



Select Committee on COVID-19

Corrected oral evidence: Living online: the long-term impact on well-being

Tuesday 15 December 2020

10 am

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Members present: Baroness Lane-Fox of Soho (The Chair); Lord Alderdice; Baroness Benjamin; Baroness Chisholm of Owlpen; Lord Duncan of Springbank; Lord Elder; Lord Hain; Lord Harris of Haringey; Baroness Jay of Paddington; Lord Pickles; Baroness Young of Hornsey.

Evidence Session No. 5

Virtual Proceeding

Questions 49 - 66

Witnesses

I: Professor Kate Cavanagh, Professor of Clinical Psychology, University of Sussex; Tom Foley, Honorary Senior Clinical Lecturer, Newcastle University; Dr Richard Graham, Consultant Psychiatrist, Good Thinking; Akiko Hart, CEO, National Survivor User Network.

II: Dr Bernadka Dubicka, Chair of the Faculty of Child and Adolescent Psychiatry, Royal College of Psychiatrists; Dr Linda Kaye, Chair of Cyberpsychology section, British Psychological Society.

Examination of witnesses

Professor Kate Cavanagh, Tom Foley, Dr Richard Graham and Akiko Hart.

Q49 The Chair: Good morning and welcome to the House of Lords COVID-19 Select Committee. Welcome to our witnesses. My colleagues from the committee will introduce themselves as they ask their questions. I remind Members that we are recording, and I ask them to wave their hands if they wish to ask a question that is supplementary to the questions that we have already run through together.

Our session today is on mental well-being as part of the broader formal inquiry that we are conducting. The context for our committee is the rapid changes that have occurred because of the Covid-19 pandemic. The challenge for us is that we are trying to look two to five years out. We are not dissecting the current situation; we are really trying to think about the longer-term effects of what has happened over the last few months, which itself is something of a changing landscape.

In our inquiry, we are looking at what the acceleration in the use of technology has done to economic and social well-being. We have been looking at lots of different areas of that, and this week we are focusing on mental health, as I said. I ask both Members and witnesses to bear those two things in mind as far as possible. We could have a wide-ranging and interesting discussion about many aspects of mental health, but we are trying to look at the longer term through the constant lens of what digitisation has or has not done in the area of mental well-being.

We have two panels this morning, so we have about an hour for you guys in this first session. Lord Alderdice will ask the first question.

Q50 Lord Alderdice: Thank you, Martha, and welcome to our guest colleagues. We look forward to what you have to say. As the Chair was saying, we are looking today at the mental health aspects of digital and well-being as we look to the next five years or beyond. I am particularly interested in today's session because I am a psychiatrist by profession and background, so I am very interested in what you have to say.

We are looking further down the line, but I would like to start with a couple of questions about where we are now with what has already happened with Covid. The first question, which might well be particularly for Tom, is: to what extent has the pandemic driven an acceleration in digital mental health services? Secondly, perhaps particularly for Akiko, what impact has that had on users' mental health? Has it impacted on different groups in different ways?

We use the word "users" nowadays rather than "clients", "patients", "customers" or whatever, but of course there is another group of users of these services and that is the therapists. I have noticed that the mental health of some of the therapists is being affected by the constant use of digital. If you want to refer to that, please do. Others—Richard, for example—may want to pick up on that question later.

First, though, I would like you to answer my questions about the extent to which the pandemic has driven an acceleration in digital mental health

services and the effect on users' mental health.

Tom Foley: Thanks a lot. It is nice to be here. How Covid has driven the use of digital mental health services is a mixed picture. The headlines have been about the increased use of telemedicine, and there is no doubt that as mental health teams—I am a psychiatrist myself as well as working at the university—we have used much more technology in communicating between and within the teams, so we have been able to work from home a lot of the time, and that has extended into the services that we provide to patients.

The big thing that we have seen is that we can do much more with video consultations, but we have also just been using the telephone. We have probably had a much larger increase in the number of telephone consultations than video consultations. That shows that it is the mature technologies that have really been most helpful during the pandemic—things that were already in place where people have the underlying infrastructure to use them, both within the service and in people's homes, and things that could be scaled up very quickly have been really successful.

I suppose you could think of digital mental health interventions as a sort of pipeline. We have the really mature ones such as video consultations at one end, but at the other end we have the things that we are still developing and doing a lot of research on, where the underlying science is not really that complete. While we have accelerated at the mature end, we have not seen the same acceleration at the research and development end. If anything, it has perhaps been pushed backwards by the pandemic, because the research teams, the universities, have been focused on Covid work or have just not been able to meet and get on with developing the stuff that they have been doing. It is really a mixed picture. You can look at it both ways.

The other issue is that either some of the regulation has been relaxed during the Covid period or the risk benefit of implementing some of these technologies has been slightly changed, so we have no choice but to get on and do it. So there we have seen an acceleration that might not be long-lasting.

For patients, it has been patchy. Some patients have really benefited from and enjoyed using the new technologies, but others have found it more difficult to engage with them. In particular, really complex patients, who perhaps have more than one service and more than one therapist involved, have found it difficult, because some services have embraced the new technologies but others have just shut down, and other services are somewhere in between. For patients who have really complex needs, it has not been quite so straightforward.

Akiko Hart: It cannot be said often enough that digital mental health support is not for everyone. Tom has touched on digital exclusion. What is really interesting about that is that we think about digital poverty, such

as people not being able to access data, or about skills: that is, people not having the skills or the confidence to access tech.

I would like to make two points about digital exclusion. The first is that the switch to digital does not just exclude the people we think it will exclude. If we look at this through the lens of privacy, for example, people who live in multioccupancy households, young LGBTQ people who might not have disclosed to their parents or people who live with interpersonal or domestic violence might not have the privacy or the safety to be able to access digital support online, so it does not just exclude the people we think it will exclude.

Secondly, it excludes people who are often already marginalised. A good example here is people with learning difficulties or those with learning disabilities. There has been very little support on the ground for people to get access to online services. [*Inaudible.*—context here is that people with mental health difficulties that do not go away, some of whom will access services and some of whom will not, are broadly more likely to live on the intersections of multiple marginalisations already, such as poverty, precarity and racism. We are seeing that one of the biggest dangers is that the switch to digital, if it is done in a one-size-fits-all way, will compound some of those inequalities.

Lord Alderdice: Thank you very much indeed. Richard, I notice that you were nodding when I mentioned the impact on therapists.

Dr Richard Graham: Yes. I was thinking of my work historically with a peer-to-peer support platform; it is now called Together. We developed a remote therapy service—I think, going back to 2011. I was supervising a lot of the therapists. Again, it was a mixture of advantage and disadvantage. The therapists definitely had to work harder to bridge all those gaps in information, atmosphere and so on that you would get in a room, but I think the attention that gave for users of the service made it a good experience. In some ways, the extra distance the therapists had to go in using the tech may have had a positive impact on service users. However, it is hard work, with back-to-back appointments. I suppose that we are all recognising that Zoom and Teams calls have a certain exhaustion quality attached.

Baroness Young of Hornsey: Before I embark on my own questions, I wanted to pick up on something that Akiko said. Akiko, you mentioned racism. You will obviously be well aware of the disproportionately negative outcomes that black people of African descent, and of south Asian descent to some extent, endure with mental health services. I wondered whether you had anything specific to say about that issue.

Akiko Hart: We know that people from racialised communities are overrepresented in mental health services, especially at the sharper end. If we look at the statistics on coercion, detention and restraint, we see across the board that people from racialised communities are overrepresented.

In the light of the George Floyd murder, Black Lives Matter and a more general awareness of racism this year, we have seen within mental health an increasing awareness of the impact of racism, particularly structural and institutional racism, on people who live with mental ill-health. We are seeing some progress in the wider conversation, but the truth is that there have been many studies and inquiries but very little has changed in 20 or 30 years. There is a sense of weariness among activists who have been working in this area for the last few decades because there has not been a big enough shift. It is really important to be mindful of that in this context. All this has been compounded, as we know, by the impact of Covid on marginalised and racialised communities.

Q51 Baroness Young of Hornsey: If you know of any research about the potential impact of further digitisation on delivery of mental health services, perhaps you could write in and let us know, because that would be really useful.

I want now to ask about the increased use of digital technology in mental health service delivery. Kate, what new technologies and uses of technology do you expect to emerge over the next five years or so?

Professor Kate Cavanagh: I thank the panel for inviting me today. I want to reflect on something that Tom said earlier about mature technologies having the potential to be implemented. We see headlines about exciting new avenues of research and high-tech ideas that have potential for mental health services, but what we are more likely to see implemented over the next few years, and what resources are needed for, are services that make the best of technologies already widely accessible and ways of working that already have a mature evidence base. That will include a need for services to deliver confidently a more blended approach that draws on technology that many people already have access to, adding what is special and supportive in digital technology to well-established, evidence-based practice in face-to-face working.

Baroness Young of Hornsey: An interesting comment was made earlier about increased use of the telephone—sort of old-school technology. It will be interesting to see how that develops over the next years and whether, at some point, there will be a switchover for some cases.

We have already heard from Akiko about some of the potential barriers. What do you and Richard think some of the barriers might be to maximising technology's potential to improve services? Do we need more incentives to develop digital services?

Professor Kate Cavanagh: Again, echoing what Akiko said earlier, digital services are not for everyone, but they might offer something additional and increase the reach and accessibility of services for many.

On barriers, digital, tech, infrastructure, hardware and connectivity issues are barriers for some services and for some service users in accessing technology, but there are also barriers such as the limited rollout of training for healthcare staff on digital working and a need for greater

support, upskilling and confidence-building in that area. NHS colleagues have been remarkable during the Covid pandemic, but that is an acute response to meet the needs of the communities they serve. In a slightly longer timeframe, more deliberate and planned training and support are needed.

I have been interested to read some work from John Torous and colleagues at Harvard about a new role in healthcare services for digital navigators, both for healthcare staff and peer support workers. Such roles would be around digital literacy and access, and helping users and staff make the most of digital potential within services.

We have seen in a number of surveys and studies over the past decade or more that there are attitudinal and belief barriers to using digital services. Things that can improve knowledge and awareness of what is possible, of what services are safe and secure, and of what evidence base there is for interventions and other ways of working can be really helpful. I see those as the main barriers and some opportunities for overcoming them.

Baroness Young of Hornsey: Richard, do you have anything to add with regard to potential barriers and maximisation, or incentives, methodologies and processes for developing digital services?

Dr Richard Graham: That is a huge question. It goes back to Akiko's comment about digital poverty and whether we will reach a point where it is your right to have access to the online world and be afforded a device. One of the most poignant comments that I read during our survey research with Partnership for Young London was the answer from a young person to "What would make the most difference to your life?". It was wi-fi. At the other end of life, people in later life would often like to access health support through digital means but do not feel confident. With the Good Thinking programme, we have made sure that we include the Good Things Foundation support, the Learn My Way courses and connections to the online network centres so that people who would like to progress further are supported in doing so.

That has to be the foundation, but, as Kate has also touched on, we struggle not just in health but across the whole public sector with our level of digital literacy. This often means that practitioners, the children's workforce or whoever it is often struggle to understand the technology, let alone to convey that it can be trusted and used in a way that leads to beneficial outcomes.

The Public Health England behavioural insights team is doing really interesting work on how the prescribing—this is perhaps where the digital navigators will come in—makes a difference to uptake and engagement. It is not just that the technology will solve all the problems in itself; we need that human conveyance of the benefits that will also help people to make use of what could be anything from information to an app that would improve their health and well-being. So there is a lot at a basic level still to do.

Baroness Young of Hornsey: Could you quickly give us an idea of what might need to happen over the next five years in order to achieve those aims?

Dr Richard Graham: On training the public sector workforce, I would say embedding digital literacy components, which would include everything from e-safety and being aware of and alert to online harms to how we can leverage technology to improve outcomes and the health and well-being of the population. We need to go back to training to ensure that everyone working with the public in different ways has some knowledge of how digital can be an asset.

Q52 **Baroness Jay of Paddington:** I am interested in the way you have all so far emphasised the importance of what you call the mature technologies, including the telephone; it is good to hear the telephone described in such a way. However, there are of course a large number of new technologies being developed, and they are mostly developed by private companies or corporations whose basic interest, quite correctly, is the health of their company rather than that of the nation.

I wonder if you think there is any strategic way in which the NHS, a big public sector health giver, can develop resources with private companies that enable their proper use in a way that does not strangle the private companies but gives proper access to people who need them. This is perhaps a question primarily at the beginning for Tom, because he mentioned the mature technologies in his first response.

Tom Foley: That is a really difficult question to answer. We often talk about the relationship between private sector companies and the NHS as if the NHS is one entity, but from the point of view of a private company trying to develop something for use in it, the NHS is a multitude of organisations.

In the first instance they are probably trying to sell the product to a trust or some sort of healthcare provider, but they also need to worry about NHS Digital, for example, which is setting the standards for data use and clinical safety. They need to worry about the MHRA, which regulates medical devices, many of which these things are. Then they need to think about NHS England and NHS Improvement, which are commissioning some of the services through the CCGs. They need to be thinking about NICE and its role in saying "This is something that should be used". Then they need to think about how the CQC will regulate the services in which these things are used, and then there is a whole multitude of other organisations. For an individual company to manage all that is a really big ask.

I know that NHSX, just to add another name to the soup, is trying hard to create a strategic approach to this sort of interface, but that will be very difficult to do. It will come down very much to individual companies managing the relationships with those organisations. For small start-ups that do not have a lot of resources to manage all that, for example, it is a real challenge. The easier that we can make that and the more

streamlined that regulation can be, while still protecting patients and providers, the better.

The really important thing is that we focus on interventions being developed by companies that have some scientific underpinning, because there are a lot of digital interventions out there that are not really based on science and do not really have a plausible route to helping people. It is very difficult for trusts, never mind patients, to understand which ones will be helpful and which not. There is a big strategic challenge there in making all that work.

Baroness Jay of Paddington: One of the strategic problems is the question of evaluation, which you touched on. Obviously you are right that the NHS is immensely complex, but it is spending public money, taxpayers' money, and you will know that there is always the possibility of a "scandal" if a private company is seen to be exploiting that. So what would you say are the basic principles of trying to evaluate products developed in the private sector?

Tom Foley: Evaluation is huge. In the case of drugs, for example, in the past we could say that a drug was a drug, it was the same here as it was there and it was not going to change over time, whereas these digital interventions are evolving over time. If we were to do a massive randomised control trial of an intervention on an app, for example, by the time it was published the thing would have changed completely and we would not know if it was still safe or effective. We need new methodologies for assessing the effectiveness, safety and cost-effectiveness of those. That is the sort of work that Kate is probably best qualified to talk about, but there are new methods for doing that.

The thing about these technologies is that they often generate data, and if we can use and harness that data to help us both to develop the underlying science and to run more agile clinical trials, hopefully we can develop a system that learns from the patients who have used these interventions in a faster way.

Baroness Jay of Paddington: Kate, do you want to comment on the notion of more agile clinical trials, or anything else that Thomas has touched on?

Professor Kate Cavanagh: I think agile clinical trials and moving towards a space where the kind of evaluation that we are doing makes sense for the technology, as Tom described, are really important. The funding to support that kind of research seems like a really important part of ensuring efficient, effective and safe digital mental health services.

In digital mental health research, we already have quite a rich history of high-quality evaluation of individual tools in a research context. Where we see the gap is in taking that evidence base and implementing it in broadly disseminated real-world practice. For me, there is a need to really understand what is needed for that implementation and evaluating

implementation in the context of blended services, not just offering one tool but drawing on evidence-based tools to offer a digital ecosystem that can help different people with different preferences and needs within the same service.

Baroness Jay of Paddington: So a blended service would need a proper strategy for dealing with the private sector?

Professor Kate Cavanagh: I think so. You mentioned the development of tools. We have seen evidence from the literature that the tools that are most likely to have successful implementation are those that are cocreated by a range of expert stakeholders: experts by experience, service users, clinicians, researchers, digital technologists and the private sector, which often has supreme expertise in engagement and appeal, which is so important for digital technologies.

The Chair: Akiko, do you have something to add to that, because you have come at this from a different “user” group, to use John’s word?

Akiko Hart: What struck me in that exchange was the fluidity of the term “mental health”. It is incredibly broad and means so many things. In the last 10 years, with all the mental health awareness campaigns in the UK, there has been a growing and perhaps more entrenched narrative that we all have mental health. That narrative has pros and cons, and one of the challenges is that it means that our attention can sometimes be more focused on the general well-being of the population or people who perhaps experience mild to moderate mental health difficulties.

That is important in the framing of this conversation, because if we are thinking about quite focused, specific interventions such as cognitive behavioural therapy for someone who experiences mild to moderate depression or anxiety, all the points that have been made about digital interventions stand, but as soon as we are looking at mental health difficulties that do not go away and about more complicated lives, we are looking at a really different picture. It is hard to see how an app might be useful in any way for someone who might experience greater distress.

The Chair: Now we will move to Lord Elder, who is with us on the phone. We should be able to hear him loud and clear, but apologies that he is without a face. He does exist.

Lord Elder: I do not want to draw too many conclusions from this, but the problems of the digital world are perhaps expressed by the fact that I am sitting in my office in Westminster but was not able to join the call formally, so am on the phone instead.

The Chair: That probably says more about Westminster than about anything else.

Q53 **Lord Elder:** It may do, but if we cannot get it right here, getting it right at home might not be all that easy either.

I do not want to draw too many conclusions from my own experience,

and this is more about the physical than anything else, but I am very conscious of the fact that when I go to see a doctor—I have had a heart transplant and various difficulties have arisen from that—doctors assess how you are when you walk through the door from how you look, how you sit down and how you speak. That must be true in these areas as well.

Is it really possible to have as good treatment in the digital world as when you are actually speaking to someone in the same room? It seems to me that a doctor's overall knowledge is based on a lot more than just a conversation or seeing a face on screen.

Tom Foley: That is a really important point. You started with an anecdote relating to yourself. I have gathered a range of anecdotes as we have progressed through the pandemic. I have met an entire range of patients, from those who absolutely love using digital technology and find it great either to speak on the phone or to speak via a video call right through to people who have found it a really unpleasant experience to engage in those ways.

As a clinician, I have had some excellent consultations with patients. You undoubtedly might miss some things, but there are ways in which you can mitigate that by probing further and asking people questions, and you can gather collateral from other people who are around that person at the time. However, in some cases I have just had to hang up the phone, get in my car and go to the person's house and see them face to face.

I have settled over time on the approach where I always try to meet the person face to face initially. After that, if they are comfortable with that digital approach, we can use it. Looking quite a way into the future, there is also the possibility that there are things that we can pick up that might be called "digital biomarkers", things that we might be able to pick up through people's use of technology that we cannot see in a face-to-face consultation—for example, their activity in using a smartphone or other sensor activity information, or even information that people might record in a more timely fashion on a phone when they are having a particular experience rather than three months later when they happen to see a psychiatrist.

So I think it goes both ways. There are opportunities as well as major challenges in this, but I think you are right: sometimes you simply cannot replace the face-to-face experience.

Lord Elder: That is very interesting, thank you. I would like to ask a little more about that. I understand entirely why we have gone so far into the digital world: because there has been no option—if doctors will deal with patients at all, they have to do it that way. That does not necessarily mean that the pace at which we have gone has been right or that we should not step back a bit when and if the world returns to something closer to normality. I am absolutely not opposed to the idea that there should be more digital intervention, but I do not think it should be seen

as the default position. Would that be fair?

Tom Foley: I think it will step back. Some services that have gone entirely non-face to face will step back and do more face to face, but it will also broaden out so that services that have not gone digital at all will then learn from the services that have. So overall we might see an increase in digital consultations, but on a service-to-service, case-by-case basis we might see that it averages out a bit.

Professor Kate Cavanagh: In relation to the first question, you are right that there are some things that it is essential happen face to face in healthcare and in mental healthcare. There was an amazing rapid survey of over a thousand staff in our Sussex Partnership NHS Foundation Trust, our mental health trust locally, getting some feedback from staff about what kind of meetings with colleagues and service users had worked most effectively by phone, by video conference and face to face. We can see a mixed picture there, with some learning about which meetings it might be more essential to have face to face.

I do not think anyone is suggesting that entirely digital services are appropriate across the healthcare spectrum, but we see optichannel connectivity and engagement in many different aspects of life. The broader public, service users and staff will have preferences for different ways of interacting for different kinds of contact. Digital platforms might offer the potential for meeting people's preferences in some cases, and they can offer effective ways of working where there is a good match between the needs and preferences of the service user or staff member and the evidence-based options that are available.

There is an evidence base for telehealth and video conferencing where face-to-face telehealth and psychological therapies have been evaluated compared to the same interventions delivered by video conference. We see similar outcomes at a broad level. Obviously, there is nuance in the detail, and some are better delivered and more effective than others, but both for individual work and for group work we see a promising evidence base emerging for videoconferencing.

Again, I think it is an area where more research is needed, along with more support for the implementation of these services where they are appropriate and wanted.

The Chair: I will pick up on that evidence base question, because it is so important. You mentioned video conferencing. Is that one of the key areas where more research is needed? Are there other areas where you would like to see a stronger evidence base built up?

Professor Kate Cavanagh: Probably the key missing piece in the evidence base at the moment is the implementation of digital services at scale. I would fully support further resources being made available to evaluate various individual technologies. That is important. There is a distinction between approaches built on evidence-based principles—using digital technologies as a way of operationalising a well-evidenced way of

working, such as in cognitive behavioural therapy for mild to moderate anxiety and depression—and the technology itself, and its implementation being effective in practice and in situ. That implementation piece is what is really needed in the research landscape.

- Q54 **Lord Hain:** Surely empathy and a personal connection, as Tom implied, are even more essential in your fields than in a GP surgery. Therefore, if you were looking five years ahead and were to recommend designing an optimal structure to pursue your professional objectives, what would it be?

Professor Kate Cavanagh: Empathy is critical. In this context, the potential advantages of offering blended digital services, with face-to-face working and the potential for adding to that with digital tools and technologies—digitally-enabled services, if you like—mean that we can increase reach, access and efficiency. Using these services in a complementary way is not a challenge to working empathically.

The Chair: Richard, I know you have done a lot of work on this kind of service delivery. Sorry, I think that you are on mute—we have decided that that is the T-shirt we all need for Christmas.

Dr Richard Graham: I so need that T-shirt. Of course, a lot of people who are struggling with mental health difficulties find it extremely difficult to see a therapist or psychiatrist and to be in a room with them. That can be quite a journey, and I would not want to suggest that it is always the ideal end point.

It is also possible to start to embed some of that empathic thinking, particularly, as Kate was saying, if we are coproducing support with that lived experience. We can sometimes give them that next step, that next level of support, that may ultimately be a very useful intervention, particularly for something like post-traumatic stress, which is widespread, especially in London. There is a spectrum of support that we can offer, and sometimes the confidentiality, the privacy, of accessing support digitally can make a huge difference to someone taking that next step. It is a complex matter, but I think that it is possible to get empathic understanding into the development of services and products.

- Q55 **The Chair:** Akiko, I see that you have your hand up. I will be cheeky and ask you a question so that you can give us two answers in one, perhaps.

You have already talked about people who will not or cannot use digital services. An important theme throughout our inquiry, across all the aspects of mental health and physical health work that we are looking at, is the inequalities that already exist and whether they are exaggerated by this digital sphere. I am interested particularly in your perspective on people who cannot or will not access services for whatever reason and whether this has exaggerated mental health issues. Can any barriers be reduced for those people, or will it just always be another deep inequality? Also, please say whatever you were going to say on the previous question.

Akiko Hart: I wanted to add to what Richard was saying. It is really important, for me at least, to think about online support as a different set of skills, or perhaps a greater skill, than face-to-face support. One of the mistakes we have perhaps collectively made in the switch to digital—and we see it all the time with back-to-back Zoom meetings all day or online conferences that last for eight hours—is thinking that we can replicate a face-to-face interaction by just switching it to online, when in fact it is a different set of skills and a different format.

We need to rethink some of those issues. Some of that is a question of time: we are all getting used to this. I agree with Richard and others that it is possible to create community and connection online, but it is harder. We need to acknowledge that in-service delivery and think a bit more deeply about training and support for those delivering services online.

To your point about inequality, I go back to what I said at the beginning: digital is for everyone. We have talked a lot about who it has excluded. I think it has also been very positive for a lot of people. That is one of the problems: it is a really mixed picture. Thinking about digital support more widely—not just statutory services, but mutual aid, community and peer support—for people who are very isolated a digital connection can be a lifeline. We have seen that through the growth of online peer support and mutual support and mutual aid during Covid.

The picture is complicated. As I said earlier, within mental health more broadly, there is generally less of a focus on people who experience greater distress and who access the sharper end of services. Covid has exacerbated that a bit. I worry about that. That is where I am landing on this.

Lord Hain: I found those responses really insightful, thank you. Do people cry online? If somebody is really stressed and you are engaging with them on a client/professional basis, can you really get the same interaction digitally? If people want to unburden themselves or suddenly to start confronting their own demons and you are encouraging them to do so, does that happen digitally? I am not a professional like you are, but that is the way I see it working.

Akiko Hart: I am happy to take that question, although I am not a professional. I have certainly experienced this, yes. It can happen. It is more difficult to create that trust. This goes back to some of the points that others made earlier: there are differences between an established relationship where you switch to digital and one where you have not met the therapist before and you are starting from scratch on digital. That does not mean that one is worse than the other, but it could be harder to create that sense of connection and trust with someone you have not met before. Equally, I have seen that happen. I am really interested in other people's thoughts on this as well.

Tom Foley: It is an interesting question. What medium is most helpful depends on the person. There is a long history of people sharing deep and difficult emotions in non-face to face ways. We have only to think

about the Samaritans, for example, and the value that services like that have had for many years. As I think Akiko mentioned, there are rich online peer support communities where people share really difficult things and sometimes find it easier to share with an online community than with some of the people closest to them.

So there are examples of where you can get that empathy, sharing and discussion of difficult experiences, as well as therapeutic relationships. But that is very much case to case and, as Akiko says, it is not for everyone. You really need to have some sort of triage when you are thinking about who is best suited to it. It is not that one size fits all.

Q56 Baroness Benjamin: It is interesting listening to everyone this morning. I was chatting to some young people recently. One said that since Covid they had been experiencing mental problems, and the other one said, "Call up Prince William. He'll help you". I think they were joking, but what I found interesting was that they were prepared to chat about their issues openly. Maybe it was because I was a stranger to them.

I want to go back to the issues about black people and mental health. They often do not talk about their problems, but, as we know, it has been documented and reported that black people experience a substantially higher rate of mental issues than white people. Black people, particularly during the pandemic, have been four times as likely to be detained under the Mental Health Act and many end up in prison. Yet finding the right psychologist, therapist or mental health worker can be difficult because only 6% of psychologists are black or from minority backgrounds. If you are searching for a therapist or any kind of mental health resource, it might be difficult to connect with someone who looks like you, so black people may be deterred from seeking therapy if they cannot see someone who can relate to them culturally and to their experiences.

As we look into the future, what can be done to facilitate and create a variety of mental health services aimed specifically at black people that focuses on the different aspects of mental well-being?

Akiko Hart: Thank you for those incredibly important points. We know that the White Paper on the reform of the Mental Health Act is due to be published any moment now. A big focus of the independent review of the Mental Health Act was to address the disproportionate representation of people from racialised communities who are detained under the Mental Health Act, specifically black men and women.

I am hopeful that there is an increasing awareness more broadly among people in mental health that this is an issue that needs to be addressed, that words are no longer enough and that we need to see some action. As a result of the work of the Mental Health Act review, there have been initiatives looking at inequalities, specifically racial inequalities, in mental health, all of which I absolutely support.

Going back to your point about therapists, that is a really important issue that is not often addressed. I want to give a shout here to BAATN, the

Black, African and Asian Therapy Network. If you go on to its website you can search for a black, African or Asian therapist.

One of the issues, and this is a really difficult one to raise, is institutional racism. We talk a lot about racism in terms of the racism that people who use services can experience, but there is also the racism that mental health professionals can experience within services. That needs a lot more attention, and I would like to see a focus on both going forward.

Baroness Benjamin: How do we get young people from minority backgrounds to take up the profession, then? What can we do to get them to see themselves in that role? They would like to be a doctor or maybe a surgeon or a dentist, but psychology or doing this sort of therapy work does not seem to be so attractive. What can we do to make it more attractive?

Akiko Hart: I can go first, but I will be interested in what others say. The rates of representation differ between the different professions. Clinical psychology, for example, is very white, female and middle-class. Psychiatry and mental health nursing are different. When you look at the detail of mental health nursing, what is interesting is the number of people from racialised communities above a certain banding—that is, in more senior positions—within the NHS. So these inequalities come out in different ways in different professions. The professions need to take that on board, and there needs to be a wider reckoning and deeper reform within the individual professions. In order for that to happen, we need to see greater representation. Whiteness is the issue that is much harder to discuss, is it not? People need to make space and step out of the way.

Dr Richard Graham: I want to make a small point about our discussions with young people on mental health support and how much emphasis they place on supporting each other. Also, they are looking to extraordinary places like TikTok. It is amazing how much mental health advice is being shared and utilised in the most unexpected places. Perhaps creators and influencers in online spaces are their version of psychology, and we may be seeing a transformation in all sorts of ways in the way that people think about and access mental health support. That does not cover the whole spectrum, as Akiko has described, but there is a lot more that we can do to engage them at that level where they support each other very well.

Baroness Benjamin: What about very young children and school children? It starts off with very young kids, even in primary schools, who are suffering from mental health issues that are not addressed. Surely the sooner they are addressed, the better for when those children get older.

Dr Richard Graham: Absolutely. My core discipline, like Tom and Bernadka, is childhood and adolescent psychiatry, and identifying as early as possible and supporting families and young people. Organisations like the Diana Award, through their peer-support programmes, are having a very positive impact. Some sort of blending of peer support with

traditional services might be a good way forward to meet the scale of need, which is always the challenge.

Q57 Baroness Young of Hornsey: It is fascinating to hear all the responses and the questions. I have been trying to make not too big and baggy a question. We have talked quite a bit about training professionals, quite rightly, but there has been only a small mention of the role of service users in designing services and thinking about what role different kinds of digital media can play, notwithstanding all the comments that Tom made earlier about quality control and so on.

Can any of you foresee a way in which, over the next five years, service users will be able to have more of an input into whatever mode of delivery we use for services, whether that is digital or otherwise? There might be—well, I do not want to pre-empt what you might say, so I would like to hear what you want to say about that.

Professor Kate Cavanagh: Absolutely. I have had the pleasure and privilege of helping self-help services in Manchester to evaluate some of their services. For a number of years, they have been training peer support workers—graduates of their digital mental health services—to support further users of those services. Those services are highly valued. They reach the more marginalised and underserved communities, and they have the potential to be a model for ways of working.

I mentioned earlier the idea of rolling out digital navigators across mental health care. That could be helpful at many levels. John Torous and colleagues have spoken about the range of ways in which people might benefit from digitally enabled services. Akiko asked earlier whether an app can be useful for someone experiencing more chronic, complex mental health difficulties. Digital technology does not make sense in a stand-alone way, but it might help to support people who are struggling in more complex ways if they learn some of the ways in which they can connect and communicate, such as using data and wi-fi, and using a phone to help to choreograph healthier routines in their lives by using reminders and notes, accessing content and communicating with friends, family, peers and professionals. Peer support workers in those digital navigator roles could certainly have a huge impact on the reach of digital mental health services.

Dr Richard Graham: In our programme, we are fortunate to work with Thrive LDN, which does a lot of work engaging with the diverse communities of London. Through that, we are linking up with faith leaders and all sorts of community leaders to look at exactly how we empower them to input into the further development of our services. That participation and engagement work is critical, otherwise people feel that they are on the margins and that they will not make a difference. That will have to be a very reactive programme to make sure that all those voices are heard and influence how we develop services.

Q58 Lord Pickles: I was quite taken aback by the suggestion that TikTok might be used to support mental health. It is not an entirely benign

environment, and I would be interested in your views on the darker side of TikTok, where it might be used to hurt someone who has mental ill health. Bearing in mind that we are looking not to the immediate term, but over the next five years, what safeguards should be introduced?

Dr Richard Graham: This was not a recommendation on my part. I was told by a younger person that they had found some information on grounding techniques to manage post-traumatic stress that was very helpful and superior to that of the psychologist they were talking to at the time.

The risks of TikTok are well known, and with the announcements today about the response to the online harms consultation there will be much greater focus on that aspect. I believe that you will discuss this further in the next session. It is extraordinary. Before TikTok, young people went to YouTube as a first step to finding health information, and this has been going on for some time.

The question is how we can establish a presence in this space, not just in order to minimise harm but to create the sort of relatable content that speaks to the lives they have now. In the NHS, we have a lot of work to do to catch up with the influencers and voices that are very actively listened to in those spaces. Some of them are also saying very helpful things, but consideration of disinformation and so on should be part of the response to the online harms consultation, and we in health need to be much further engaged in that area.

Baroness Chisholm of Owlpen: The points that I was going to raise have been covered, so I am happy to go quietly.

Q59 The Chair: I have a final question. The witnesses have covered a huge amount of material and the session has been fascinating. You have been extremely interesting about some of the ideas for policy recommendations.

Our committee wants to be very clear and very specific, which is a challenge, so I would very much appreciate all your thoughts on specific policy recommendations to ensure that the mental health environment over the next two to five years is as effective as possible for as many people as possible, bearing in mind, as all of you have said, that the underpinning of digital will probably roll back a bit. Who knows, but it has both benefits and massive disadvantages.

I have already pencilled in some of your ideas, such as the digital navigators, which Kate mentioned, and wi-fi and the importance of digital skills across the NHS. I have worked on that for a long time, and clearly a huge part of this is looking at inequalities and people for whom digital technology or mental health online does not come easily.

Again, I am very keen for you to suggest one or more policy recommendations to us. That clarity might help us to poke the Government into action, so if it is not too mean I will go round and ask people individually. Kate, would you like to start?

Professor Kate Cavanagh: My recommendation would be that in order to meet the needs of all those who could benefit from mental health services, including digitally enabled mental health services, we need further resources in order to build capacity. Those resources include new workers across the mental health professions, as well as training resources for the training of existing and new staff, and ongoing support and supervision to enhance these new ways of working, which, as you say, are likely to change shape post Covid; let us hope that there is a post Covid. Some of these digital opportunities are likely to be implemented more broadly.

Then there are the technical needs. Reliable, stable hardware platforms and wi-fi for services are all essential, while definitely keeping in mind that digitally enabled services are not for everyone. We need to make sure that all the populations we serve are well catered for by well-funded mental health services.

The Chair: Richard, you talked very eloquently about cocreated services. Do you have any specific policy recommendations?

Dr Richard Graham: For the Good Thinking service, one of the greatest challenges is that, compared with the funding for the use of medications within the NHS, we do not have a model for costing and pricing digital products that recognises the cost involved in their development and their building. The cost of that cocreation, that codesign, should also come in.

There is also a lot of uncertainty that makes it very difficult to understand value. We have mechanisms such as medication committees and so on for the use of drugs within the NHS. Something is needed at quite a practical level in the procurement and funding of services that, again, might fit with what Kate describes as upskilling the workforce and getting those implementation programmes to be effective. That would be my wish.

Tom Foley: I have noted down a few things as we have gone through the conversation.

Encouraging digitally literate leadership at every level is really important, as is focusing on the science behind all this, because the shiny apps do not come out of thin air, and if they do they usually do not work. More support for the science is needed. Along with that is evaluation in real time. Codesign, coproduction, cocreation, whatever you want to call it, is absolutely central to the whole thing. We need a focus on implementation science, which as Kate said is working out how these things actually roll out in real life to trusts and real patients.

There is the funding for innovation, but also more funding for the implementation science and more support with a focus on digital exclusion, not just in respect of an individual product but at a societal level. We also need support for individuals who are unable to engage for whatever reason.

Finally, we need to stay focused on the underlying causes of mental ill health and try to prevent it wherever possible, rather than trying to come up with solutions to sort things out afterwards. When I say support, I am talking about funding, but also about policy and regulatory support. They are the key things for me.

The Chair: Akiko, you have been extremely helpful in helping us to think about different user groups. What are your recommendations for us?

Akiko Hart: If we are serious about tackling inequalities, we need to work more closely with grass-roots user-led community groups, which support people from marginalised and racialised communities. This work needs to be valued, understood, recognised and funded in a way that it is not at the moment. When we are thinking about mental health, we should look at it not just through the prism of secondary mental health services but more broadly; we need to look at how mental health support is often delivered through informal community means.

The Chair: Thank you. That is very clear. For some reason, my Zoom prevented me from seeing any hands raised, so I apologise to colleagues if I have missed anyone. I hope that we covered everybody's questions and supplementaries. Miraculously, we are not too far beyond time, so thank you all very much. The session was extremely helpful and illuminating. I can see that Eric will go off and use TikTok frenziedly now to try to understand what is going on.

Thank you very much for joining us today, and happy holidays; I hope you get some.

Examination of witnesses

Dr Bernadka Dubicka and Dr Linda Kaye.

The Chair: Welcome to our COVID-19 Select Committee, Bernadka and Linda. It is very nice to see you both. Thank you for joining us. As I am sure you know, our committee is tasked with looking at the long-term implications of Covid. We are looking in our inquiry at the effects of digitisation on social and economic well-being, of which mental health is an enormously important part. As you know, we had just had a session with some experts looking at the delivery of mental health services. If you could help us to understand some of the broader mental health implications, that would be fantastic.

Q60 **Baroness Jay of Paddington:** Good morning, and thank you for helping us. The growth in the use of modern technology, particularly personal technology, during the pandemic has been clearly understood, but at the same time we have seen a rise in mental stress. I am not saying that the two are connected, but obviously there has been considerable evidence of a level of anxiety that is directed not just specifically towards people's fear about the virus.

In the longer term, do you think this kind of anxiety will decline? More broadly, what do you think the impact of people using technology to such a broad extent—and obviously much more widely as the years go by—will have on people's mental health, and how are we going to deal with that? This is really a question to both of you, so whoever wants to start, please do.

Dr Bernadka Dubicka: It has been a very interesting morning's discussion. A lot of the issues discussed were very pertinent to my practice as well, so I would like to say thank you.

That is an extremely broad question. It is very difficult for us to predict anything in the future. I am coming at this from the perspective of a child and adolescent psychiatrist, as Richard mentioned in the previous session. First, I shall make a couple of broad generic points. In terms of where we might be in five years, the news at the moment regarding child and adolescent mental health is not great. After 15 years, the Government commissioned a prevalence survey in 2017 that showed a rise in emotional problems, but since then we have had a follow-up survey, published in October this year, covering the pandemic period, and the news is really shocking. The rates of mental health disorders in children and adolescents have moved from one in nine to one in six. How much of that is directly attributable to the pandemic is not entirely clear.

The second issue is that, back in 2017, we found that more than half of older adolescent girls with a mental health disorder were self-harming or had attempted suicide. That gives you a perspective on where we are at the moment, which is incredibly worrying.

So the trajectory of mental health problems in this country is not good. Again, very unfortunately, when we compare the mental health of young people in this country to that of others, we do very poorly.

Then there is the question of how much technology has to do with any of this. That is a hotly contested issue among academics. I cannot give you a definitive answer, but I can give you the Royal College of Psychiatrists' position and the way we see this at the moment.

In terms of the research, a number of reviews on mental health were published earlier this year that show that there is no confirmatory evidence of a direct causation in relation to the increase of tech on mental health problems. However, even those researchers acknowledge that the research has been extremely limited, and it really has not focused on the group that the college and I are interested in: the most vulnerable. We have heard a lot today about inequalities. However, there is agreement that the most vulnerable children and young people, and the most vulnerable people in society, will be disproportionately affected.

In terms of a crystal ball, in societies like South Korea and places in south-east Asia there has been an exponential increase in things like internet addiction. We might go in that direction, but it is difficult to know

because there is a whole complex interplay of different factors, both protective and risk.

Baroness Jay of Paddington: I absolutely understand that you cannot look into a crystal ball—nor, indeed, can we—but we are trying to see what the permanent effects of the pandemic might be and what things would have happened anyway because of the way society is developing, particularly in the IT world. I do not know whether it is possible to disaggregate that. From what you said, it is probably not.

Dr Bernadka Dubicka: That is very difficult, and then there is the complexity. There is complexity in the sorts of vulnerable people who might be accessing social media and digital technology. Often in the research people talk about screen time, but most of the time it is not about screen time per se; it is about what young people are doing on screens, what sort of platforms they are using, who is supervising them and what they are accessing. The questions that need to be asked have to be far more nuanced.

From the point of view of children, obviously the developing brain is extremely vulnerable to effects. That is another area of research that we need to look at. What is the mass, global impact of the increased use of technology, of likes and notifications? How is that shaping developing brains at very vulnerable times of development? Then, in the future, in five years' time, how might that impact on children and young people?

A large population study from Bristol published this week showed that teenagers who were particularly concerned about body image were much more likely to develop depression five years down the line. There is lots of evidence now showing that looking, for example, at idealised images such as cosmetic surgery on social media can really impact on developing teenagers and how they perceive themselves.

So there is certainly the potential for an increase in mental health difficulties based on lots of lines of emerging evidence. The World Health Organization has said that very young children should have extremely limited access to screens on the basis of emerging evidence on developing brains.

Baroness Jay of Paddington: You must have heard one of our contributors in the previous session saying, to the surprise of some of us, that TikTok can be a positive ingredient.

Dr Bernadka Dubicka: That moves on to the complexity. For every study that I could show you demonstrating the potentially damaging effect on teenagers who are self-harming, I could show you one that shows that teenagers also find online sites to be a source of support and help. There is conundrum and complexity. We need to learn how to harness the internet for the positives as well as trying to minimise the potential harms, which hopefully the online harms White Paper will now do.

We also need to research how we can increase the benefits. We have seen the connectedness across the pandemic period, and obviously for many young people the internet has been hugely beneficial in their education and in keeping up with their peer groups. In the clinic, the really vulnerable children and young people I see are the ones who are self-harming and who say things like, “When I’m feeling down, when I’m self-harming, I look at social media sites and I can be triggered into that self-harm. However, when I’m feeling good, I’ll go out there and try to help my friends and stop them from self-harming”. There you have the conundrum.

Dr Linda Kaye: I agree with some of the things that you have said, particularly that looking at screen time will generally not be particularly useful. I entirely agree with the point about the complexities.

On the longer-term impacts, at this point we have been looking at a snapshot of time when we have been responding to a stressful situation, and that stress has been exacerbated by the context of Covid. When we are thinking about the longer term and look at the historical research in this area, we find that we do not yet have enough evidence about those long-term impacts. Most of the research has been cross-sectional, looking at these issues in a timeframe that does not tell us much about the cause and long-term effects.

That is not particularly helpful at this point, but we have to remember that there are many different complexities in this, not just what we—whether children, young people or adults—are engaging with, but why we are using technology and the internet. That tends to get missed when people are thinking about the impacts. We do not just use it as an individual behaviour and it is not just driven by that; it is very much framed by why we need to use technology. That can come from the digitalisation of economic sectors or from having to use these for professional or work purposes.

When we are thinking about trying to tease out where this stress and all these effects of spending time using technology come from, we have to look beyond just the individual and their own experience of this and try to frame it much more broadly in order to understand organisations’ structures around this and what we deem to be healthy and functional use at a societal level.

A lot of the recommendations and things that I want to bring to this take that broader perspective, because it has to move beyond just being an individual issue.

Baroness Jay of Paddington: Both you and Bernadka have emphasised that we need to do more work. Essentially, research in this area is what is needed.

Q61 **Lord Pickles:** I would like to return to the TikTok conundrum, as you have put it so well. The digital world is not an entirely benign environment. Bearing in mind that we are not talking about what is

happening now but are trying to project five years hence, what kind of safeguards or enhancements should be there to make it a healthier environment so that the positive side of being online can be emphasised and the downside, the harming side, can be minimised?

Dr Bernadka Dubicka: We are meeting today on the same day the Government have announced the online harms regulation. We at the college definitely welcome the introduction of Ofcom as the regulator, and although the complexities around that are enormous, we certainly think it is a step in the right direction.

In terms of what can be done, there needs to be some sort of regulation that takes account of the impacts on children and young people. The age verification code is coming in too in that it ensures that social media companies make some effort to use those tools. There needs to be a risk-based approach, so the riskier the content the more stringent the measures that have to take place. Those issues are coming into play now.

There also needs to be a lot more work done on young people and users being able to have much more control of what happens online. Think, for example, about the sorts of things that you used to do when you were a teenager. That is now broadcast to the world, and teenagers have no way of taking that down or controlling it. That can have really damaging effects on young people, so they should be allowed much more control over their own digital footprints.

Social media companies, technology companies, need to take a social-responsibility approach. For example, they need to give users warnings about content that is coming up and being much more proactive about that, not just pushing pernicious algorithms that pop up immediately. There need to be warnings so that people and children can choose whether they view and become involved with that sort of material.

Then, as we have talked about, there is a very complex situation with education. There has to be a societal approach. There has been some digital education in schools, but this is not enough. It has to be across the board, including for parents and carers; children are often well ahead of their parents and carers when it comes to what they are doing. There needs to be much more education within schools.

Also, employees of social media companies and technology companies need to have much better awareness about the potential harms that their algorithms might be having on developing brains.

Lord Pickles: Linda, would you care to address the TikTok conundrum?

Dr Linda Kaye: That is a new one on me, the TikTok conundrum. It was interesting to hear about it from the previous panel. It was a really nice example of the positive use of technology, particularly in that kind of environment.

I was going to talk about behaviours. We have talked about content and the particular types of things that people might be interacting with, but

there is also the issue of how benign or toxic environments can be based on the behaviour not just of users but of other people in those environments. Certain social tech companies have started to address this—for example, with warning nudges for users to indicate that they might be putting something out that might be hurtful to others or might violate community standards. Those kinds of regulations, those nudges about people's behaviour, are a really positive thing to see companies starting to do.

Instagram has ways to enable people to avoid just passively consuming content, such as its "You're All Caught Up" feature. That is a really neat feature that allows people to think, "Okay, this is the content I've already seen. I don't need to see it again". It is trying to avoid people consuming in a mindless sort of way and potentially encouraging them to make more active and functional use of these technologies. Some social tech companies are starting to get the hang of this, but there is so much more to do. Still, this is really encouraging to see.

The other issue is organisational and social norms about what is appropriate and healthy functional use of these. This is where we can start to unpick community standards a little and see how we as individuals, at this pivotal point in time, are making social norms and creating good etiquette in different online environments. This cannot be regulated at a global level, but, in different communities, we as users—or citizens, I should say—in these environments are at a point where we can start building good etiquettes. We all have that kind of responsibility in line with what these communities are offering and the standards that they set out.

So there is the issue of the content of the regulation, which is immensely important, but then there are the multidimensional things that these environments do. We do not just passively consume content in the way we might with a TV broadcast; we engage with it. That element, that interactional aspect, also has to be addressed.

Dr Bernadka Dubicka: I completely agree with that last point. Education is so important when it comes to social responsibility, with children able to discuss those issues in school. We know that children ask for that and want that. Signposting is also important and something else that companies should be doing.

If I was talking on the BBC, for example, initially there would be a content warning from the broadcaster—"You may find this distressing, so you can turn it off"—which is what companies need to do too. Secondly, the BBC would signpost you to the Samaritans or elsewhere. That needs to happen regularly. If there is distressing content, such as suicide content, it needs to happen. It is still too easy to access this stuff. I gave a talk about it quite recently: a couple of clicks, and you have lots of graphic images about how to kill yourself and the best way of doing it. It is that easy.

Q62 **Lord Pickles:** If you were to make three asks of the committee for

making digital technology safer for those who have a mental illness to use, what would they be?

Dr Linda Kaye: I am thinking of three. Do others want to go first?

Dr Bernadka Dubicka: Default privacy settings are No. 1. Even if I try to change my cookie settings, how long does that take? You just give up. It is made so difficult. Privacy settings are by default at their lowest, which is not going help vulnerable users. My No. 1 ask would be that. No. 2 is what I have just talked about: content warnings—opt in or opt out—and signposting to helpful resources. Thirdly, users should have much more power over their digital footprints, so that they can take down content that will affect and damage their future prospects.

Lord Pickles: A lot of politicians would like that.

Dr Linda Kaye: Those are all really good examples. There is another one that I keep coming back to and wonder about. Digital games have tutorial levels and you get familiar with what you need to do in that environment. Would it not be wonderful if social media platforms had something equivalent, where you learn the etiquette and ways of behaving, and you have a way of rehearsing these ways of being and living in these environments?

I do not think that social media companies would ever do that, because they might be environments that do not have ads and so would not make any capital for them, but I honestly think that something like that, where you learn to engage in a positive and functional way, would be wonderful. If I could wave a magic wand, that is what I would love to recommend. I know it is a big ask, but it would solve a lot of the digital literacy and other issues. That would be my magic wand moment.

Lord Pickles: Maybe we should have a Debrett's for usage of the internet.

The Chair: Yes, there could be an alternative Debrett's for TikTok.

Q63 **Baroness Benjamin:** I am really pleased that we are talking about children and young people in this session. We have mentioned social media providers, the design of material and Ofcom the regulator, but given that children will have more and more screen time, what can we do to get children themselves to take responsibility for how they deal with the temptation, without becoming addicted to screen time? As we all know, it is addictive if we do not control it. Do we need to emphasise that children should also have responsibilities?

Dr Bernadka Dubicka: I do not think we can put all this on children, particularly young children. We made recommendations in our college position statement earlier this year. We have talked about education, which needs to start at a very young age. It is also about parents and carers. Those conversations need to start at a very young age with parents and carers.

It is also about example setting. It is no good telling your kids not to be on social media all the time if you cannot leave your smartphone off the dinner table and constantly take it to bed. There also needs to be modelling by parents and carers. It is about very early conversations and having open discussions. We know with children and teenagers that the more we tell them not to do something, the more likely they are to do it. There needs to be a much more informed approach across the board, starting at home, starting very young and starting with modelling.

It is not necessarily screen time per se that is most damaging, but what it displaces; for example, very young children are not getting enough face-to-face contact or not playing face to face with their peers, which is obviously difficult at the moment with Covid, or if they are not getting enough sleep. I saw a primary school child the other day who was depressed and self-harming; they had multiple social media accounts and were up late at night. It needs to start in the home, but there need to be open discussions. It is not so much about banning as about demonstrating the appropriate use of screen time and smartphones and ensuring that children have a healthy, balanced environment—enough sleep, enough fresh air, enough exercise and enough playtime and face-to-face contact.

Dr Linda Kaye: I agree with a lot of that. We also have to remember that the use of technology, as with any other behaviour, is about learning self-regulation. We learn self-regulation as we get older: not eating biscuits at 9 am and things. It takes self-regulation to do that. A number of different things feed into that, and it is a developmental process. When we think about how we encourage our children and young people to use technology, we have to acknowledge that it is happening as a developmental process and to be respectful of that.

I completely agree that conversations and modelling are immensely important at those younger ages. When we get to adolescence, when we might be gaining more autonomy or learning about self-regulation and what our capacities are, again that is not driven just by an individual and their use of technology. We have to think about how self-regulation works in relation to the context that the young person is in and why they might be using that technology. We need to think about things that might impact on why they are using it.

Could a self-monitoring process be brought in that encouraged young people to make use of screen time apps, for example? It is not about saying, "Look, you've been using it too much", but about asking what proportion of that time has been used for X and what proportion for Y, and whether there are ways to balance it out so that a proportion of use might be more functional use. The self-regulation issue is important to consider in that it is not necessarily any different from any other kind of behaviour that we might want to encourage our young people to do healthily. The problem is that we do not necessarily always know what healthy use is in different contexts. It might differ from one context to

another. That needs to be determined at a number of levels for us to be able to establish it better.

- Q64 **Lord Hain:** Is not a lot of the discussion that we have had based on responsible parenting? There is a lot of irresponsible parenting.

Dr Bernadka Dubicka: I completely agree that parenting is very important, but we have also talked a lot about inequalities. Research has demonstrated that offline vulnerabilities will be reflected in online vulnerabilities. It is children from wealthier backgrounds, with parents who have the time and the know-how to monitor their children's online time and what they are doing, who will be less adversely affected.

Where a child is living in poverty, which is a major driving factor for inequalities, parents may have to hold down several jobs. They may have mental health problems themselves and struggle to do just the basics of what is required. Their children will be at a huge disadvantage, as has been shown in the literature. It is about good-enough parenting, but we have to recognise the profound inequalities in our society and how there are parents and carers who will really struggle with this.

- Q65 **The Chair:** That is such an important point and it is fundamental to the discussion that we have had today. I want to pick up on that, but ladder out from it as well. We have talked a lot about the specific effect on mental health of overuse of screen time. I am interested in whether either of you have seen research on, or can predict, the two to five-year horizon in relation to the mental effects of working from home, which for most people involves using digital technology. We have not talked much about that in this session, and I am interested in whether you have seen research or have ideas that you could share with us. Linda, you are nodding.

Dr Linda Kaye: At the moment, we do not have the empirical academic and scientific research, but we have experienced things ourselves, which gives us some insight into the adaptabilities that we have used and how we have started to navigate them.

We have certainly learned through this pandemic about the adaptations that we have made, some of which have been okay, but some of which perhaps have not. What we can predict is a continued adaptability; that is one of the things that we can be certain about. We have not quite got to the point where we are doing it right, and some adaptations are still needed. The impact on mental health will be based on what additional adaptations we make. There will be differences in working from home arrangements based on an individuals, organisations and so on, but we can predict that the impact will be greater if we do not adapt in a healthy way.

We are still learning what is and is not working, and that will be different according to contexts, organisations and social structures. There will not be a one-size-fits-all solution in terms of what works and what the impacts will be. The key for me is knowing what healthy adaptation is

and what works. That can help us to understand much better what those impacts will be.

The Chair: Bernadka, do you think this issue exaggerates existing inequalities?

Dr Bernadka Dubicka: Working from home for professionals?

The Chair: Yes.

Dr Bernadka Dubicka: We said something about this in our submission. We have a major recruitment problem in mental health, as you probably know, for both psychiatrists and nurses. We have a huge problem with retention and recruitment. If we get this right, there is the potential to improve work-life balance, which might aid recruitment. I do not have figures on that, but it is really important and we need to consider it. There are administrative tasks that you can do quite easily, such as meetings with other professionals. The technology has been brilliant for that; you do not have to travel, you do not have to be in the same place, and you could you do it from home from your computer. There are definite advantages.

Moving on to the therapeutic space, we heard a bit about that this morning and referred to it in our submission. Therapists are definitely talking about burnout from the intensity of the online experience of doing therapeutic work. We heard before about a potential blended approach. There are some things that are very quick, easy and straightforward online. For example, if I wanted to do a quick medication check with a child and family I knew well, I would not have to drag them in but could just do it by video and that works really easily.

However, and this is reflected in a recent survey we did at the Royal College, it is very difficult to interact online with really risky teenagers, for example, or individuals whom we do not know very well. You really need to see them face to face. In our submission, we also talked about the difficulty of trying to engage quite complex young people by video.

We talked earlier about trying to support non-verbal communications, which is very difficult. You have to work much more intensely. There are lots of other issues, such as privacy. I did a video consultation and, about 20 minutes in, I heard another voice from the corner of the room. It was a younger child who was in the room answering questions. You do not have that same control of the space.

It is wrong to think that online working will be much more efficient for staff and less stressful, because it is not necessarily the case. Again, we need to find the balance of that blended approach for patients as well as staff. We need to do more research into that.

I have one more point. We talked about inequalities and vulnerable groups, but we have not talked very much about autism and learning disability. I have been surprised by how many young people are requesting face-to-face appointments with me rather than doing it by

video or telephone. I thought that most of them would automatically prefer that, but it is not necessarily the case. Some do and some do not. It is young people with autism and social anxiety who really struggle to do things remotely, and a lot of them would rather come in.

Q66 The Chair: That is an important point. Thank you for reminding us of that and raising it.

Eric has asked you about your wish list, which is perhaps more directed at the service providers. We are trying to provide specific policy recommendations to government. I am interested in whether you guys have anything you would like to add to your wish list, beyond the Debrett's for TikTok, which is a mind-boggling idea. Do you have specific recommendations? We have mentioned skills for staff and professionals in the sector. We have also mentioned making sure that we reach vulnerable groups in the most appropriate way. Clearly, children are a huge topic. Linda, did you have anything else in specific policy terms?

Dr Linda Kaye: What would be immensely useful is co-operation from social tech companies about data sharing. This would give us a much better, data-driven way of understanding behaviours on things like social media and enable us to do better research. To know what the impacts are, we have to move beyond the research that has been done, which is very cross-sectional and reliant on people's estimates of how much they use.

A growing body of evidence suggests that those estimates are nowhere near good enough; they are just not accurate. There is a likely inflation about understanding the impacts based on the fact that those estimates are perhaps not very accurate. Co-operation from social tech companies on sharing data to corroborate those estimates would be immensely useful in relation to mental health. Speaking as a researcher, I know that would be very helpful.

Something that came out for me when thinking about these issues was the importance of matters to do with health and safety and the need for work policies to be much more mindful of health and safety considerations when using technology, because there are risk associations with using it. The Government's bullying and harassment policy does not mention social media. The only things included are letter, face to face, email and phone, which seems to overlook a huge area where harmful and toxic behaviour can happen. I would like to put forward things like that as recommendations.

Dr Bernadka Dubicka: The college has also called for data sharing, so I completely agree with that. It also needs to be within the right ethical framework, because, as you know, it takes months to get anything through an ethical committee, even for a number as small as 10 people. Data and tech companies just take all this data and do what they want with it, so we need urgently to look at the right ethical framework for sharing data. Models have been proposed for that.

The college has also called for digital tax. We need research, but who will fund it? Companies are making huge profits, but we need some of those profits to be put into trying to make the internet a safer place for children, young people and vulnerable users. The research has to be focused much more on specific vulnerable groups and how they interact with various platforms.

As for other recommendations, the Government funded a prevalence survey. We have a representative sample of children and young people that should be followed up annually, and the right questions need to be asked about digital technologies so that we can see what happens to them year on year. We are never going to answer those questions unless the Government fund that kind of good, longitudinal research.

As I said previously, we need research on developing brains and some of the neuroscience on that. Lastly, we need to look at the benefits of digital technology, which we talked about earlier. We also need to look at how regulation might affect use and what any unintended consequences might be.

The Chair: Thank you. As many of you have mentioned, one of the challenges for us as a committee relates to early indicators in research. When we look out two to five years, it will be important to keep an eye on what research is emerging and encourage it into the right areas.

Thank you very much for an extremely interesting session. I feel like we have learned a lot this morning. All that is left for me to do is to wish you a happy holiday and thank you very much for your time. I formally close this meeting.