHSTs help prevent children and young people entering crisis

Strongly Agree

Agree

Neutral

Disagree

Strongly Disagree

How has the Covid-19 pandemic effected the implementation of the MHST you work in or with?

What do you believe to be critical to the success of the MHSTs you work in or with?

What has been the main barrier in the implementation and success of the MHST you work in or with?

Any other comments you would like to make?