

#Women and Equalities Committee

Oral evidence: Mental health of men and boys: follow up, HC 90

Wednesday 8 June 2022

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Watch the meeting

Members present: Caroline Nokes (Chair); Carolyn Harris; Kate Osborne; Anum Qaisar and Bell Ribeiro-Addy.

Questions 70 - 116

Witnesses

I: Gillian Keegan MP, Minister for Care and Mental Health, Department of Health and Social Care; Will Quince MP, Minister for Children and Families, Department for Education; Matthew Hopkinson, Deputy Director of Life Skills Division, Department for Education, and Zoe Seager, Deputy Director of Mental Health Policy, Department of Health and Social Care.

Written evidence from witnesses:

- [Add names of witnesses and hyperlink to submissions]

Examination of witnesses

Witnesses: Gillian Keegan MP, Will Quince MP, Matthew Hopkinson and Zoe Seager.

Q70 Chair: Good afternoon, and welcome to this afternoon's session of the Women and Equalities Committee and our one-off session on the mental health of men and boys. Just by way of explanation, the predecessor Committee did a piece of work on this in 2018, and this is very much a follow-up to that with a small pandemic hiatus in between. I know you need no introduction to appearing in front of the Committee, but obviously colleagues will ask you questions in turn.

I wanted to start with a question around data, specifically to Minister Keegan. Something that the predecessor Committee noticed was that the data collected was not necessarily the right data, the data that was most helpful to the Department, and I just wondered, Minister, whether, throughout the course of the pandemic and the challenges that we know there are with relying on self-reporting, there had been any improvements, and whether you thought the data was giving a clearer picture on the effects of mental health conditions on men and boys.

Gillian Keegan: Thank you, Chair. It is a pleasure to appear before your Committee for first time. It is fair to say that there have been improvements in data and there have been improvements in the collection of data, but there is still more to do. We are doing more in terms of laying out plans for addressing various data. We have the advancing mental health equalities strategy. We also have data that will be picked up on different characteristics, and so there is some more critical work as part of the strategy. One of those is still data collection and monitoring and also training the workforce and workforce development as well. It is fair to say that there is now routine quarterly monitoring and reporting to the national mental health programme board. There are more metrics in IAPT. We are looking at waiting times, which we have consulted on, and the NHS is looking at those as well so, obviously, we collect that data.

We have more data on children and young people's mental health routinely included in the NHS digital mental health services data set. There is more data being collected, and you will understand when you have been in these roles that quite often the data is the thing that you are lacking and the data to be able to make those timely decisions. I would imagine in most cases the data will lag behind what a Minister wants in terms of being able to understand what is actually happening and how policies actually impact in people. Zoe, do you have anything to add in terms of any other datasets that I have not remembered?

Zoe Seager: We are also commissioning the next adult psychiatric morbidity survey, so work for that is under way. That will be followed by a children and young people's mental health survey, which will provide us with the prevalence data updates that we need. The last adult psychiatric



morbidity survey was in 2014. During the pandemic, we ran several waves of the mental health of children and young people survey, following up from the 2017 survey, so that we could understand what was happening to the mental health of children and young people during the pandemic, but those sample sizes had to be smaller because it was a follow-up wave.

Q71 Chair: We repeatedly hear from the Government Equalities Office that much of their work has to be data driven. How closely is DHSC working with them?

Gillian Keegan: We do work with the Government Equalities Office, and we do try to work with them to pick up more equalities data. We look at other characteristics—not just age, not just sex—as well as other disparities. As you will know, when you can identify disparities, it is one of the best ways to focus on policy areas to address those disparities. We also have OHID, the new Office for Health Improvement and Disparities, which, I think, later this year will be issuing a White Paper on disparities. We are also working closely with the GEO to identify those areas where we do not have enough data on the characteristics or we are concerned that there are inequalities and we see lots of inequalities coming through. I know that when we look at certain things in terms of suicide or certain focuses in terms of other strategies or mental health services, we look very much at where the inequalities lie, both in terms of characteristics and in terms of geography as well.

Q72 Chair: A phenomenal amount of work has been done over the last few years to break down the stigma surrounding mental health conditions. Has any of that been targeted by gender?

Gillian Keegan: What we have been doing is to provide several projects, so there have been some by various characteristics. For example, we had the Better Mental Health fund in 2021-22, and that was provided for specific projects aimed at reducing stigma in particular groups. We had, for example, the Black Men's Consortium in Lambeth. We had Men in Sheds¹ as well. We had specific projects that were looking at areas where we had identified that there were inequalities for men, and black men in particular in those cases, and they will be evaluated over the summer.

We have also recently published a call for evidence to inform our new 10-year mental health and wellbeing plan. That recognises the need to get all the different groups and we are trying to outreach at the moment. This is a brilliant way of saying to people, "Please come forward and input into that call for evidence," because this is a very important opportunity to be able to set our new 10-year mental health plan, which will take into account where we are right up to date in terms of moving from what we

¹ "Men in Sheds" refers to Men's Shed (Blackpool) rather than UK Men's Sheds Association, the national organisation. Men's Sheds (Blackpool) received funding through the Better Mental Health Fund, through which £15 million was invested in 2021/22 in local authority areas in the most deprived parts of the country to help stimulate and boost prevention and early intervention services.



have had in the past and seeing where the updates are. We have had some specific funding since 2020 to look at those specific projects and specific areas and we will be evaluating them in the summer this year.

Q73 Chair: Some of the evidence that we have seen has indicated that women might have come through the pandemic in better shape for their mental health than men. What is the Department doing to understand that and to counteract that to ensure that men's mental health does not get hidden, masked, forgotten about?

Gillian Keegan: In terms of mental health services and access to mental health services, it is pretty balanced in terms of gender and access to the services, and they are also reasonably balanced in terms of outcomes.

However, there are some things that are coming through from some of the statistics. For example—it depends on certain conditions—loneliness, obviously, has gone up. That affects certain groups more than others. Eating disorders affect certain groups more than others. Although the prevalence is growing in terms of young men and boys, the numbers are still predominantly girls and women, but there is more and more focus in terms of trying to get people to come forward to talk about their mental health and reduce that stigma.

One of the reasons we are both here is, obviously, to try to have those conversations early on in schools. With men and boys—boys in particular—we are trying to normalise those conversations around the stigma of, for example, eating disorders. There is an increasing concern with men and boys about body dysmorphia, muscle dysmorphia or other conditions, as well as general health and mental health conditions within schools. We are very much trying to focus on educating people to be able to have those healthy conversations.

Q74 Chair: That will give me an opportunity to bring in Minister Quince in a minute, but specifically on the subject of eating disorders we have seen a dramatic increase in hospital admissions and also recognise that very few get the hospital admission they might need. If we look at the 24,000 hospital admissions in 2021, what specific work is being done to address the fact that admissions for young men more than doubled in that time?

Gillian Keegan: We do need to build our understanding. There is a general understanding that eating disorders can affect anybody and we are trying to raise awareness of this with boys and men. In some of the roundtables that I have attended recently we have had boys who have had the condition talking about their lived experience. We need to do more to build our understanding of that to support early identification and so on.

We are continuing to identify opportunities for the call for evidence for the 10-year mental health strategy. We are very keen to try to understand more about what is impacted. We know there is a lot of online influence; we know there is a lot of peer pressure. We know there



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is stereotyping as well, but to just get more understanding and a better picture of the range of experiences that young boys and men are having, particularly around eating disorders, because while it is a smaller area, as you say, it is growing, and it is growing quite rapidly and that is concerning.

Q75 Chair: When looking at the call for evidence, if you are looking to get evidence in from eating disorder sufferers, those charities that work with them, and the various organisations and experts, how are you making sure that language is accessible to young men who we know are the least likely to engage, the least likely to come forward and talk of their experiences?

Gillian Keegan: We have tried to do that in a way that is more accessible. In terms of mental health in general, we have had campaigns where I think we have been to barber shops and other places to try to raise the conversation, as it were. We are working with specific charities, specific people who have that lived experience and trying to use them to get that message out. Zoe, is there anything specific you want to add to that?

Zoe Seager: For example, for the call for evidence, we launched it with a campaign on Twitter where a representative from Andy's Man Club published videos on Twitter and is making it known in his networks and other networks that work directly with men in the different kinds of contexts that the Minister has talked about.

Q76 Chair: Which charities specifically?

Zoe Seager: As the Minister said, Men in Sheds, Andy's Man Club, James' Place² and various other suicide prevention organisations that we funded through the suicide prevention grant fund last year³. We have a list we can send.

Gillian Keegan: There are about 113 of them who we funded as a result of the suicide prevention money to try to work on, because that is something else which does affect men and boys more than women. We are concerned about suicide overall, obviously, in preventing any suicide, but it does have a bigger impact on men, so we have been specifically working with those. There are 113 of them. I did have quite a long list of

² These are examples of men-and-boys focused mental health and suicide prevention organisations that the Department engaged during the call for evidence or that are known to have engaged with networks and/or service users. UK Men's Shed Association were attendees at an official level Men's Mental Health Roundtable hosted by the Department of Health and Social Care. Andy's Man Club engaged its network on Twitter to respond to the call for evidence. James' Place, and other members of the National Suicide Prevention Strategy Advisory Group were encouraged during the quarterly meeting to respond to the call for evidence.

³ James' Place is the only named organisation to receive funding through the Voluntary, community and social enterprise organisations suicide prevention grant fund.
<https://www.gov.uk/government/publications/suicide-prevention-fund-2021-to-2022/voluntary-community-and-social-enterprise-organisations-suicide-prevention-grant-fund-awards>



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them this morning for a debate that we did in Westminster Hall. I co-chair a national suicide prevention advisory group and there are many groups on there as well. It is co-chaired by Professor Louis Appleby from Manchester University, who is a leader in this field. We are using all of those networks to ensure that we reach into those conversations and, as you know, we are always keen to get as many inputs as possible.

Q77 Chair: Minister Quince, on young people and eating disorders, there has been an enormous amount of working going on in schools as part of PSHE, so that it is identified. Is any of that specifically targeted at young men?

Will Quince: RHSE will cover both and we very much encourage all schools to take a whole-school approach to mental wellbeing and mental health. A lot of it is left at the discretion of the school. We have specific training for senior mental health leads, of which I think we have had over 8,000 so far, and we put in additional funding. We want to get to two thirds of schools by the end of this Parliament. The answer is yes.

Matthew, you can probably come in and give a bit more detail, but we largely leave it to the discretion of the school because they are best placed to know the support that their particular cohort requires. You are right to ask the question because what we have seen—and Minister Keegan and I meet regularly about this—is that there used to be a very high prevalence of eating disorders within young women. We are now seeing an increase in young men, in particular during and post pandemic and that is something we know we are going to need to tackle.

Chair: Thank you. Can I turn to Kate Osborne for the next set of questions?

Q78 Kate Osborne: Thank you. My first question is to Minister Quince and, more broadly, leading on from the previous question. DfE research shows a greater increase among males than females in the age group between four and 18—so, young people—in behavioural or emotional attentional difficulties or disorders during periods of lockdown, particularly during the second lockdown. Can you tell us what work DfE is doing to understand and address gendered effects of the pandemic on the mental health and wellbeing of children and young people?

Will Quince: We certainly can. Much of this, as you rightly point out, is linked to SEND and alternative provision. It will not have escaped your notice that we recently launched the SEND alternative provision review, the consultation of which is live until 22 July. A huge amount of work is being done in this sphere because too many children and young people that are excluded from school are excluded because of behavioural issues and there is a very high prevalence of children with special educational needs. That is why the heart of the review is early identification, ideally in earlier settings, be it in primary or, if necessary, secondary school, to identify any underlying SEND.



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I often get calls to say, "Well, look, why don't we just ban all exclusions from school because we know the damaging impact they have?" That is something we are not considering because we believe headteachers should have the discretion to do so very much as a last resort. Working alongside the Schools Minister, what I am committed to ensure is that being excluded from school is in no way being excluded from education. That is why, as part of the review, we have to ensure that alternative provision is working closely with and providing support to mainstream schools, so that where there are behavioural issues they are identified early, and that if there is an underlying SEND, the first port of call is support and, if necessary, exclusion, but into an alternative provision school and then back into mainstream as quickly as possible.

Q79 Kate Osborne: Can I take you back to gender? Why did behavioural and attentional disorders increase disproportionately among younger boys during covid lockdowns? What is being done to address that? I understand what you are saying about SEND, but what about boys specifically?

Will Quince: It is a fair question, and, in truth, I do not have an answer to it because we have not undertaken the analysis. We know there is that disparity; you are right to point it out. As part of the review it is recognised, but the question is whether we need to take a different approach to boys and girls in relation to exclusion. We know, for example, that boys are permanently excluded something like three times more than girls, so it is considerably more prevalent. The question is whether we need a different approach to boys compared with girls. In the majority of cases, it is behavioural driven and in very many of those cases there is an underlying special educational need that is undiagnosed. At the heart of it, the SEND review and our response to it as part of the Green Paper will largely address many of these issues by getting that support early on, early identification and support into mainstream schools. If we can avoid exclusion wherever possible we have to do it.

Q80 Kate Osborne: Minister Keegan, concerns have been raised about the mental health and wellbeing of men from particular ethnic minority backgrounds. For example, while all male ethnic groups reported declines in mental health and wellbeing during the pandemic, Pakistani and Bangladeshi men reported greater declines than white British men. Why has the mental health of men from some ethnic minority groups been disproportionately affected during the pandemic?

Gillian Keegan: Again, it is a difficult one to answer with any detail because obviously we only have some of the statistics and some of the information. When we talked to many of those communities, we were talking about the stigma attached to mental health and wellbeing with men in particular, and in certain communities it is even less common to talk about mental health. One of the things I hear anecdotally, particularly in some of the Asian communities, is that it is not very widely discussed. Again, we try to reduce and/or possibly remove the stigma of being able to talk about mental health. We are trying to get the message



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across that anybody can have an issue with mental health—particularly if two or three things go wrong in life at critical times—and anybody can recover. That is the message we are generally trying to get across, that even though it is harder for men in general to talk about mental health, it is even harder within certain communities for men to talk about mental health because of stereotypes and culture.

Q81 Chair: Can I ask a follow-up to that? We all accept that it is harder in some communities, but what specific programmes has DHSC put in place, either working with NHS England or with local authorities where there are diverse communities to particularly tackle that?

Gillian Keegan: These are some of the campaigns that we did. Again, we put campaigns into, as I said before, barber shops and in various communities. We have pilots and trials with, for example, the Lambeth Black Men's Consortium and others. There are a number of different trials, or pilots, going on that, as I say, we will be evaluating over the summer to see which ones really work. As many of us are aware in these roles, you need to ensure that the communities you are trying to address partake in them, that they do come forward and that they feel that it is addressing their needs. Getting that right is something we will have more on after we have looked at the impacts of these in the summer.

Q82 Chair: What is the timescale on the pilots?

Gillian Keegan: Summer of 2022 will be the first time that we will be seeing some early results from those, so not that long to go.

Q83 Chair: Summer this year, evaluation, and that would presumably see roll-out of what has been demonstrated to be effective by when?

Gillian Keegan: I am sure I will be getting some subs on the issue, but until we have those, I have no further information. Zoe, is there is anything I am missing on that?

Zoe Seager: The other thing to cover is the patient and carer race equality framework, which was one of the recommendations from Sir Simon Wessely's review of the Mental Health Act. That is still under development by the NHS advancing mental health equalities taskforce, working with the South London and Maudsley Trust and various other bodies. There is work under way and it is locally driven and co-developed by communities, but we can provide data.

Q84 Chair: When was his recommendation?

Zoe Seager: The review was published in 2018. The patient and carer race equality framework has been developed since then and is still being developed.

Q85 Chair: It is still in development after four years?

Zoe Seager: It is being developed and implemented in different settings.

Q86 Kate Osborne: If I can address my next question to Minister Quince,



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please. In follow-up evidence submitted earlier this year, stakeholders raised concerns about other groups of boys and men, including those who have been in local authority care. What have been the mental health and wellbeing effects of the pandemic on children and young people in the care system and care leavers, and have care-experienced boys and young men been affected disproportionately?

Will Quince: It is a fair question and we do not know if they have been affected disproportionately, but my experience of working with and alongside care leavers and those who support them would suggest to me that, generally, when there are wider issues in society, care leavers tend to be disproportionately affected because of the challenges that they have already had in their lives before and during their time in care.

We have pretty good and robust data of children and young people in care. In terms of those in care, the latest data we have is from 2021. For five to 16-year-olds, around 12% had a borderline mental health condition score. I believe it is 37% where there is a wider cause for concern. Of the 37% I think the breakdown is 40% for boys and 33% of girls, so there is a higher prevalence for boys.

Where we have a bigger challenge is around the collection of data of care leavers, and that is what worries me the most. We do not collect care leaver data, in part because it is very difficult but also because local authorities are not required to collect that data because they are over 18. Where care leaver data is collected, it is collected by their personal adviser through the local authority and that tends to be on things like where they live, what they are doing, if they are in work, if they are in receipt of benefits.

The personal adviser, through the local authority, is not trained in any way in mental health, so will not have given any assessment. Any information that is held would be held by the Department of Health and Social Care and it would require permission to share it because they are over 18. The gap, if you like, is care leavers but, looking at the experience of those in care, I would suggest there is still an issue for care leavers.

In terms of the support throughout the pandemic and lockdown, there has been discretionary funding available by local authorities. We have provided extra funding of, I think, £200,000 to two care leaver charities to ensure there is more regular contact, and we prioritise care leavers for help with technology. More broadly—I sit on the Care Leaver Covenant board, which is a cross-Government board—we need to do a lot more in this space. To some extent it is self-selecting as to what a care leaver chooses to tell any other Government Department or agency, but if there are ways in which we can improve our data collection and, therefore, better provide support for those leaving care because we know the considerable challenges that they face, we should make every effort to do so.



Q87 Kate Osborne: You say we need to do more and you mentioned data collection, but what else can the Government do to ensure earlier intervention and better mental health for this group?

Will Quince: For those in care, that is already, largely, being done. Of course, there is always more that we can do. For care leavers, that is something I will have to take away. Again, the problem, largely, is the data and the fact that it is self-selecting. We will not necessarily know if somebody is a care leaver unless they notify. Matthew, do you want to add to that?

Matthew Hopkinson: I would just add that, in terms of continuity, one of the issues the care leavers face is sometimes gaps in services as they move from children to adult services. The move within the NHS Long Term Plan to make more mental health services available for those aged nought to 25 is important in the context of making sure that we continue to provision across those gaps so that it is maintained, and you can maintain better mental health support for care leavers as we go along.

Will Quince: It is probably important to stress care leavers are a priority group for transition when it comes to mental health support. There are trials ongoing, one of which does not sit with us, but it is within Middlesbrough, where a senior mental health practitioner is embedded within the local authority care leaver team. If there was a model for a direction of travel, that, I would suggest, is probably one that we should look at exploring further. As I say, that is a pilot at the moment, so we would have to explore that, but I would be amazed if it did not bear considerable fruit given the work that they are doing.

Q88 Kate Osborne: You focused your response on care leavers, but what early intervention could be put in place? What more support could be put in place for children and young people who are not at that point?

Will Quince: They are already a priority. As part of the support in school under the designated safeguarding lead within a school, they will be aware of every child and young person's background and are specifically trained to be able to identify and support children and young people with any mental health needs or support that they have.

The question is equally applicable to the Department of Health and Social Care in terms of access to CAMHS services where required, but at the heart of it comes the training for the senior mental health leads in schools and then the mental health support teams and that work with the designated safeguarding officer within the school that has the information about a child's particular challenges and vulnerability and, therefore, has the ability to identify and get them the support they need as and when they need it.

Q89 Kate Osborne: If I can go back to Minister Keegan, please. What learning has emerged from the work of the Mental Health Equalities Champion and the advancing mental health equalities taskforce about



providing for the needs of ethnic minority boys and men?

Gillian Keegan: We understand that we have disparities in terms of services and access to services. In terms of the laid-out plans to address those inequalities, our strategy to meet the needs of all those people with protected characteristics has three basic workstreams. It supports local health systems by developing support tools and guidance. Zoe referenced the patient carer race equality framework, which has taken a few years but is under development. Improving data quality—we also talked about that—and reporting will enable better performance monitoring and to understand better the current disparities. And we are working with Health Education England and other partners to make the training pipeline more representative in terms of tackling those inequalities in the local communities.

In general, we are investing a lot of money in trying to build up our mental health support services—an extra £2.3 billion a year by 2023-24. One of the challenges is the workforce and to try to grow that workforce, to keep up with the demand, which is outstripping what we have in terms of capacity, which is why we see some of these waiting times and us not meeting some of these waiting times. One of the things that we are trying to do is to ensure that those roles are more accessible. Instead of having to wait eight, nine years before you are at the level where you get some of these key roles, we need to try to have more peer support workers, have more people with lived experience, and generally have more accessible routes or apprenticeship routes to try to build out that workforce. One of the things we know in every part of society is that you need to have that representation within the system as well to make that more of an organic thing. They are some of the main things we are doing as a result of that report.

Q90 **Kate Osborne:** If I can go back to Minister Quince, what are some of the key mental health issues for school-age boys from different ethnic minority groups, and what have mental health support teams in schools done to support them?

Will Quince: In truth, the evidence around ethnic minority groups is pretty mixed and not very conclusive, which is part of the challenge. Unlike the Department of Health and Social Care, we take our data slightly differently because my focus is not just on mental health, but on broader mental wellbeing within a school and how we can build resilience in children and young people to try to avoid, wherever possible, them needing more intensive support by the NHS.

We work from the “State of the nation” report that was last published in February of this year and covers the previous academic year. It is not a stand-alone survey; it brings together a range of different government, voluntary, third sector and private sector organisations’ data, which is analysed and then that gives us a picture, including probably the most comprehensive Children’s Commissioner’s “The Big Ask” survey, which surveyed about half a million children.



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What we saw was that minority ethnic pupils reported lower life satisfaction during the pandemic and less happiness during the autumn term in particular, but there was no difference seen in other measures of anxiousness and feeling that life is worthwhile, so it was quite inconclusive in terms of the data. One thing we definitely know is that there is significantly lower engagement in physical activity among ethnic minority groups, and that is something we need to address because we know the difference sport and drama and extracurricular activities can make to general wellbeing.

One of the beauties of mental health support teams is we do not mandate or tell them exactly how they should operate. They are very much locally based, commissioned by a local integrated care system or a clinical commissioning group. They are a mixture of senior practitioners, clinical leads, educational mental health practitioners, and they work in the school to generate and create a whole-school approach to mental health. If they see particular issues around mental health or issues in specific groups—be it boys, girls, ethnic minorities—then they would take action, but it is very much demand-led alongside the broader work that they do around resilience building among the whole school population.

Q91 Kate Osborne: Again, you mentioned data. Can your data, or will your data, tell us how many children mental health support teams have helped? Are you able to give us a breakdown by gender or ethnicity?

Will Quince: I cannot give you that. The reason I cannot is that mental health support teams are funded by the NHS locally, or ultimately nationally, but locally via ICSs or clinical commissioning groups, so not funded by DfE or, indeed, schools themselves. I can tell you how many there currently are. There are 287 mental health support teams in operation and the plan is to grow that to over 500 by 2024. What does that mean in terms of current coverage? As we stand today, it is about 22%. By next year it will be 27%, and then 36% by 2024. It takes about 12 months to train a team. There are a number of teams in training at the moment, and as part of that training many will be in school as part of it. What I cannot give you are the exact figures in terms of children.

Q92 Kate Osborne: Do you have an idea?

Will Quince: No, because I do not have that data. It sits within Health, but I still think it is too early even for the trailblazer sites.

Gillian Keegan: It is too early. Most of these figures that Minister Quince is mentioning, if we had asked for them a year ago we probably would have had hardly any. They are being rolled out very recently in terms of the collective but, of course, we will want to know how many children have been seen, and also the outcomes for those children as well, so that will be data that we will be collecting.

Will Quince: It is almost an impossible question to answer because having seen mental health support teams in action—and I went on a visit



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relatively recently with Dr Alex George, the Prime Minister's mental health ambassador—they all do different things. For example, they could do some cognitive behavioural therapy or another therapy with a particular child or a small group, or they could do whole-class work around resilience building. Would you then classify it as the whole class having had support in the mental health team? Yes, they have, but in the same way you would have had far more intensive support for one individual child. Eventually we will have that data, but at the moment it is too early and we very much want them to do those different approaches because we know there are individual children and young people that need that support here and now. If we can build resilience more generally among the whole school population, then ultimately it will lead to fewer children needing that intensive support and, ultimately, CAMHS services in the fullness of time.

Gillian Keegan: It is supposed to be preventive; that is the real focus.

Q93 **Kate Osborne:** When you do have that data, will you have it by ethnicity and gender breakdown as well?

Gillian Keegan: I assume so, because we collect pretty much everything by ethnicity and gender breakdown.

Zoe Seager: The intention is definitely to have it in the same way that the advancing mental health equalities strategy is looking to improve the collection of all those characteristics. In mental health data, it is the same datasets that this data will flow into, so there will be the same challenges where people may choose not to disclose different things but, ultimately, we are trying to improve the breakdown of data across all those characteristics.

Gillian Keegan: I think it is very important because we do see big differences both in gender and in race, and in age actually, when we look at various mental health conditions, so it is vital in being able to target solutions.

Q94 **Kate Osborne:** The next question is to both of you. I will come to Minister Quince first. We know from the 2017 LGBT survey that gay, bisexual and transgender boys and men face barriers to mental health support. What has the Government done to help them access tailored support via the NHS and schools?

Will Quince: No specific work in terms of GBT in relation to access to mental health support teams or access to school counselling and others. That would be exactly the same provision as for anyone else. I completely understand why you ask this question because I think being a child or a young person today can be really tough. If you are a child or a young person that has not come out yet or is in the process of coming out, I cannot imagine how difficult that would be in a school environment. We know how difficult it is with social media and with bullying, and



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children and young people often find the smallest of things to pick on others about.

I speak with enough children and young people and those from the LGBT community to know how difficult it is, but the struggle is the data and how difficult it can be to capture it in the context of wider research. We struggle to do that with the data we hold. Then, of course, I have absolutely no doubt that there are many children and young people within a school setting who are yet to come out. They may be discriminated against, but their teachers and mental health support staff will not necessarily know that they are LGBT.

The answer is they will get the same support as any other child who needs it via the provision within a school, be that school counselling, other therapies or mental health support teams or support via the senior mental health lead. I would be interested to know, maybe as part of the recommendation of this Committee, if there is more that we need to do, first, to identify and, secondly, to support those children with these characteristics further.

Q95 **Kate Osborne:** Is there no particular tailored support?

Will Quince: As far as I am aware, there is no particular tailored support other than the broad mental health support that we have available, certainly within school settings.

Kate Osborne: Thank you. Minister Keegan?

Gillian Keegan: How the services will probably develop is that you have the senior mental health leads in teams, then you have the mental health support teams and then obviously they will be able to signpost and get access hopefully to specific services quicker. In terms of what is being done for gender identity services for children, there is a review of the Gender Identity Development Service and that is under way chaired by Dr Hilary Cass, who is the former president of the Royal College of Paediatrics and Child Health. This is quite wide ranging in scope and it is looking into several aspects of gender identity services and focused on how care can be improved for children and young people, including how and when they are referred to specialist services and looking at all those pathways and referral routes.

There are interim findings, which we welcome, and that have been presented to NHS I&E but we look forward to the publication of the full review in the future. That is where we are looking to try to get a lot of our information and recommendations about what we should do in this area, which, as Minister Quince says, is very important. Then there is separate work going on to improve access to gender identity services for trans men, so for the adults as well. There is some piloting of new models of service delivery for adults. Four new clinics have been established under this model and there will be another one established this year in Sussex.



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Will Quince: I know your question was specifically about support for LGBT pupils who have mental health issues or raise issues, but it is also important to stress the other work that is being done as part of the RHSE curriculum work, which is now compulsory for five to 16-year-olds. Also, the fact that we have guidance around respect in school communities and we have put in an extra £2 million to five anti-bullying charities to do work in schools covering largely the preventive piece around what does a respectful school community look like, and how there should not be any bullying or harassment. There is broader preventive work ongoing throughout schools, too, which I think is also very important.

Q96 **Kate Osborne:** My last question is to both of you and is about sexual violence support. Should there be more attention and support given by the Government and civil society organisations to men and boys who experience violence, domestic and sexual abuse and related trauma, and mental health issues? Minister Keegan, if you would like to go first.

Gillian Keegan: I do not actually have much input or information on this. It is an important point, because there has obviously been a lot of work done recently on sexual violence and domestic abuse in general. I was on that Bill Committee as well, and while the numbers were overwhelmingly women who were impacted, people were none the less very keen to make sure that men's voices were heard in that conversation, and that we did have those specific services for men. Again, it will be another area where it is probably more stigmatised in terms of men coming forward. We have been building a lot of these services as a result of the landmark legislation we recently passed, but probably there will be more work to do, which Zoe may have more information on, or whether it is something we ought to come back and see if there is any specific work for men.

Q97 **Kate Osborne:** On the back of what you said, what more do you think the Government could do to make it easier to destigmatise and encourage men and boys to come forward?

Gillian Keegan: It is about understanding that this is everybody's conversation, engaging not just health services but employers and other groups, where you can build those relationships so that you feel comfortable enough to have what are quite difficult conversations for anybody. But it is really about normalising those discussions.

I attended a men's group meeting in Cramlington recently, a woodworking group not held in a shed at all, nothing to do with allotments or whatever. They were making things there, but what it was really all about was building those relationships in a lower risk way with a commonality. Maybe those conversations could lead to all kinds of understanding of what more we need to do to support men, who for decades probably have not been as open in talking about some of these issues as women.

Q98 **Kate Osborne:** I know that project from Cramlington, which is not a



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million miles from my constituency. You talk about other agencies, but is there anything else you think the Government could be doing?

Gillian Keegan: We do support many of those agencies, so we funded many of these voluntary community groups as well to make sure not only that they are there, but that they continue to be there, because that is another thing we find with voluntary and community groups. One of the issues with changing the whole integrated care system model is to make sure that the voluntary sector partnerships understand the importance of their role, which is quite vital for a lot of tier 1 and 2, and in some cases tier 3, mental health support services. It is important that they are given a secure financial footing as well, to make sure that their work continues. This is a growing and developing area, and the ICSs will also play an increasingly important role as they develop that partnership working through their ICPs as well.

Will Quince: From an education perspective, less so on the stigma point, although as part of RHSE we do a lot of work around the harmful male stereotypes, and encouraging all men, especially boys without a positive male role model at home, who may make assumptions from TV and video games about what a man is supposed to be, and not be emotional and not raise personal issues affecting them.

Putting on my children's social care hat, I also see that there are children out there that have the most horrendous experiences of adversity and trauma. We would be fools to think that this does not have a huge impact on their educational attainment, and therefore they are education disadvantaged. That is why we have the designated safeguarding leads that are trained specifically to be able to know these pupils, their backgrounds and the challenges that they face, and to be able to put support in place for them throughout their education to ensure that they do feel supported.

But there is no question that there is always more that we could do. Again, I would be very interested to hear more about other evidence that the Committee has gathered in this regard, because I know some of the experiences of adversity and trauma of young people. Unfortunately, the worst part of my job is reading that report that comes in on a weekly basis, and it affects boys as much as it does girls.

Q99 **Chair:** Can I just ask some follow-up questions going back to care leavers, Minister Quince? People get very anxious about data-sharing between Government Departments. I know I am going to give the wrong date, but the children Act in 2012 or 2013 gave local authorities responsibility for care leavers up to the age of 24, so how are they losing the data?

Will Quince: It is not that they are losing the data. We will largely know because the local authorities will know who are care leavers, but they will not necessarily share that with us from an education perspective. Then you have the fact that they will not be asking them questions about their



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mental wellbeing. There are questions as to whether they should be, but because personal advisers are not trained in mental health, they would not be asking those kinds of questions.

Then you have interaction with other Government agencies. For example, putting on my DWP hat, I remember, having been a Minister there for two and a half years, it was so frustrating to me that we could put in so many different elements of support if someone was a care leaver, but unless someone tells you that they are a care leaver at the point at which they apply for universal credit, you do not know. Now we have made changes—for example, just before I left the Department a box has now been inserted into the application form. It seems like a small thing, but when you are making an application, there is a box where you tick that you are a veteran, a care leaver, or have experience of domestic abuse. These were all coming, so it helps people; it acts as a trigger.

But there are many people who just do not want to disclose that they are care experienced or that they are a care leaver, for all sorts of reasons, and I do understand why. But it does make it more challenging because we are not able then to put the support in place.

What frustrates me is, looking at the data in terms of mental health and wellbeing for children and young people in care, we know that the rates are very high, that it must also be very high for care leavers because we know the challenges that they face transitioning to adulthood and later life. If there is a way in which we could capture that data, I would be very keen to explore it.

Q100 Chair: I am going to delve into some serious aspects of intersectionality, which is going to begin to get complicated. If we were to look at a particular group of children in care/care leavers—unaccompanied asylum-seeking children—we know that the vast majority of them will be boys between the ages of 15 and 17 who will go into local authority care and then become care leavers. We also know that they will most likely have suffered horrendous experiences en route to the UK and may be victims of PTSD and so on. We are talking about young men, probably from an ethnic minority background, who already have experience of trauma. Is there any mechanism whereby, whether it is DfE, DHSC, DWP or—and this is where people get anxious about data sharing—the Home Office, we can sweep them all up into a category that effectively identifies them as likely to be in need of additional help, support for their mental health?

Will Quince: At present, no.

Gillian Keegan: No, and I have asked the question in relation to quite a lot of what we see going on at the moment, obviously. As constituency MPs, we are all busy trying to get people into the country, or out of hotels and into homes if they have been here for a while.

It is fair to say that right now the way they are funded is it is just, effectively, a single service, as it were. It is not funded by specific groups



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or even by different interventions, so mental health is funded in a different way from physical health. It is just a single group, there for them to really focus locally on what they think is the right thing to do. There are lots of local activities, because I know in my own area there is a great deal of care taken to try to help people successfully settle into their new lives and get the support that they need. But I do not think it is specifically targeted, or even identified as, "This is the way you go," for that group. I have specifically asked that question and have not had an answer, but that is how we fund it.

Zoe Seager: I agree that there are examples of local services that have been designed specifically for asylum seekers or refugees, recognising the specific needs they have. But they are locally designed and locally commissioned, as the Minister has said. I know the Home Office is also thinking about the way this is addressed, and we will be talking to them through the development of the mental health plan, as this is a group that we recognise has significant mental health inequalities.

Will Quince: May I just come in? One of the things we could and should be doing more is making sure that care leaver charities and other organisations are aware that care leavers are a priority group for mental health support and other Government support. We probably have a bigger role to play in making sure that we make that clear to the organisations that support care leavers so that they know they have that eligibility.

Q101 **Chair:** Thank you. Can I also take you back to SEND and the Green Paper? I am sure every one of us in this room is inundated on a weekly basis with constituent cases of children who have been waiting far too long for CAMHS support, may well have fallen out of education as a result, are awaiting tribunals for which, in many instances, local authorities are failing to attend, failing to give evidence. My local authority used the phrase to me that if they had the resources they would need to build an additional special school every single year to accommodate the children with additional needs that are coming through the process. What is being done to address that?

Will Quince: A really good question. The first thing is we recognise that there is a real challenge in this area, hence why we launched the SEND review and we have launched the Green Paper. I keep repeating it, but the consultation is live until 22 July, and we need as many people as possible to give us their views and thoughts. That sets out the direction of travel in terms of what we plan to do around a focus on inclusion and investment in mainstream, a new national SEND system, huge changes around the EHCP process.

But largely your focus will be on what is happening now, not what we are going to legislate for and be doing in a handful of years' time, so the answer is an additional £1 billion this year into the high needs budget so that the next academic year we will be spending £9.1 billion on the high needs budget. But the big thing which will be game changing is the £2.6



billion we are investing in capital, of which £1.4 billion will be spent this year on building new special schools. There will be a mixture of specialist settings, but also special school places within mainstream settings—it might be a unit in mainstream schools. We have released £1.4 billion to get building now, and we hope those schools will be built by 2025. Initially, we will see 60 free schools, as I announced only yesterday. From memory, that is a mixture of 40 special schools and 20 alternative provision settings. However, there will be more investment by local authorities using that funding into smaller units within mainstream schools, because ultimately most parents tell me that, wherever possible, they want their child educated in their local school amongst their friends in their community but getting the support for the individual need they have. There is rightly a huge amount of focus in this area, because my postbag reflects the parents' concerns as much as yours do. I hope that, as part of the review, we are going to address that issue around parental confidence, but I would encourage as many people as possible to read the SEND review itself and take part in the consultation process, which is open until 22 July.

Can I add one more thing? You added one more very fair question, that the heart of the SEND review is about early identification, which is about wherever possible in early years and then in primary school identifying need at the earliest available opportunity and getting a child the support they need. That is a good ambition, and we are going to have better initial teacher training, a new SENCO qualification. Every teacher is a teacher of SEN, but we need them better equipped and more confident to identify and support children. But alongside that has to go health, because it is all well and good identifying, but the key thing is to get the diagnosis and the therapy, be it speech and language or other therapy support you need as quickly as possible, because otherwise it all falls down to the point of parental confidence. That is why we are working very closely across Government, and you will notice the forward of the SEND review is both by my Secretary of State and the Secretary of State for Health.

Q102 Chair: It was the point of the EHCPs to bring together education, social care and healthcare. Why has it not succeeded?

Will Quince: For numerous reasons. Sorry, I am probably answering in Minister Keegan's area, but in part it is because where we have ambition at a national level here in Whitehall, what actually happens at a local authority level, or a school level is often very different. When you look back at the SEND reforms of 2014, they were the right ambitions, but the implementation was poor, something that we are going to get right this time. The other challenge is, as much as—

Gillian Keegan: It is capacity as well, and demand and supply. The actual numbers are probably a lot greater than they were thought to be.

Will Quince: Also, accountability. When Minister Keegan, again, might say this is our ambition and this is what we want every integrated care



system and clinical commissioning group to do at a local level, it does not mean that they are actually going to do it. That is why we will have local inclusion panels and dashboards for the first time, there will be visibility as to the data around speech and language, so local communities can say, "Well, hang on a minute, why are children waiting two years for this diagnosis?", and for the first time you will have that visibility, and health will have to be around the table at a local level as a partner, and be held to account accordingly.

Q103 Carolyn Harris: I have vivid memories of when I was a young child and my gran hiding tablets from my grandfather, and he then took his own life. We never talked about that as a family. In fact, if any of my cousins are listening to this, they probably just found out for the first time how my grandfather passed away. My father, two years after I lost Martin, we know now it was a nervous breakdown, but we never talked about it because he was the strong one of the family, and we ended up paying privately for him to be counselled. At the height of the pandemic, I was having conversations with men of a certain age, probably my age, who were really struggling with their mental health but were embarrassed to talk about it because it was not what men did. They were the breadwinners, the ones who were in charge of the family. That is a generational thing and I understand that, but then within the last eight months there have been two young boys living quite locally to me obviously suffering from depression, both of whom took their own lives, because "big boys don't cry". How effective are we in teaching young men and boys that gender stereotypes are really harmful?

Will Quince: In truth, historically not very good, and we have had our own conversations on other issues about traumatic events in our lives. I am stereotyping myself here, but men are often the worst at sharing emotions and feel like they have to be the strong one in a relationship to hold the family together. This is very much something that is perpetuated by the media, films, video games, magazines and social media, as we know.

We now have compulsory RHSE for the first time, which includes a lot of work around harmful stereotypes, how men should show emotions and vulnerability, and how stigma can create a barrier to boys and men sharing their emotions, so we are getting a lot better. Actually, I do very regularly go into schools, and I always ask the children and young people, "How are you feeling? What sort of support are you getting?", and boys are now often the first to volunteer.

When you look at what mental health support teams and the senior mental health leads are doing, because of the £1,200 grant and the training they have had to put in place—that whole school approach—for the first time you have headteachers talking about how they are feeling or, at the beginning of assembly, they are talking about how one of their loved ones has just passed away and how they feel. That just would not have happened five, 10 years ago but it is regularly happening now.



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When you walk into a classroom and every single morning there is a chart up, and every child can go up and put up a smiley face, a more middling face or an unhappy face as to how they are feeling that day, so the rest of the class knows, so people are talking far more about their emotions.

We have that best practice in school where we are starting to see things like peer support schemes, mental health ambassadors in schools, so boys in particular are able to talk to other boys if they do not feel that they are able to talk to teachers or their parents.

We are coming on in leaps and bounds, although we still have a long way to go, but at the heart of it there has been that whole school approach to mental health, which more and more schools are adopting. We are looking at how we can bottle some of the best practice I have seen and share it all around the country.

- Q104 **Carolyn Harris:** To take that a step further, in terms of young men whose mental health may be leading them to some form of addiction—for example, alcohol, drugs or gambling, which is something I am passionate about—we have seen a huge increase in the number of people who are taking their own lives because they have a mental health problem associated with an addiction. Are you using external organisations to actually get that message to the young people in school as part of the curriculum, not just teaching through a normal lesson? Because some of these issues are so very important in preventing mental health issues.

Will Quince: It is a really good question, and there are two points to that. The first is that we tend to trust schools to do what is right for their population and their pupils. But gambling is certainly something that is included now in the RHSE curriculum alongside addiction and other issues of that nature.

But we are currently in the process of doing two randomised controlled trials of five different approaches, which is probably the biggest in the world. This is around the teaching of mental health in schools and looking at whether teachers or external experts are the best people to be providing this kind of tailored support. It is probably one for us to take offline, because we can look into those in a bit more detail. But we tend to trust schools to do what is best for their individual circumstances. As you will know, in some areas there are brilliant outside and third-party organisations that do specific work, be it on anti-knife crime or gangs, which in other areas the country just would not be as applicable, so to some extent it is horses for courses, but—

- Q105 **Carolyn Harris:** Addiction is pretty universal; it is not specific.

Will Quince: Addiction is pretty universal—you are absolutely right—hence why it is included as part of the RHSE curriculum. But there are not addiction charities that specialise in going into schools and giving that



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kind of support in every part of the country, hence why we could not mandate it, even if we were inclined to.

Q106 **Carolyn Harris:** There are some that go all over the country doing specific projects.

Will Quince: Some.

Q107 **Carolyn Harris:** How are you assessing the success of the work that you are doing? How is that being monitored and are there any results showing the impact that it is having?

Will Quince: On an individual level, with something like gambling, that is very hard to do. But Ofsted are now looking at schools in terms of how they teach the RHSE curriculum. As I say, anecdotally, every time I go into schools I am asking, because compulsory RHSE is a relatively new thing, and the new RHSE curriculum, too, but we are going to keep a very watchful eye on it.

Matthew Hopkinson: We are going to do surveys with school leaders and qualitative research, as the Minister said. Just going back to the previous point, it might also be worth mentioning that within the randomised controlled trials that the Minister mentioned, we selected the mental health teaching programmes, one of them selected precisely because it had a really good international evidence base in terms of reducing suicidal ideation. We are taking some of the best things that are available and working out how to apply those into English schools, and the results of those trials should help us to develop that further and improve things.

Q108 **Bell Ribeiro-Addy:** I want to ask some questions arising from the LGBT 2017 survey about bisexual and transgender boys and men, and the barriers they face with mental health. Firstly, to Minister Keegan, delays in accessing CAMHS have often demonstrated really negative impact on the mental health of young people overall. I just wanted to find out what steps your Department is taking to address this?

Gillian Keegan: The NHS Long Term Plan for mental health has very much been focused on trying to build up the capacity to try to address some of those waiting times, which effectively we have seen because there has been a huge increase in demand for the services.

That is £2.3 billion for children and young people, which should generate the capacity for 2 million more general appointments. For children and young people in particular, the target is to get 345,000 more children seen. In the NHS Long Term Plan, we have some funded work, which is going up to £2.3 billion per year by 2023-24. The huge challenge of that is the workforce, and we are on track to recruit 20,000 more mental health specialists as well to try to cope with that demand.

We do know that the waiting is too long, but we are also trying to intervene earlier, because the other thing we are trying to do is work



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more on prevention, to avoid having a lot of people waiting a long time for something they need quite urgently. It requires a different model, and we are looking at some of these earlier interventions such as the mental health support teams in schools, talking therapies and self-referral therapies as well, to try to just manage that demand and maybe try to intervene earlier.

Q109 Bell Ribeiro-Addy: Has a target been set in this plan to handle not only the backlog, but the amount of new referrals that we might have?

Gillian Keegan: Yes, that is the target they have put together—this 2 million. We have also put an extra £500 million to accelerate aspects of that post the pandemic as well, to bring forward the acceleration. That is why we have these mental health support teams being brought forward a year earlier, which will have 35% of the schools covered. That was originally going to be a year later, but we recognise that we need to try to accelerate some of these things.

The challenge is not underestimated though, because, as Minister Quince mentioned, it takes a year to train mental health support teams in schools, but some of the other roles take a lot longer, the pipeline and building, and we spend a lot of time working on the workforce, as well as trying to attract people to come into it. We are also developing many more routes into the workforce; otherwise it will be difficult to get the amount of people we need to deal with the demand that we have. This problem is not just in our country; there is a rising demand in general for mental health support services.

Q110 Bell Ribeiro-Addy: Minister Quince, I put the same question to you, but is it the same budget that you would be referring to?

Will Quince: In terms of mental health support teams, it is, but they are not DfE or school funded; they are DHSC funded, and it was an additional £79 million out of that £500,000 that was used to accelerate—I do not know if that is a public figure, but I suppose it is now—and that was the money used to accelerate the mental health support teams by a year to get us to that 36%.

Gillian Keegan: Yes, and that figure is correct.

Will Quince: There we are, that is always reassuring.

Q111 Bell Ribeiro-Addy: Just finally to both of you on this particular subject. As we have heard through a lot of the evidence we have had on this Committee, conversion therapy can have a really dire impact on mental health. A 2019 study by the Ozone Foundation found that 68.7% of the respondents said they experienced suicidal thoughts. What consideration have each of your Departments given to the Government's U-turn on conversion therapy and the impact this will have on the mental health of trans young men?



Gillian Keegan: As far as I am aware, that is still something that is being discussed and is under review. But as I mentioned earlier, NHS England and NHS Improvement and DHSC are piloting some new models of service delivery for adults, to build that clinical capacity in primary and sexual health services, and to reduce the waiting times for specific gender identity services as well.

In terms of aspects of the gay and trans conversion therapy discussion, it is not either one of our areas, but one of our colleagues. But my understanding is that this is something they are still wanting to get more information on.

Q112 **Bell Ribeiro-Addy:** I suppose it is more if your Departments, given the outcomes of people who experience it, have given any thought as to what impact this would have on the young people that you support.

Will Quince: We have not particularly given any thought to that, other than that I have had some comments on this issue for a similar Committee taken somewhat out of context. I take the view that all children and young people should feel safe and supported in any educational establishment they are in. Those who are questioning their identity deserve our maximum compassion and support without any hesitation.

We know these issues are hugely complex and sensitive for obvious reasons, and they are difficult issues to navigate for Government, schools and wider society. We are working really closely with Minister Kemi Badenoch and others at the Equalities and Human Rights Commission, to develop guidance for schools in this area. I have no timeline for that, but I know Minister Robin Walker, who is leading on that, will update further in due course.

Q113 **Bell Ribeiro-Addy:** Given the health disparities for men, notably having a lower life expectancy and disproportionate deaths from suicide, is there not an overwhelming case for a men's health strategy to sit alongside a women's health strategy? That question is for Minister Keegan.

Gillian Keegan: I was actually expecting that maybe your colleague, the Member for Don Valley, would be here because this is something that I have spoken to him a lot about. I just want to make clear that we definitely take the issue of men's health extremely seriously, particularly in some areas, and the hon. Member for Swansea East was mentioning some of the areas around suicide, suicide prevention, gambling, drug and alcohol addiction, much more prevalent in men than women.

However, I understand that the reason there is a women's health strategy is that actually the systems that we have in place have more or less been designed mostly by men. Most of the clinical trials that have taken place over the decades have not really had a representation and certainly not enough women in those trials, and also not enough women involved in research. We know, particularly in women's health, that there



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are many areas that have been completely ignored for years, and there are a number of hon. Members on this Committee who are campaigning on some of those right now, to great effect.

The reason we put that in place is that we noticed, and it started with cardiac arrests and looking at some of the data, treatments and access to that and then we looked at other particular women's issues, so menopause, mesh and other areas, some of the abuses in terms of some of the surgical treatments as well. That is what led to the women's health strategy, but that does not mean that we do not take men's health seriously, particularly with the new 10-year suicide prevention plan, the first one being in 2002, updated in 2012 and now we are updating it again. We will take input from the mental health and wellbeing call for evidence that is under way, which closes on 7 July. A lot of the focus is expected to be on some of these issues we were talking about before, where there have been disparities that have worked the other way, which is talking about mental health and suicide and trying to really reach those groups that we know are more at risk, as suicide is the biggest killer of men under the age of 50.

Q114 Bell Ribeiro-Addy: I am wondering if your Department has done any sort of assessment of men's health strategies in other countries to inform your decision, such as Ireland and Brazil, and whether or not you think that they might have demonstrated the effectiveness of a strategic and holistic approach to men's health.

Gillian Keegan: They are relatively new, but they have looked at Ireland and Australia and they may have put some things in place. Obviously, we are always looking for good ideas from anywhere to see what works. From what I have seen, and I have not gone through it in a great deal of detail, one of the real focus areas was the whole area of suicide and suicide prevention, because you do see that the prevalence of men taking their own life is higher in most countries around the world, which has driven a lot of their focus as well.

The suicide prevention plan is definitely a focus, and also some of those key risk factors we talked about—drugs and alcohol, gambling. There is a lot of new information on gambling, which I am pretty sure was not really understood when we last looked at this in 2012. There is a lot of work and we will be focussed on that, but of course we will look and see whether there is something other countries have that we think is a good idea. We will always keep everything under review to close any disparities and offer a better service.

Q115 Chair: The call for evidence closes on 7 July. Do you think it is likely that that will lead you to look at different ways that you will communicate with different genders? Suicide is the really obvious one, but you have also highlighted gambling and alcohol addiction. We know there are disparities. What work does the Department do with things like the Behavioural Insights Team to better understand how you can communicate preventive measures more effectively to different groups?



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Gillian Keegan: I am pretty sure that will definitely be the case, and we have already been delivering some campaigns for men to raise awareness and reduce the stigma. We have looked at sporting, barber shops, first-aid training, and in different groups we have looked at various projects in different parts of the country as well.

When you are talking about trying to overcome barriers and reduce stigma, how you communicate is really important. They are all trying to get to what it is that works and how we lower the barriers for somebody to start those conversations, which may be different for the younger generation due to all the fantastic work that is now going on in schools. But all of us know that none of that happened when we were at school; in fact, quite the opposite was the case. These stereotypes were probably reinforced during our schooldays, and that is now the age group at the highest risk. The age group where people take their life more is men aged around 40 to 49, or 45 to 55, so this is our school cohorts who are now in that age group. Certainly, language is going to be absolutely key to reducing the stereotypes and providing that environment that people feel comfortable to do something that they have, almost, been brought up to do the opposite for probably most of their lives.

Q116 **Chair:** We know that financial pressures have a huge impact on people's mental wellbeing and suicide rates. What work is happening now in the Department to prepare for the cost of living crisis that we know is headed towards us at alarming speed?

Gillian Keegan: One of the initial things being done is just giving some breathing space around debt and debt management, which is something that has been introduced. In terms of the cost of living, obviously this is a key worry for pretty much everybody across not only the country, but probably many parts of the world. We are also acutely aware of the impacts after economic recession we have seen in the past, as you mentioned at the beginning, Chair.

There has been a lot of work done since 2012 in training people. There are many people in the NHS and in other partners who are now trained to be better equipped to deal with those conversations, or to spot people who may be at risk of taking their own life. But hopefully, we can build on that and build on the work we are doing now with the suicide prevention plan update, and we know that financial impacts, losing homes, relationship breakdown, not having access to children, all of those things can be a trigger for men of that age, as well as gambling and drug and alcohol addiction, which we know are often related to trauma.

There is so much to do. We have been doing a lot of work with veterans again, which is another very distinct group who often have an overlap between a mental health condition and drug and alcohol misuse. We are now, in Op Courage, trying to integrate those and build them more around the veterans. As Minister Quince says, it is identifying them, making it easy to identify the groups that, if you just think about what they have gone through in their lives, and what kind of experiences they



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have had, it is pretty clear that you could probably target those groups knowing actually they are probably more at risk of PTSD because of the roles they played and the things they have seen.

We have become much better at focusing on that, and there has been a lot of work done in the last five years alone, so hopefully we will be in a better place than we were after the last recession. But this is an ongoing thing that we are always trying to learn, to do more and to do better, which is why the refresh plan will be very important.

Chair: Thank you. Unless any other members of the Committee have any additional questions, may I thank the Ministers for their time this afternoon? It has been very much appreciated and hugely helpful, and I draw the meeting to a close.