



## Education and Health and Social Care Committees Joint Inquiry into Children and Young People's Mental Health

### Response from Place2Be – March 2026

[Place2Be](#) is a children's mental health charity with over 30 years' experience working with pupils, families and staff. We work in over 650 UK primary and secondary schools, reaching a school population of over 300,000 children and young people. We offer evidence-based mental health interventions in schools, training and support for school staff, parents and carers, and qualifications for anyone wanting to become a qualified counsellor for children.

This evidence draws on our experience delivering evidence-based mental health support in school communities; working within and with Mental Health Support Teams; and delivering children's counselling qualifications. We would be delighted to provide oral evidence on these topics, as well as on the mental health and wellbeing of children and young people general.

#### Summary of recommendations:

1. Evidence-based mental health whole-school support should be **embedded** in schools to build and ensure an inclusive environment. This involves school and education staff capacity and skills with **embedded professional mental health support** through a joined-up approach involving health, education, VCFSEs (Voluntary, Community, Faith and Social Enterprise organisations) and philanthropic support.
2. The government should set out the Universal Community and School-based Children's Mental Health Offer that will be available to every child by 2030, incorporating MHSTs, Hubs and school-based support, focused on early intervention and prevention with schools, the key civic institution and asset and already established in every community, as the key hub of support.
3. The government should support the creation of an Apprenticeship in Counselling as a tangible and long-term solution to increasing the availability of timely, skilled mental health professionals to support children and young people.
4. The government should commission an independent post-implementation review of the initial roll-out of MHSTs, particularly on their ability to meet the needs of all children, informed by the evaluation process already underway and due to be completed in May.
5. A one-size-fits-all single national model approach to the further roll-out of MHSTs should not be taken. There should be local flexibility to take alternative approaches proven to be effective, including those developed and delivered by evidence-based VCFSE providers, with Integrated Care Boards held to account for their delivery of outcomes for children.
6. Ofsted inspections should consider the extent to which schools leverage and work in partnership with health services, community hubs, and VCFSE providers to create inclusive environments where children can fully engage in education, develop to their full potential and thrive.



## **From treatment to prevention: intervening early in children's mental health**

With half of all mental health problems presenting by age 14 and three-quarters by age 24, childhood is our chance to act. 1 in 5 children and young people in England now have a probable mental health condition, and almost 120,000 are referred to CAMHS every month. While this trend is not unique to the UK, the UK does lag other wealthy nations in terms of child wellbeing and life satisfaction. According to UNICEF, the UK ranked 21 out of 36 wealthy countries for child wellbeing and 27<sup>th</sup> for mental health<sup>1</sup> and 33 out of 36 for life satisfaction.

We know too that not acting early can have a negative impact on a child's academic achievement and life-chances:

- Young people experiencing poor mental health are 3.2 times more likely not to meet the GCSE benchmark<sup>2</sup>.
- Children with mental health issues are three times more likely to be excluded compared to other pupils<sup>3</sup>.
- 37% of the children we supported in schools aged 11-18 were persistently absent (missed 10% or more school day sessions).

Where we don't intervene early, it has a big impact on public services too, particularly schools. Children waiting on care for mental health issues cost public services an estimated £295 million per year, with more than 90% of the costs falling on schools<sup>4</sup>.

Investing in early intervention can ease pressure on CAMHS too. In 2024-25, 10% of the children and young people who were referred to Place2Be and continued into 1:1 counselling following our Assessment and Formulation process were on the waiting list for CAMHS at the time of assessment. In fact, a 2021 study found that school-based counselling from Place2Be supported children with higher complexity of needs in schools, which reduced demand on specialist mental health services such as CAMHS<sup>5</sup>.

There is a clear need to go further and faster in our shift from treatment to prevention. To do that, there should be greater investment in evidence-based interventions embedded in schools,

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<sup>1</sup> UNICEF, 2025: [https://www.unicef.org/innocenti/reports/child-well-being-unpredictable-world?\\_gl=1%2Ak0q5uv%2A\\_ga%2AMTU4NzQ0MjcxNC4xNzY2MTM5OTQz%2A\\_ga\\_4QVKT2Z86S%2AczE3NjYxMzk5NDMkbzEkZzAkdDE3NjYxMzk5NDUkajYwJGwwJGgw](https://www.unicef.org/innocenti/reports/child-well-being-unpredictable-world?_gl=1%2Ak0q5uv%2A_ga%2AMTU4NzQ0MjcxNC4xNzY2MTM5OTQz%2A_ga_4QVKT2Z86S%2AczE3NjYxMzk5NDMkbzEkZzAkdDE3NjYxMzk5NDUkajYwJGwwJGgw)

<sup>2</sup> Adolescent mental health difficulties and educational attainment: findings from the UK household longitudinal study, Smith et al, BMJ Open, 2021: <https://pubmed.ncbi.nlm.nih.gov/34305046/>

<sup>3</sup> IPPR, 2024: <https://www.ippr.org/media-office/revealed-school-exclusions-and-suspensions-rise-by-a-fifth-last-year-finds-new-report>

<sup>4</sup> *Future Minds*, Children and Young People's Mental Health Coalition, 2025: <https://www.centreformentalhealth.org.uk/wp-content/uploads/2025/02/Future-Minds-Report-2025-WEB.pdf>

<sup>5</sup> Impact of counselling provision in primary schools on child and adolescent mental health service referral rates: a longitudinal observational cohort study, Grant et al, 2021: <https://acamh.onlinelibrary.wiley.com/doi/full/10.1111/camh.12519>



which can promote good mental health for all children, as well as expert services, including targeted 1-1 support, for those with greater needs.

We share the ambition of the Schools White Paper that all children should be able to “seize opportunities to achieve and thrive, grow with confidence and shape their own futures as well as the future of our society.” Our own data shows that integrated and embedded can help us achieve this:

- In 2024-25, 76% of children and young people with severe difficulties supported through Place2Be’s targeted interventions showed improvement in mental health.
- In 2024, teachers reported an improvement in classroom learning for 63% of children who had 1:1 counselling with Place2Be and 66% of pupils caused fewer problems for their teacher or class.
- An evaluation of Place2Be’s work in primary schools in Salford showed that children in our partner schools there had a high sense of connection with their school, with most feeling that there was always an adult in school that believed they would be a success<sup>6</sup>.

Importantly, we believe that it’s not just about therapeutic interventions. **All** schools should be supported to be places where children feel they belong, where they feel seen and heard, where they are inspired, challenged and stretched to become the best version of themselves. We recognise and support that ambition in the Schools White Paper.

**Recommendation 1:** *Evidence-based mental health whole-school support should be embedded in schools to build and ensure an inclusive environment. This involves school and education staff capacity and skills with embedded professional mental health support through a joined-up approach involving health, education, VCFSEs (Voluntary, Community, Faith and Social Enterprise organisations) and philanthropic support.*

**Recommendation 2:** *The government should set out the Universal Community and School-based Children’s Mental Health Offer that will be available to every child by 2030, incorporating MHSTs, Hubs and school-based support, focused on early intervention and prevention with schools, the key civic institution and asset and already established in every community, as the key hub of support.*

### **Expanding the workforce**

A strengthened, diverse mental health workforce is essential if we are to deliver early, accessible intervention and reduce inequalities. Increasing the availability of qualified counsellors in educational and community environments would support earlier identification of needs, reduce the burden on specialist services, and help prevent difficulties from reaching

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<sup>6</sup> AL Philanthropies Salford Research Programme- Autumn 2024 interim report, Place2Be, 2024: <https://www.place2be.org.uk/media/dpqhfxmn/al-philanthropies-year-3-report.pdf>



crisis point.

Place2Be has been working with partners from education and mental health on the development of a new Apprenticeship standard in Counselling, with a key aim to enable schools to leverage their existing Apprenticeship levy funds to train and develop their own counsellor and help pupils directly, as well as support the whole school community.

An apprenticeship route brings important benefits for the workforce itself. It would create a clear, quality-assured career pathway for individuals who may not otherwise be able to access traditional training routes, including those from under-represented backgrounds or facing structural barriers. By enabling people to train and qualify within their own communities, this apprenticeship can help build local, sustainable expertise – ensuring children and families receive support from professionals who understand their lived experiences and the contexts in which they are growing up.

This addresses immediate workforce pressures and builds the long-term capacity we need to ensure that every child can rely on accessible, high-quality mental health support. Embedding counselling expertise across education, community and family support systems is vital if we are to improve outcomes, close inequalities, and help children to thrive rather than struggle in crisis.

Building the mental health workforce so we can address mental health issues early is also key to addressing the rise in the number of young people Not in Education, Employment or Training (NEET). The *Keep Britain Working* review found a 76% rise in economic inactivity among 16–34-year-olds due to mental health conditions between 2019 and 2024<sup>7</sup>, and the latest figures show that 1 in 5 of NEET young people aged 16-24 report having a mental health condition.

**Recommendation 3:** *The government should support the creation of an Apprenticeship in Counselling as a tangible and long-term solution to increasing the availability of timely, skilled mental health support for children and young people where they already are – particularly in schools and community settings.*

### **A system where no child faces mental health problems alone**

The 2024 Labour manifesto committed “access to specialist mental health professionals in every school”, and the government has chosen to fulfil this by expanding MHSTs to 100% of schools by 2029-30. There is also a move towards a uniform roll-out of MHSTs, with services delivered by EMHPs (Education Mental Health Practitioners) from within the NHS. While the further roll-out of MHSTs is a welcome expansion of the support available for children, it is not

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<sup>7</sup> Keep Britain Working, 2025: <https://assets.publishing.service.gov.uk/media/6909fac488a98da87e292282/keep-britain-working-review-final-report.pdf>



adequate to meet the commitment to specialist support *in* every school, nor to provide an adequate range of support.

With each MHST covering a population of 8,000 to 8,500 children and young people<sup>8</sup>, this limits their ability to provide early and easy access to support. Indeed, a 2025 evaluation of MHSTs found that just 17% of MHSTs spent up to a day in school and only 7% spent up to two days in schools – 37% said they spend less than 3 hours in school per week<sup>9</sup>. The same survey found just 15% worked with three or less schools – the government’s own data shows that as of May 2025, the average MHST worked with 17 schools<sup>10</sup>. We believe that embedding mental health support in schools can be more effective, not just to provide early support to children, but to provide advice and guidance to school staff and leaders on delivering wellbeing for all. By being a consistent and integrated part of a school, services can build trust across the school community, amongst pupils, school leaders, teachers and families.

A uniform roll-out of MHSTs would see interventions delivered by EMHP roles and from within the NHS. In the 2025 evaluation of MHSTs, 97% of interventions delivered by MHSTs were low-intensity CBT, and 30% of schools surveyed said that there were groups of young people for whom the interventions available were unsuitable for<sup>11</sup>. The groups included younger children (particularly those aged 7 or below), children with SEND and children whose difficulties were beyond the ‘mild-to-moderate’ threshold but did not meet the CAMHS criteria. This leaves a so-called ‘missing middle’ without the right intervention for their mental health difficulties.

### **Who are the ‘missing middle’?**

Education Mental Health Practitioners (EMHPs), who provide support in MHSTs, are trained to support children with “mild to moderate symptoms of anxiety and depression, and behaviour problems”<sup>12</sup>. A ‘missing middle’ of children have moderate to severe mental health issues but do not reach the threshold for NHS CAMHS services, meaning EMHPs cannot provide an appropriate intervention.

School-based counselling can reach this group. For children who received 1-1 counselling from Place2Be in primary schools in 2024-25, 40% had severe difficulties according to their teacher and 57% according to their parents. For those in secondary schools, 38% had severe difficulties

<sup>8</sup> Hansard, 2025: <https://questions-statements.parliament.uk/written-questions/detail/2025-12-16/100283>

<sup>9</sup> Evaluating the implementation of the Transforming Children and Young People’s Mental Health Provision Green Paper programme, Mundy et al, 2025:

<https://www.ncb.org.uk/sites/default/files/uploads/attachments/CYP%20MH%20GP%20survey%202024%20report%20-%20Mundy%20et%20al%20%282025%29.pdf>

<sup>10</sup> Transforming Children and Young People’s Mental Health Implementation Programme Data Release, 2025:

[https://assets.publishing.service.gov.uk/media/686d3640a08d3a3ca3b678de/Transforming\\_children\\_and\\_young\\_people\\_mental\\_health\\_programme\\_2025.pdf](https://assets.publishing.service.gov.uk/media/686d3640a08d3a3ca3b678de/Transforming_children_and_young_people_mental_health_programme_2025.pdf)

<sup>11</sup> Ibid.

<sup>12</sup> NHS, accessed 2026: <https://www.healthcareers.nhs.uk/explore-roles/psychological-therapies/roles-psychological-therapies/education-mental-health-practitioner>



according to their teacher and 52% according to their parents. Several groups of children we support are more likely to start in the severe range of mental health difficulties:

- those with SEN support or an EHCP
- children who receive Pupil Premium, particularly white British children
- those on a CAMHS waiting list

A significant proportion of the children we support through our embedded school services have severe difficulties – the support provided by EMHPs would be inadequate to meet their needs. Around 1 in 10 children we support were on the waiting list for CAMHS when referred – highlighting their higher level of need. Similarly, around 29% of children we support through 1-1 counselling have special educational needs. Indeed, a greater proportion of those with SEN Support or an EHCP that we provide 1-1 interventions to start in the severe range of difficulties.

Our own data tells us that the children from the most deprived backgrounds are also more likely to have severe mental health difficulties. Indeed, ‘white working class’<sup>13</sup> young people – identified by the Education Committee in 2021 as underachieving in education – who we support through 1-1 interventions were significantly more likely to be assessed as having severe mental health difficulties than their peers. It seems counterproductive to design a system that would be less likely to meet the needs of these children.

Our experience of working within MHSTs in Greater Manchester is that MHSTs can be embedded in schools and meet a wide range of needs: our counsellors were embedded in primary schools one day per week delivering 1-1 interventions, including for children with moderate-to-severe difficulties. A flexible approach that includes VSFSE providers working in schools and alongside the NHS can provide a greater level of support to children in a more easily accessible way than a uniform model using only EMHPs within the NHS.

**Recommendation 4:** *The government should commission an independent post-implementation review of the initial roll-out of MHSTs, particularly on their ability to meet the needs of all children, informed by the evaluation process already underway and due to be completed in May 2026.*

### **A flexible approach that puts partnership at its core**

The roll-out of MHSTs is a welcome investment in children and young people’s mental health, but implementation is key: we need to reflect on the experience of the initial roll-out and ensure that further investment reaps maximum benefits for our children, communities, and public services.

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<sup>13</sup> Defined in our data as white British children who receive Pupil Premium.



A 'one size fits all' model, without flexibility to meet the needs of schools and communities, is not appropriate for the further roll-out. MHSTs should be developed and delivered through true partnership working between health, education and VCFSE organisations. They should not operate in isolation from schools but work in partnership to ensure a range of support is available. Neither should MHSTs seek to replace existing support – the roll-out should stay consistent with the commitment in the Green Paper that MHSTs “...work alongside existing good practice and services, rather than disrupting or replacing them.”<sup>14</sup> We are concerned that in some areas this is exactly what is now happening. We believe the roll-out could make better use of existing resources rather than simply creating new systems – leveraging experience already in education, not just focusing on NHS services. Local communities should be given the flexibility to design MHSTs that best meet their needs, including to support or scale up existing services.

A more flexible approach should include VCFSE providers, who can be more focused on outcomes, rather than process. In Greater Manchester, where VCFSEs have been partners with the NHS in a blended model of MHST delivery, there was a high level of satisfaction (93%) with delivery of 1-1 interventions by VCFSEs in primary schools<sup>15</sup>. VCFSEs were also found to provide good value for money in Greater Manchester, with lower cost per contact<sup>16</sup>. VCFSEs with practitioners trained beyond CBT can also offer greater flexibility to understand and meet the needs of the school's demographics, and diverse teams can better meet their cultural diversity.

#### **Case Study: The roll-out of MHSTs in West Kent**

From our experience of working in both primary and secondary schools in West Kent, where MHSTs are in the process of being rolled out, the relationship between MHSTs, schools and VCFSEs has worked well where:

- Schools have a good understanding of the MHSTs offer and how this differs from embedded, school-based support like Place2Be
- Triage processes are simple and are held by the school's pastoral team
- There is mutual respect from practitioners, who understand each other's role and are seen to work effectively together – for example, attending parents' night together

There can be frustration felt by some schools from MHSTs being limited to dealing with lower-level issues and delivering psycho-educational work that a school itself is well-placed to do. MHSTs cannot support those cases which are beyond the expertise of school pastoral staff but do not make the CAMHS threshold, where there is more risk and a need for health expertise.

<sup>14</sup> Government Response to the Consultation on Transforming Children and Young People's Mental Health Provision: a Green Paper and Next Steps, Department of Health and Social Care and Department for Education, 2018: <https://assets.publishing.service.gov.uk/media/5b583d30ed915d0b6985cc21/government-response-to-consultation-on-transforming-children-and-young-peoples-mental-health.pdf>

<sup>15</sup> Greater Manchester - Mental Health Support Teams Review, GMCA Research, January 2025

<sup>16</sup> Ibid



From our 30 years of experience, we know that services are best implemented and delivered in partnership with schools – working alongside them, not ‘doing to’ them. While schools want a consistent offer for all children and young people, they also value an approach that accommodates local flexibilities and demographics. This cannot be delivered through a ‘cookie-cutter’ approach to implementing new MHSTs that does not listen to the needs of school leaders.

We support the commitment in the Schools White Paper to a “new model of local partnership and shared accountability for children’s outcomes”, but implementation will be key. This model should ensure a joined-up system, where every child and family has the mental health and wellbeing services they need, with schools as the key anchor of support.

**Recommendation 5:** *A one-size-fits-all single national model approach to the further roll-out of MHSTs should not be taken. There should be local flexibility to take alternative approaches proven to be effective, including those developed and delivered by evidence-based VCFSE providers, with Integrated Care Boards held to account for their delivery of outcomes for children.*

**Recommendation 6:** *Ofsted inspections should consider the extent to which schools leverage and work in partnership with health services, community hubs, and VCFSE providers to create inclusive environments where children can fully engage in education, develop to their full potential and thrive.*