HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: Children and young people's mental health, HC 1194

Tuesday 23 March 2021

Ordered by the House of Commons to be published on 23 March 2021.

Watch the meeting

Members present: Jeremy Hunt (Chair); Paul Bristow; Rosie Cooper; Dr James Davies; Dr Luke Evans; Neale Hanvey; Barbara Keeley; Sarah Owen; Laura Trott.

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Witnesses

I: Emma Thomas, Chief Executive Officer, YoungMinds; Lynne Green, Chief Clinical Officer, Kooth; and Sophie Corlett, Director of External Relations, Mind.

II: Dame Rachel de Souza, Children's Commissioner for England; and Martin Lennon, Head of Public Affairs, Office of the Children's Commissioner for England.

III: Claire Murdoch, National Mental Health Director, NHS England; and Professor Tim Kendall, National Clinical Director for Mental Health, NHS England.

Examination of witnesses

Witnesses: Emma Thomas, Lynne Green and Sophie Corlett.

Q1 **Chair:** Good morning, and welcome to the House of Commons Health and Social Care Select Committee's first session of our inquiry into children and young people's mental health. This has been on everyone's mind during the pandemic. Even prior to the pandemic, it was a big area of focus for the NHS and the Government. We want to look at the progress that has been made, as well as the lessons we have learned from the pandemic. We are going to look at a wide range of issues, but in particular, in this inquiry, we will focus on the safety and appropriateness of in-patient care in some of the secure units, the overall focus on prevention, and the recent worrying growth in self-harm.

Later this morning, we are going to hear from Dame Rachel de Souza, the new Children's Commissioner for England; Professor Tim Kendall, NHS England's national clinical director for mental health; and Claire Murdoch, NHS England's national mental health director. Before that, we have a panel with three experts: Emma Thomas from YoungMinds, Sophie Corlett from Mind, and Lynne Green from a digital health and wellbeing organisation called Kooth. Welcome to you all and thank you for being with us today. I should say, for the purposes of transparency, that Kooth is owned by a personal friend of mine.

I want to start by looking at the pandemic and asking you, Emma Thomas, a question about it. Could you give us some sense as to what the overall impact on young people has been of not being able to go to school and not being able to socialise in the normal way?

Emma Thomas: Thank you, and good morning. What we and many of our partners across the sector have seen is that two key groups have been affected. The first are those with existing mental health needs. Our research has shown that around 30% of those, quite early on, had lost access to the support that they would normally be relying on.

The second group is a cohort of young people for whom the natural response of anxiety and distress to what we have all experienced is to be expected. We can see concern about ensuring that we do all that we can to mitigate the risk of those young people having lasting impact. The former have lost access, and the latter have started to experience early stage struggles. That is a consequence of lack of access to their support networks; not being able to access support they might rely on; the changes to their normal work and school patterns; and obviously fear around the circumstances of the pandemic.

There have been key audiences who have been more directly affected. What the pandemic has done, in terms both of infection rates, sadly to do with deaths, and the socioeconomic, is to impact groups disproportionately. Those in the lower socioeconomic groups, and black and minoritised ethnic groups, have been really affected. Many of them

are not necessarily accessing services. The lack of school as the opportunity whereby their needs can be identified and met has obviously had a direct impact on referral rates to access the support they might need from CAMHS.

Q2 **Chair:** Sophie Corlett, have you come across the same phenomenon at Mind? Are there any examples that spring to mind of people you have been dealing with who have been suffering the kinds of things that Emma is talking about?

Sophie Corlett: Yes, that really mirrors what we have found. We did a big survey towards the beginning, back in April and May last year. We did weekly snapshots of the people that we found were most affected. We had about 16,000 people altogether, and just under 2,000 of those were younger people, 24 and under. We found the same sort of pattern as Emma. People who already had a mental health problem were really affected. Children from households with lower levels of income, but also young women, were seemingly more affected than men. Across the piece, we found that people from black, Asian and minority ethnic communities were more affected.

Even within the groups that we have already talked about, those with eating disorders and obsessive compulsive disorders were the people who seemed to be most affected. A high proportion of people in the 18 to 24 age group—71% of that group—told us that they were either eating more or eating less, which is a really high proportion. Similarly, we found that more than a third said that one of their coping strategies was self-harm. It was a big picture, but with some quite specific things that we were concerned about within the overall picture.

Q3 **Chair:** Sophie, is there a distinction between schoolchildren who are living with their parents and have one set of issues, and young adults who may be college or university age, who are hit particularly hard in a different way?

Sophie Corlett: Yes, we found a different pattern. With eating disorders, the high level of people eating more or less seemed to be the older age group. We found a slightly different pattern. I can send on to you the detail of how that broke down. We only talked to people aged 13-plus. We do not have a picture from that piece of work of younger children.

Q4 **Chair:** Thank you. Let me bring in Lynne, if I may. One of the silver linings of the pandemic has been the speeding up of the adoption of digital services across the NHS. Have you noticed that in the mental health space?

Lynne Green: First of all, I agree with both my colleagues, Emma and Sophie. We have seen an increase during the last 12 months. In 2020, we had over 1 million log-ins from children and young people. That represents over 174,000 unique users. That is an increase of around 39% compared to the year before. We have absolutely seen the same increases.

I would like to stress that, in addition to seeing an increase in demand, we have seen an increase in severity. When people log on to our service—it is an anonymous service—they complete a very brief initial questionnaire. It is a validated, standardised questionnaire. It is self-report data, and gives us a good snapshot of how young people are feeling in the week prior to accessing our services. According to that data, around two thirds of young people would fall within the severe category when it comes to mental health. That is supported by our wider data from practitioner assessment and so on. Yes, we are absolutely seeing a real increase in both demand and severity.

Q5 **Chair:** Obviously, in a pandemic people have had to use digital services in a way that was not the case before. Even in a period when you did not have to use digital services, is there a sense from young people that they find it easier to communicate digitally than they might in a face-to-face traditional appointment?

Lynne Green: Yes, that's right. Kooth has not come into being as a result specifically of the pandemic. We have been working with the NHS for the past 20 years as part of a wider commissioned service. It is all about choice. While some young people, and indeed adults, will always prefer to talk to somebody about their difficulties in a face-to-face setting, we know that many young people feel more comfortable talking about difficult psychological issues in an online, digital environment. We were seeing gradual increases in demand for our service prior to the pandemic. Of course, due to some of the logistical issues that some of my colleagues have already mentioned, we have seen an increase as a result of the Covid-19 pandemic.

Q6 **Dr Davies:** Continuing on that theme, Lynne—the access to online mental health resources—can you give us an idea of the degree of prominence of those resources among young people? Where do they find out about them? Are they promoted adequately through schools? As a GP, I recommend them, but I do not think that all my colleagues do. Is there more work to do on that front?

Lynne Green: That is a really good question. There is no point having great services—services can be as great as we want them to be—unless people know about them, otherwise it is no use. We certainly place a lot of emphasis on that, in addition to our practitioners who, in the main, work remotely. We have some face-to-face services as well. We have teams of people who are on the ground, if you like. They are integration and participation teams who work very closely with local commissioners, local providers and, crucially, in schools. They physically go into schools. They support assemblies and work with school leaders, SENCOs and so on, as well as with GPs. It is a really good point; we would love to get our services out there more widely. As I say, if people do not know about them, they cannot access them. They are so important in getting people crucial, early help.

Q7 **Dr Davies:** Indeed. I know you have free-of-charge services for someone

who logs in, but you also of course have the commissioned services. Can you give us an understanding of the difference between the two and the degree to which those commissioned services are available across the UK?

Lynne Green: Yes. All of our services are free to the end user. For children and young people, they are primarily commissioned at the moment by CCGs and local authorities, but it is important for me to stress that our services are free to the end user.

Q8 **Dr Davies:** Excellent. Are there learnings that you can describe from the pandemic on moving forward, post pandemic, for young people's mental health provision?

Lynne Green: Sure. As I said previously, it is about choice. It is so important that we enable easily accessible services in the way that people want them. We know from many years of working with children and young people, not just during the pandemic, that choice is important, and that digital and anonymous access is really important to them. When we survey children and young people, the No. 1 reason that always comes to light about why they like our digital service is its anonymity.

Of course, with that comes a real responsibility for us to make sure that our services have excellent clinical governance and are safe. We have to listen to what young people want. It certainly is not an either/or. It is absolutely not that one type of service delivery mode is better than another. It is horses for courses. Different things suit different people. It is important that we remember that. If we do not listen to the voice of our young people, we ignore that at our peril.

Emma Thomas: I agree with Lynne about choice. In the adoption of digital, we have seen the NHS roll out virtual counselling very quickly, and access to the 24/7 crisis helplines. It is important to understand that for many young people what we saw was that those virtual sessions, as opposed to face to face, were not appropriate, given data access or privacy problems. Young people need to be able to have the choice of face to face that might work for them, with a trusted adult and an ongoing service.

I agree that we know that services like Kooth, The Mix and text chat with Shout, and the crisis text Messenger provide vital support to enable young people to get help early on. The signposting feels critical, but we are offering it as an integrated model so that young people can have support face to face from those they trust, but for those kind of midnight moments when they are on their own, digital plays a key role. It is making sure that there is both, and that young people have access to appropriate face-to-face as well as appropriate digital support.

Q9 **Dr Evans:** Sophie, I have a personal interest in the impacts of body image and the way that affects young people. You mentioned eating disorders. Do you have any feel about where body image fits in currently,

both pre-pandemic and during the pandemic, with regards to mental health in young people?

Sophie Corlett: I could not give you a well-researched answer on that. From anecdotal information and the information that we have collected when we produce information—we do a lot of collecting of views from people when we do that; for instance, on body dysmorphic disorder—we know that people pick up views from all around and feed into things.

Very interestingly, linking back to the previous conversation around digital, there is an assumption that a lot of it comes from the digital space. We get quite different views from young people, who say that on balance they find the digital space more positive than negative for them. It is obviously quite a mixed picture, and I suspect it is quite different for different people. That is from our—

Q10 **Dr Evans:** Lynne, I see that your hand shot up. I would love you to come in and answer that because you are my next question.

Lynne Green: Thank you. I come from an eating disorder background, so I am also really interested in that area and concerned to see the rising numbers.

The numbers of young people experiencing eating difficulties have been rising for some time. This certainly is not something that has just happened as a result of the pandemic. To pick up on the point around digital and social media, I have three children of secondary school age, so I live with this. I think that social media generally and digital services are one of the things that has changed almost unrecognisably the way that our children and young people live their lives.

As somebody who has worked in the eating disorder field for a long time, I do not subscribe to the view that social media and digital services cause eating difficulties; absolutely not. There are so many benefits of social media. However, the role that social media can play is in worsening people's feelings of not being good enough and feeling that they have to strive to some often unrealistic and unhealthy ideal, whether that be about physical appearance or just generally. I think that is important. We know that those two things—the striving and the feelings of not being good enough—contribute significantly to the development of eating difficulties in people who already have some vulnerability and some risk factors. I think that is really important.

In terms of the Covid-19 pandemic per se, for all of us our sense of control has been threatened. Control and sense of control is generally central to people with eating difficulties. For the young people who are coming to us, that has been pivotal. It is not just that they are not necessarily able to access the service that they have been used to accessing or their traditional face-to-face therapies; it is about lockdown restricting, for example, exercise or being able to go to the shop and buy particular foods, as well as a sense of control generally for young people

about their future prospects. Are they going to get their exams? Are they going to get to college? All those sorts of things have exacerbated eating difficulties.

As we have already heard from Emma, there are two groups of people. We have people who already had existing difficulties that have worsened. We are also seeing people who are developing eating difficulties for the first time.

Q11 **Dr Evans:** There is so much to unpack there, and I could spend the next hour pulling it apart. Given the scope of what we are dealing with here today, I am going to take it right back out. A lot of what you talked about is mental wellbeing, stepping into mental health issues. The White Paper is currently being put forward to Parliament. There is an obesity strategy. There is fluoridation of water. What are your thoughts about mental wellbeing being something that is deemed a public health issue and, indeed, body image as a public health issue within that?

Lynne Green: Absolutely. Mental health and body image—all of the issues that we are talking about—are public health issues. Part of the difficulty is that we have looked to one service provider, predominantly the NHS, to solve our issues around mental health and eating disorders and so on. What will be so important going forward is that we see this as a shared problem and therefore find more shared solutions. That is public health, the NHS, social services, the charity sector, the private sector and the education sector. I really think that now is the time for us to start seeing this as a—

Q12 **Dr Evans:** If I can push you on that a little bit further, how would you get further upstream? They are interventions once someone has a problem. What do you see is the way to try to stop young people suffering from mental health and getting into those services in the first place? Once they are there, it is very hard to get them out by the very nature of the issues that have come along for months and built up. What could we do to prevent it from getting that way in the first place?

Lynne Green: I think that is right. I spent nearly 20 years in the NHS, primarily in child and adolescent mental health services. What we know about children and young people is that at best they are typically very ambivalent about seeking help. That is particularly the case for eating disorders. There are the general stigma-type issues. There is also a fear of, "Maybe I'm just not ill enough to warrant help," or, "Maybe all the control I've worked really hard to get"—for example through restricting diet, or exercise or a coping strategy such as self-harm—"is going to be taken away from me if I set my foot in the door of services." At worst, some young people are entirely reluctant to seek help, much to the utter despair of their parents and the people around them.

One of the important things that we need to do is to make sure that our services are not just high quality but accessible. Kooth, like other services, is anonymous. It means that young people can tip their toe in

the door without fear of loss of control, because the control is with them. You do not have the same traditional doctor-patient power dynamic. The control is with them and the ball is in their court. Of course, that enables us to get in early and provide the help that they need or, crucially, signpost them and support a referral to a specialist service.

Q13 **Chair:** Thank you. We are going to come back to eating disorders later. There is a lot to get through this morning, so apologies for moving on. I want to ask the panel about some of the improvements in children and young people's mental health that were being planned before the pandemic. One of them is very close to my heart and is a Green Paper that was published in December 2017, when I was Health Secretary, called "Transforming children and young people's mental health provision".

That promised a trained mental health lead in every secondary school, with a quarter to be in place by 2023. Emma Thomas, are we on track, in your view, to meet that commitment, and indeed the other commitments that were made in that Green Paper?

Emma Thomas: We really welcomed the work of the Green Paper. Recently, we have seen the aspiration to move from the 15% coverage of the mental health support teams and increase it to 35% with the recent funding. What we have not seen is the roll-out of the senior designated leads for training. We know that has been an impact of Covid, but it is unfortunate that it has been delayed. We understand that it will soon start to be rolled out.

What we are talking about with schools, and the start of that Green Paper, is a whole-school approach. It is not about one single teacher or model being right, but how you create a school that is informed and really basing its approach on the wellbeing needs of young people. The mental health support teams are a positive approach. We would call for them to be expanded, because we see that as an integral model for making sure that young people are not only supported earlier but are supported in their pathway to get that referral.

The senior designated lead is a teacher who can ensure that wider teaching professionals are also adopting this, but it is wrapping around schools. They are not meant to be mental health professionals, so it is about making sure they have the support. Balancing that training is key, and we would love to see it being rolled out as quickly as possible, with the mental health support—

Q14 **Chair:** Has that training actually started, Emma?

Emma Thomas: No, it hasn't. The tender was put on hold before Covid. In January 2020, the tender was paused. We have had—

Q15 **Chair:** Why was it paused?

Emma Thomas: At the time, the information did not come out. What we know is that since then Covid has been the delay. What we are hoping for is that the remaining budget that was allocated for that, the investment, will continue, and that the work can now start. We have not had an understanding as to why it was delayed.

Q16 **Chair:** That is a question for us to ask Claire Murdoch later. Sophie, could I bring you in? You have your hand up, so you want to comment on that, but can I ask you about something else in that Green Paper, which was the commitment to train 8,000 more professionals? That was so that we would have the service that Emma was talking about but, in particular, so that we could avoid the terrible problem that shames us all, where young people approach CAMHS and are told, "You're not ill enough yet. Come back when you are worse." Is that recruitment process happening, and is it happening at the pace it needs to so that we can deal with that issue?

Sophie Corlett: If I could comment on the mental health support teams, we are still waiting for the training for the designated senior lead. Also, for mental health support teams, we are still waiting for the evaluation. We know that they are being rolled out. We would like them to be rolled out beyond the 35% of areas. We need to know whether they are working, and whether they are working for all groups. As Lynne was saying earlier, some groups of people are less likely to approach services, so we need to know that those services are reaching some of the groups who often do not approach services.

There is a really important point about people who are referred on and whether they are able to get into something when they are referred. We know at the moment that about 26% of people who are referred are rejected by CAMHS. That is a group of people that one service thinks needs specialist help, but the specialist services will not take them in. That is a key group of people, and we are concerned about them, particularly because it seems to us as if—speaking anecdotally—the bar for getting into those services seems to be going up. That is really concerning.

We know that recruitment is a problem. There are still a lot of vacancies, but what is most needed on the staffing side is a multi-year settlement for funding, so that we can invest in training the people who need to move into those posts. Obviously, a single-year financial settlement is not enough to get people both trained and into posts. Both the training provider and the future employer need to know that the funding will be there in subsequent years to support that. That has been a big brake on the pace of recruitment. It feels a bit back-room, but it is an important fundamental for change.

Chair: That is something about which we will obviously ask Claire Murdoch shortly. Let me bring in Barbara Keeley.

Q17 **Barbara Keeley:** I want to go back to the question the Chair has just asked about the trained mental health lead in up to a quarter of schools

by 2023. I want to ask about alternatives to that. The other three nations are looking to have counsellors in all schools, and I have read that that works quite well. I have some experience of that in my constituency, with individual high schools having counsellors.

Is there a danger, do you think, that children and young people in England are going to be left behind? We hear about the slow pace and things being stopped at the moment. If other countries in the UK are going ahead with counsellors, is that something we should start to look at again?

Emma Thomas: As part of the whole-school approach, we agree that we should be careful that we do not presume that a single trained teacher will be solely able to ensure that we support young people as we need to in schools. Balancing the model of the senior lead being trained and the mental health support teams, and the opportunity for counsellors in schools, allows us to make sure that young people can talk to whoever is appropriate for them.

At the moment, there are varying numbers; around a third to 40% of schools have access to counsellors. They can play a really important role in early support and engaging a child over a number of times, as well as supporting the wider family. We would support looking at how we adopt a whole-school approach that is not just one model but allows for teachers to be trained appropriately to support their wider community, and to have the mental health support teams, but also to look at the important role of counsellors. It is about how we see this as a start and go further on what needs to happen within schools.

Sophie Corlett: I absolutely agree with that. We should make sure that people can be referred on to other services they might need. One of the things that we know from our pandemic research is that people have concerns about the situation at home, particularly around poverty and whether there is food on the table. There are all those sorts of practical issues. It is making sure that whatever service is set up in school not only works with teachers and parents on mental health, but on some of the practical things that might have led to people's mental health getting worse. It is a wraparound of the whole school and all the issues that might be affecting somebody. That could bring in the voluntary sector and local authorities, making sure that the school is well connected into what else is available locally.

Q18 **Barbara Keeley:** I understand that that is important. Do either of you have a preference around a mental health lead or a counsellor? When I have talked to counsellors working in schools, they know that some children come to them who would not go to a teacher. For some children and young people, it is very difficult to go to a person who is also teaching you to talk about your mental health problems, eating disorders or whatever.

Sophie Corlett: Yes. People want to go to different people. Some of the interesting things that we have again picked up through that research during the pandemic is that, when they were suddenly not at school, some people's route to finding support was cut off; they said they would talk to a teacher or a counsellor. Different people find different routes in, which is why it is important to have a whole-school approach, where all teachers are trained to know how to refer. The teachers do not have to take on the issues, but they need to know how to refer people. There need to be counsellors and other types of support and, I would say, community services that sit outside school, because for some school will never be the setting where they seek support because they are worried about privacy, or it does not feel a comfortable setting. It is about many routes for different people.

Lynne Green: I agree with what both my colleagues have said. I think the role of counsellors in schools is absolutely invaluable. When I left the NHS after 20 years, I joined the school-based charity Place2Be as their clinical director. They are an excellent example of how integrating counselling in schools makes a huge difference. I am a real advocate for that.

As has already been suggested, not every young person requires counselling. We need to be mindful of not pathologising difficulties that do not need to be pathologised. That is really important. We predominantly employ counsellors as our practitioners. One of the things that we have done in our service increasingly, particularly during the Covid-19 pandemic, is to recruit emotional health and wellbeing practitioners, who are not professional counsellors but come from backgrounds such as education, the criminal justice system or social services. They are people with good hands-on experience with young people. They are also in a good position to support some of the difficulties that do not require a formal counselling approach. It is a both/and.

Q19 **Barbara Keeley:** I have a couple of questions. We have had comments about the surge in demand, and eating disorders have particularly been mentioned. I understand that there are greater numbers of children restricting their food and drink. We were in a situation where rates of self-harm and suicidal ideation were going up anyway. We have had evidence of that since 2017.

What do you feel about what is planned? For eating disorder services, there are planned increases, but what is needed now, given what we know about the surge? How will existing services manage that surge, and should we have in any sense a different approach?

Emma Thomas: I think what we have seen between September 2019 and September 2020 is very worrying. There was a huge surge in referrals. That was pre the third lockdown, so there are concerns about meeting the demand. We know from the Children's Commissioner, who I am sure will talk about it, that there are varying levels of investment in CCGs in young people's mental health. It differs in comparison to the

investment into adults. We are all aware of the statistic that 50% of lifelong mental health illnesses start by the age of 14, so investing early feels critical. We welcome the £79 million that was announced in the spending review last autumn. There is much more that we need to be doing to support the NHS to be able to meet that demand.

In contrast, it is how we are starting to look at a holistic system. With the wake-up we have had around those two cohorts of young people needing help, we have to look at early intervention to make sure that we are not allowing young people to hear the message that they are not ill enough to get support. I would welcome support for those who need pathways into treatment.

As Lynne said, we have to ensure that we are not pathologising, and that young people get early support, so we need to place investment in youth services, the frontline supporting young people, with trusted adults around young people. We strongly advocate, along with others in the sector, the need for early intervention and open access hubs for young people, particularly for 17-plus young women and others we are not reaching. There are different groups, of different ethnicity and different levels of need, who are more likely to turn to community-based support. It is the same evidence in terms of impact but reaches different communities. That feels really vital.

Q20 **Barbara Keeley:** I understand that Mind and YoungMinds have both talked about open access hubs. Could you comment? Do you think that is the right model that we should be going for?

Emma Thomas: That work has come from the Children's Society, Youth Access and the Children and Young People's Mental Health Coalition. It is very much based on the evidence that we have seen from Youth Access members and the youth information, advice and counselling services model in the UK, and from Australia and Canada where we were able to learn how that allows young people to self-refer at an earlier stage, and present as an individual. It may start with a conversation about debt that might lead into wellbeing, but it allows us to look at the whole young person, rather than necessarily thinking about them from a medical point of view.

For me, the balance is between the brilliant NHS services that we need to support more and the in-school approach that we have with the mental health support teams. The missing third for me, and for others across the sector, is the community-based model, particularly for those for whom schools will never be the appropriate place to get support.

Chair: I need to move on. I will bring in Paul Bristow. Paul, could you direct one of your questions to Lynne Green because she has had her hand up for a while?

Q21 **Paul Bristow:** Of course I will direct it to Lynne, but I want to go back to what Barbara was saying about services that are available in schools. In

that conversation, and I totally understand that it is horses for courses, someone said that in certain schools there will be mental health leads and in other schools there may be counsellors, and for certain children it may be that community-led services are more appropriate. Others may just want to speak to a teacher.

I have met a number of schools in my constituency and a number of very impressive young people came to me to talk about mental health among young people and the impact of Covid. For them, what they felt was incredibly useful were peer-led sessions, where they were able to validate their experience of Covid and lockdown among their peers.

I do not know if you have any comments, Lynne, about whether that might be particularly useful. With all these flexible approaches, and this horses for courses, is there a risk that some schools will be left with no support and no idea how to approach this challenge post Covid?

Lynne Green: Thank you. I am really glad that you have raised the notion of peer support. We have a peer support option in Kooth. It is hugely important. Just as the children have shared feedback in your constituency, so the children we talk to at Kooth also tell us that that is a really important aspect of care.

Of course, with peer support, particularly for us in a digital online anonymous setting, it is important that the right governance is in place to support that. We have to make sure that everything is moderated, so that any information that is shared or communicated in a public forum is moderated by a real person to make sure that it is safe. I go back to my point earlier around social media. There is not the opportunity for disinhibition where people can use social media, either deliberately or non-deliberately, in a malicious way. I think that is important, but yes to peer support.

In relation to the wider issue about horses for courses, it is important that we have choice. Something that has not been mentioned yet today, and I am keen to stress its importance, is the use of data. We need more evidence to demonstrate that all these different approaches are effective. We need to be transparent about the data. We are talking lots today about working in partnership in integrated ways with communities. We have to be transparent and share our data, not only so that we can see what is working but so that we can see the different gaps in the different localities.

When we saw huge increases right across the board in eating difficulties, we also saw very specific increases in certain localities. We went back and tracked that against the national referral to treatment data and said, "Wow, the increases that we are seeing in area X are the same as the increase in the waiting times for area X." We start to see some parallels. When we do that, and we share our data, we can start working together to identify the gaps and look at the evidence of what is working in the

different areas, and put those interventions in place where they are needed.

Q22 **Paul Bristow:** Emma or Sophie, do you want to comment on my question?

Sophie Corlett: A big yes to peer support. We run a big digital peer support community. There are some people who find that so empowering. It is supportive, but also empowering to know that you can help somebody else. It is such a positive and confidence-building thing to realise that you can support somebody else. It gives people back agency and confidence for the future. It is a very powerful thing. It is a digital peer support service. We are a big fan at Mind of peer support.

On the wider question of horses for courses, and do you end up with nothing, I think increasingly across mental health we are learning, for adults and children, that there is a wider ability to get in through many different doorways. There is the voluntary sector, the NHS or debt advice services, whatever it is. There is a wider route in, and a wider range of services to support people with the different things that they might have going on in their lives, whether that is a practical, social thing that is part of the cause of their worsening mental health, or whether it is specifically around the mental health. Those are the things that work best for people.

If schools are more able to offer a mixed service that supports staff, parents and children with a different range of needs, I think that will be really powerful. Certainly, that is where the NHS is going with its community services, and where the voluntary sector and we around the table feel that we can also contribute.

Chair: Could I ask the panel to be brief in your answers because we are going to have to move on very shortly to the next set of witnesses?

Q23 **Paul Bristow:** I have one last question, picking up what Lynne Green said. You said what we need is data in order to bring this together. What do you think needs to be done to get an accurate picture of the impact of this pandemic on the mental health of young people? It is going to be a varying picture. There are going to be lots of different datasets and everything, but, if we want to get an accurate picture in order to inform policymakers, what needs to happen?

Lynne Green: I will try to be brief. In short, we need to make sure that we have fit for purpose outcomes and do not just rely on traditional outcomes that have been used, for example, during IAPT and other such things. We need to find out what is important for children and young people, and not make the mistake of assuming we know what they want. Certainly, in the 20 years of Kooth we have learnt that we have to listen to what young people tell us they want, and then we need to measure that. Some of the traditional ways of measuring outcomes do not do that. I would love to share a paper that we have written on exactly that, doing a bottom-up approach—a theory of change—to understand what our

services need to provide to meet the needs of young people. I would love to share that with you.

Chair: Thank you very much indeed, Emma, Sophie and Lynne for your excellent evidence this morning. It has set the scene extremely helpfully. We are very grateful to you for your time.

Examination of witnesses

Witnesses: Dame Rachel de Souza and Martin Lennon.

Q24 **Chair:** We now move on to our second panel: Dame Rachel de Souza, the new Children's Commissioner for England, and Martin Lennon, the head of public affairs at the Office of the Children's Commissioner. Thank you both for joining us this morning.

Dame Rachel, first of all, congratulations on your new role. I appreciate that you are brand-new. Perhaps you could start with your observations about the general state of mental health provision for young people in England.

Dame Rachel de Souza: Our report is clear on this. Services are improving, but they are not improving quickly enough. The gap between provision and need was big before Covid, but will have grown.

I have spoken to hundreds of young people and children during Covid. I was in school all the way through. Subsequently, in my role now, I constantly speak to children, and the one marked thing that stands out is that young people and children are telling me that mental health is a problem—theirs and their peers.

We know that before Covid there was an issue. There was a gap between need and provision, and that has greatly increased. Indeed, I am so concerned about that that my first act last week was to launch a Childhood Commission, which will have wide-ranging reach and will include the Big Ask, which will ask all children in England what problems Covid has caused them; what are the barriers; and what can we do about it.

Q25 **Chair:** You said that overall more needs to be done, even though improvements are being made. In terms of the practical changes, we have Claire Murdoch coming on next, who runs mental health for the NHS in England. What would be your priorities?

Dame Rachel de Souza: We have got children back to school now. We are coming out of the lockdown period. I would be keen to see, first off, the NHS reach out to school leaders, to show them how to identify some of the problems and the things that they can be doing.

I work with lots of schools. They are doing amazing things in the area of mental health and have worked incredibly well during the lockdown period, but there is a real concern: "What should we be doing now and how can we do it?" There is the instant thing, but what I want to see are

the mental health support teams rocket-boosted so that we can meet and exceed the targets and ensure that all the fantastic counselling work and digital work that we have been talking about continues. I hope that you will ask me later about some of the great things we have seen. There are some brilliant models in schools. We want to make sure that the system is built in a coherent way and that those services are supported. The child must have all those opportunities to get support and we must have coherent systems.

Different local areas are spending very differently on mental health services for children. There are some absolute stars. Grimsby and Thanet are way exceeding their targets, but there are others that are not. I am quite keen to see some accountability there, so that the good can be rewarded and praised, and that we can learn from that, and that the others can see what is possible.

Q26 **Chair:** The mental health support teams are very much focused on people with mild to moderate needs in order to try to deal with the prevention side of the equation. When you talk about people with more severe needs and people who need specialist care, do you think we are on track, as things stand, to meet the aspiration in the NHS 10-year plan that by 2028 all children who need specialist care will get it?

Dame Rachel de Souza: I think the commissioner's report shows that progress has been made, but it needs to be accelerated. Yes, there has been an improvement, but the uptick in need is big as well. I think we have to move much more quickly. We have had all those Government initiatives—the 2017 paper and the NHS 10-year plan. We have seen progress but I would expect to see more progress, and I would expect it to move more quickly.

Q27 **Sarah Owen:** Dame Rachel, you just said that you would like to see services rocket-boosted.

Dame Rachel de Souza: Yes.

Sarah Owen: In order to be rocket-boosted you also need fuel. How much funding do you think we need to see to close that gap and to meet demand?

Dame Rachel de Souza: That is a really good question. We have been looking at what the local area spend is on children's mental health. There is a big disparity between what is spent on children and what is spent on adults. On average, local CCG areas spend less than 1% of their overall budget on children's mental health and 14 times more on adult mental health. There is a clear disparity. There is funding, but there is also the way we are doing things and the joined-up-ness of them that we can pick up on.

Q28 **Sarah Owen:** Thank you. That leads to my next question. You talked about fantastic examples, but access to these services is still patchy and is not widespread across each region equally. What can we do to ensure

that services are equally spread, but also where we have particular high demand or challenging issues how can we be flexible enough to meet that greater need?

Dame Rachel de Souza: That is a great question, and the answers are not always straightforward or obvious. The two examples of local areas that are doing incredibly well were not very affluent areas. They were just areas that prioritised the issue. We need to look at what they are doing and share that practice.

I mentioned accountability, but I also think there is something about our schools and community services being able genuinely to support the lower-level issues so that they do not become higher level as well. It is that joined-up approach and support for the entry-level service as well. A lot of it is knowledge. Like I said, in one of my old schools—a 16 to 18 maths and science college with very academic pupils; we are totally inclusive but aiming for Oxbridge and the top 20 universities in tech—I have seen a high level of mental health needs. We had a senior leader who was absolutely trained in that area. We had a whole-school ethos that was supported. Everyone knew how to pick up children and young people with issues. There was lots of positive modelling and good relationships of referral to services, together with strong advocacy to get the specialist support that children needed.

The answer is at many different levels, but, back to services, clearly some areas are doing better than others. Spend is important, but we also need to look at their experience. Rather than just saying, "Yes, we are going to hit our 2023 target for specialist services," we need to look at those who are and those who are not, and have better accountability, and look at what is working well with those that are.

Q29 **Sarah Owen:** I spoke to young students who met me and presented a survey that they had done of students across Luton. They showed high levels of anxiety. At least 70% of the respondents said that they were anxious about how the next couple of years were going to affect their lives, basically, and how the pandemic had affected their lives. Do you think impact assessments on future policies would be useful when it comes to children's mental health and wellbeing?

Dame Rachel de Souza: Impact assessments, yes. You may have read in the press with our launch that I am passionate that we have a children's and young people's strategy that puts children's mental health and wellbeing, as well as the range of things that they are concerned about, right at the heart of Government. I am keen to see that. Nowhere is more important to me than Luton because my first headship was in Luton, so it breaks my heart to hear that. I will be making a beeline over there to talk to those young people and make sure their views are amplified.

Sarah Owen: Thank you.

Q30 **Neale Hanvey:** Good morning, Dame Rachel. I want to talk more about

social policy and its impact on the mental health of young people, particularly the normalisation of generational poverty and inherited deprivation and the consequences of that. Young people may have grown up in a second or third-generation household where mental health is a day-to-day challenge. They may be impacted by that. They may suffer themselves, or they may be a young carer, which brings with it a whole lot of additional challenges.

I am interested in some of the sequelae of that around drug misuse, alcohol abuse, gang culture and knife crime, to name but a few of the more pronounced elements. Within all of that, there is a much lower level of mental health problems that is rooted in deprivation and poverty. I wondered what your views were on how we tackle that root cause, while obviously we have a job to do with those who have found their way into mental health services as is.

Dame Rachel de Souza: In terms of ensuring that things are tackled well, I want to see the roll-out of the mental health support teams. I want to see that go quickly. That will not solve all the problems that you have just identified. Our schools, our community workers and our community services can do a huge amount.

I have seen schools on the Great Yarmouth coast, in some of the most deprived and neglected areas, achieve wonderful things and the young people are flourishing. They do it by a very honest appraisal of all the things that you have talked about. It is great teaching, but it also recognises that individual young people are under a lot of family strain and a lot of community strain. We need to support them. I have talked to head teachers who say, "I've just had to eke £17,000 out of my budget to make sure a particular child gets one hour of counselling a week and that will keep them in school."

The pandemic has transformed how teachers and schools see their work. Suddenly they have been looking into children's lives by doing online and remote learning. There have been loads of lessons learned, and people have been very responsive. Teachers, schools and communities have been very responsive about getting help. My feeling is let's build on that.

Q31 **Neale Hanvey:** Exactly. How you translate that from those areas of excellence to the wider population is the real challenge. One of the things that I have always held a view on is that, to change some of this, young people need to feel that they matter. They need to feel it. What are your thoughts on how you can influence policy change to help us enable you to do that, which is a very important piece of work? I am delighted with your response; thank you.

Dame Rachel de Souza: Indeed. Last week, we launched the Big Ask. We are going to use every avenue we can to get out and ask young people their views. I think you picked up the intergenerational things. It is the barriers to their success and flourishing. I will be working right across the children's sector and with every partner we can to put

together our plans for the Children Commission, and I would like to see every Government area putting children at the forefront. We are in a Committee discussing mental health today. Already NHS England have reached out to me about this. I know that they are committed to working with us to put children as the priority. That is what we aim to do.

Neale Hanvey: Thank you ever so much. That was fantastic.

Q32 **Barbara Keeley:** This is a question for Martin Lennon. What do you think are the main pressures on children and young people's mental health services that cause them to struggle to deliver the services that children and young people need? Specifically, how important do you think workforce pressures are? I think your office identified a postcode lottery in services as a problem. Is that persistent, and how can NHS England ensure that improvements happen across the piece, so that we do not get a postcode lottery of services for children?

Martin Lennon: It is a very good question. To start with the postcode lottery element, that has certainly been a repeated feature of our work over the four years that we have been doing the survey. It is very much a postcode lottery. It is not that some regions do better; even within one hospital trust, different CCGs can have radically different approaches.

Obviously, it is about local prioritisation. There is an issue with how NHS England have got their national targets. NHS England have a series of national targets but they do not have local ones. NHS England have met their national targets by some areas—in our latest report we pick out 50—that have done particularly well at increasing access. There is, therefore, no incentive to deal with the lower performing areas because it is a national target. There is a real danger that that polarisation will get worse.

We will now have mental health support teams that will come on stream in the next two or three years. NHS England tell us that they are absolutely crucial to them meeting the 2023 target to increase provision, so what we are likely to see is that some of our very good areas will now have mental health support teams added on top of that, and they are likely to get further ahead of areas that are performing poorly.

We would certainly see it as a key element of the NHS reforms that were announced a couple of weeks ago to look at the accountability of individual CCGs who are not prioritising this. It looks to us that the way that some CCGs, as we have seen in several successful ones, have managed to increase services much more quickly is through all the issues that were discussed in the first session. They have a more diverse range of approaches, working better with the voluntary sector and using existing staff but also existing training programmes and master's courses, and so on. Some of those will be in traditional therapies such as art therapy.

One of our worries about the approach that NHS England laid out with the MHSTs is that they are creating a whole new workforce. That very much slows down the roll-out. In some cases, we definitely know that services have been decommissioned because their existing staff were too highly qualified for that band 5 work. What we want to see is prioritisation of children's mental health in the commissioning and a wide range of different approaches so that you can speed up quicker, as well as all the issues you discussed earlier about better use of digital, and so on.

Q33 **Barbara Keeley:** How much are workforce pressures playing a part, particularly in the poorer areas that you referred to which are not delivering? Is it that, or is it that they are just not pulling it together?

Martin Lennon: It is hard to say how much workforce is in an individual area. One of the things that Rachel was picking up earlier was that a lot of our top-performing areas are in areas of the country that have traditionally struggled to accrue public sector workforces. Rachel mentioned Grimsby and Thanet, and Hartlepool is consistently one of our top-ranking areas for children's mental health. If those areas can recruit the workforce, why has, for example, west London, which has a cluster of very poor-performing CCG areas, been struggling for five years? I do not think that workforce can be the only limiting factor. There is a whole range of approaches that we see in other parts of the country.

Q34 **Barbara Keeley:** I have a question for Dame Rachel de Souza about the role of schools in providing accessible mental health support for children and young people, which we talked about quite a lot in the first panel. Are you concerned about children being in and out of school as a bubble or year group self-isolating, which may end up continuing to happen? It may be that their mental health problems—they might be in crisis—go unnoticed. We cannot stop the need for self-isolating, but is it time to reduce the continued use of practices like off-rolling and long-term exclusions? Children out of school, if they are battling mental health crises such as eating disorders and self-harm, are not going to be able to be helped, are they?

Dame Rachel de Souza: No one was more delighted than me to see the return of all children to school. Hopefully, we will never have to close schools again. I think schools are going to great lengths to ensure that, if bubbles, small groups or individuals are having to isolate, individuals are supported using digital and home visits; a range of things are going on in schools. Hopefully, that will settle down now that the vaccination programme has been rolled out.

Off-rolling is not legal and should not happen. Certainly, discouraging elective home education is critical, and Ofsted has a key leader to do that. The exclusions question is constantly and heavily debated. I think the answers lie in a range of places. I do not know anybody who wants to see exclusions or the exclusion of any child. Some of the things we have talked about around picking up early issues and getting the right support

early for children, particularly where we have behaviour issues very early in primary school, will pay dividends right the way through.

There are bigger structural answers as well. There are some great models of groups of schools, trusts now, creating provision within those trusts so that exclusion can become a thing of the past; and what would have been called alternative provision but does not need to be called that any more— really good provision that meets the needs of young people in terms of therapy, curriculum and providing a kind of revolving door back into the mainstream—can happen.

I think we are going to see a lot more of that. The APPG on exclusions is looking at different models, and I am hugely supportive of that. It is about picking up early needs, making sure that the whole child's needs are met with good provision in local areas that is part of the school's family rather than being put out. That has to be the answer. No one is more committed to that than me. Having worked in very disadvantaged areas, where schools had had difficulties in the past, I have had to manage some of those issues. They are the things that keep you awake at night as a head teacher. Nobody wants to do that, and we must find structural and individual support answers for children.

Q35 **Laura Trott:** Dame Rachel, you have talked a lot this morning about the mental health support teams. I have seen that at first hand locally with New Ash Green Primary School, which has been a trailblazer. Can you talk a little bit about the impact you have seen nationally of the support teams so far?

Dame Rachel de Souza: The support teams are in their very early days. I think most schools have not been impacted by them yet, but they bode well in the sense that you are seeing a great primary school doing amazing things and it is, hopefully, well supported by its local specialist services. What the impact will be is what I was trying to get at earlier. A strong mental health support team, with a key professional trained in school, can help lead that school in thinking about a good-quality ethos, mental health provision and low-level provisions right the way through the school.

One of my worries is that lots of schools want to do well but do not necessarily know how to. They are trying to come up with ideas on their own. They find a local counsellor and put together a package: "Is it the right thing?" I hope that the mental health teams, as well as adding capacity in providing the service to young people, will also add a good training and support capacity to help schools know that they are doing the right things.

Q36 **Laura Trott:** In terms of evaluation, because we have talked about lots of different options today and lots of things that are going on, all of which are very effective in their own individual ways, how are you looking at what you would advise is the most effective option from a Children's Commissioner perspective?

Dame Rachel de Souza: That is a great question. Martin, is it worth thinking about some of the evidence we have sourced in the past and then I can come in on the broad brush?

Chair: Could we be fairly brief? We have to wrap up this session fairly soon. Martin, you come in and then we will go back to Rachel briefly.

Martin Lennon: We would not be hugely prescriptive about what the model looks like. As we have gone across the country, we have seen loads of good examples that have worked slightly differently. It is important that there is a clinical model and that it is well evaluated, and that where all the different charities across the country—there is a whole network of them locally—have a good clinical model, that that is what is worked with and built on and you build on that capacity rather than imposing a model down nationally: "It must look like this," because that will undo the good work that is there.

Dame Rachel de Souza: The dream is that we have well co-ordinated services across every area. That for me is a 2028 all children's needs have been met vision.

Laura Trott: I have lots more to say, but I know that the Chair wants to wrap up. Thank you.

Chair: Thank you very much indeed. We have so much to get through, but we have had really good answers. Thank you very much, Dame Rachel, for joining us. If I may say, your enthusiasm for your new role shines through, and I think that bodes well. Thank you, too, Martin for your expert experience and putting it at our disposal this morning. We will take on board everything you say in our report, and we are very grateful for your time this morning.

Examination of witnesses

Witnesses: Claire Murdoch and Professor Kendall.

Q37 **Chair:** We now move on to our third panel to hear from those who are responsible for mental health in the NHS. We are delighted to have with us Professor Tim Kendall, who is NHS England's national clinical director for mental health, and Claire Murdoch, who is England's national mental health director. A very warm welcome to you both. As we always ask, could you pass on the Committee's thanks, and indeed Parliament's thanks, to all the mental health professionals across the NHS who have been working so incredibly hard during the pandemic? We are incredibly grateful for their work and their dedication.

I want to start if I may, Claire Murdoch, with a question about capacity. There are reports in the *Health Service Journal* this morning from senior clinicians that last week we ran out of child and adolescent mental health beds. Is that correct?

Claire Murdoch: We had child and adolescent mental health beds last week. We can get the numbers to the Committee if you would like them.

However, it is true to say that we are experiencing huge demand on our in-patient services. We know that there are a number of children and young people waiting for a bed. We also know though that through close monitoring they are receiving intensive packages of support at home or in paediatric wards. At the moment, we are absolutely satisfied that they are safe and well cared for.

The final thing I would like to say—Professor Kendall will say much more about this—is that we want to drive quite a radical change in the model of service, such that fewer children and young people need beds in the future. We are doing that by investing very significantly in community alternatives, which I am sure we will have the opportunity to talk about either later this morning or on a future occasion.

Q38 **Chair:** Thank you. Let me put to you what Rory Conn said. He is a member of the Royal College of Psychiatrists, Children and Adolescent Mental Health Division, and says that there has been a big growth in young people with eating disorders during the pandemic. I think we heard that from our earlier panel this morning. Very specifically, sometimes they need to be fed with a nasogastric tube, which is something that often cannot happen on a general paediatric ward. His concern is that there are some people who are not getting the safe care that they need. Is that the case?

Claire Murdoch: Professor Kendall may like to come in. Our model of care is that often the preferred place for children and young people with an eating disorder who need refeeding will in fact be a paediatric ward. Most paediatric wards in the country are very well versed at passing a nasogastric tube and other physical interventions. In most cases, the clinical model of care that is desirable is that children and young people with an eating disorder go to a paediatric ward for a short while. They will, and should, have mental health in-reach, making sure that the acute team and the mental health team are working together around the care of that child.

I certainly think that most paediatric wards and most paediatricians and their teams would be able to pass a nasogastric tube. The bigger issue is making sure that the psychological and mental health support is there. Indeed, the final thing I would say—Professor Kendall would be much better placed than I—is that the NICE guidelines that we are now trying to implement throughout the life of the long-term plan would actually suggest that we reduce, if not eradicate completely, specialist eating disorder beds for children and young people. The evidence is that generally they do not fare as well there as they would in a paediatric ward and then onwards to intensive community support. Professor Kendall has eyes on a lot of that research.

Q39 **Chair:** I will bring in Professor Kendall, Claire, but I have a final question for you. I want to check that you are satisfied, as the boss of NHS England's mental health, that everyone who needs specialist eating disorder care at the severe level is actually getting it.

Claire Murdoch: They are receiving it. I want to say, though, that we have seen a doubling in referrals. We will say more about that in a moment. We have seen a doubling of eating disorder referrals this year. There is something about the pandemic, which I am sure Professor Kendall will talk about more, that has led to a big increase in eating disorder referrals. A lot of our investment plans, and a lot of our focus currently, are to make sure that we have adequate treatment and support in place.

It would be fair to say that it is an area that we are concerned about, focused on and giving high priority to. I do not think that a year ago any of us anticipated a doubling in referrals in 12 months. We are working with colleagues, including the Royal College of Psychiatrists, our third sector partners, our paediatric partners and acute partners to understand this. I want to acknowledge that the system is working very hard to look after those children and young people.

Q40 **Chair:** Let me bring in Professor Kendall on that.

Professor Kendall: The truth is that the evidence around the treatment of eating disorders—I led the development of the NICE guideline on eating disorders—is that community treatment is probably better than in-patient treatment. Having said that, there are occasions when people become very physically ill, particularly if the time between the onset of the illness and them getting some evidence-based treatment is long. If that is a very long time, people present quite ill.

If we can get a service that avoids the use of nasogastric feeding as far as is humanly possible, I think that is preferred. The way to do that is to get in there quickly. There are still people who are getting nasogastric feeding. To be honest, that is probably best done in a physical health hospital setting. I am absolutely at one with Claire on that. That probably is the best place to do it, but you need mental health support in a paediatric setting. Where it works, that is exactly what happens.

Q41 **Chair:** Thank you. There is lots of ground to cover in our inquiry. I want to ask questions in three chunks, if I may. First of all, progress on the Green Paper; the broader question of in-patient units, which we have already touched on a bit, and their appropriateness; and then the biggest question of all, which is about whether we have the right model of care and whether we want to change the model of care altogether.

Claire Murdoch, I want to go back to the Green Paper and ask you a little bit about that. It was published in 2017 and promised that a quarter of schools would have mental health leads by 2023. Why was the training for those positions stopped last January?

Claire Murdoch: As you know, there are three components to the introduction of the mental health support teams. Thank you again for being the catalyst in Government for bringing them to fruition.

One component is the senior teacher lead; one was a piloting of the four-week waits; and one was mental health support teams in schools. We have been working jointly with the Department for Education on all three of those components, but it is true to say that the senior teacher lead is something that DfE is leading on. It is their responsibility to deliver that. There was a hiatus with that last year in the wake of Covid. I think you are best to ask the Department for Education about that.

Q42 **Chair:** We will, but perhaps I could ask you, because you are responsible and you are our contact point into Government, to write to us when you have spoken to the Department for Education about that. My concern is why it was stopped in January. I had understood that it had stopped during the pandemic, but January was before the pandemic. From your point of view in the NHS, and from Professor Kendall's point of view, I want to check that it is still a very important part of the plan to have trained senior leads in schools who are mini experts on mental health.

Claire Murdoch: It is a really important part of the plan. The changing model that you are talking about is very much earlier intervention, providing more support to youngsters who experience mild to moderate mental health problems. We want the mental health support teams to be bedded into schools that are also running a whole-school approach to psychological and emotional wellbeing. Those senior educational leads are a pivotal part of the model, as are school nurses, GPs and others. The mental health support teams will deliver at their very best when they are nested in a whole-school approach.

Q43 **Chair:** When you write, could you let us know whether you think we are on track to deliver them to a quarter of all schools by 2023, which is the aspiration in the Green Paper?

Let me ask you about the others you mentioned. What is the progress on the four-week waiting time for mental health services?

Claire Murdoch: We have been running 12 pilots, looking at how we understand the delivery of four-week waits, what we need to do, how we measure it and what the workforce and investment needs are. There has been some disruption to that with Covid, but we are on track—we are writing our report now—to be part of Professor Steve Powis's clinical review of standards. We are working with Steve Powis at NHS England, our chief medical officer, to ensure that our findings are part of that review.

We are on track. We have had to work very hard. There was definitely some hiatus throughout Covid. Over the last year, we gave clear instruction to the services, given what we knew was happening with children and young people's mental health, to put their main focus on delivery and responding to the increase in referrals. We are very much committed to that work. It is appearing in Professor Powis's clinical review of standards.

Q44 **Chair:** I think there is progress being made on the mental health support

teams, but the Green Paper talked about the need overall for about 8,000 more professionals to be trained up in order to deliver the very big ambitions. How far are we towards that 8,000 target?

Claire Murdoch: We are making really good progress. We have seen huge increases in the numbers overall of children and young people's workforce. We can give you more numbers on that, but it is very impressive. I do not have the actual number of therapists trained to date, but I can tell you—maybe even by the end of this session; I might be able to find it in my notes—that we are confidently on track. We now have 13 universities training therapists. We have 180 teams in place today, with a further 104 teams coming on train this year. We will have 400 teams in place now, and we are very confident of our 2023 ambition. In fact, the £79 million that was announced by Government two weeks ago for additional CYP recovery post the last year will enable us to go further faster by 2023.

Chair: Thank you. Would you write to me and tell me how many of those 8,000 you have recruited? That would be helpful.

Q45 **Dr Evans:** I have a very quick question for Claire Murdoch. From the anecdotal side, having dealt in particular with CAMHS, one of the key things when I worked all around the NHS—I worked in about five different geographical areas—was always the delay. The example is a child who has come in at 12 or 13 and is starting to cut. You would refer them to CAMHS and they would say, "They're not severely ill enough," or there would be a very long waiting list. Another one would be a query diagnosis of autism, and it would take 52 weeks for someone to be seen to get a diagnosis worked up.

Part of that is because it is clinically quite difficult to do, but you are left as a GP trying to manage the initial assessment and a patient potentially with autism to get their support with no help for the parents. Is that your assessment of what you think is happening at the moment? What is being done to try to address that?

Claire Murdoch: For sure, when we first set out the five year forward view for mental health, and then more recently the long-term plan for mental health, we absolutely acknowledged the rather low starting point for children and young people's services. When we began back in 2016-17, we were at something like 25% of all children and young people who needed a specialist intervention receiving it. That is shocking. Our whole plan and long-term plan to 2023 and five years beyond that, where we set out the ambition to make it 100% of all children and young people who need specialist intervention receiving it, has been about increasing access and covering more of the population. We set an ambition that we would get at least 35% coverage and greater access. We are hitting that.

Q46 **Dr Evans:** What do you define as access? This happens in adult mental health care as well. It is for the people who are in the middle. They are not going to go and throw themselves off a bridge; they are equally not stable and being monitored for the long term. It is the people who need

some form of support within about three to four weeks. Access often means a telephone conversation and an assessment. Then the NHS can tick and say, "We've done that," but then there is a great big, long lag to actually getting the follow-up treatment. Could you define access in your terms for me?

Claire Murdoch: The way we have been measuring it to date is access from referral to first assessment, and then second appointment. We are looking at the two combined at the moment, to make sure that it is not just, "We've had a telephone call; Jack will be fine. Refer back to us if needed." We have been looking at the two and treatment within that.

The important thing is that the mental health support teams will be there for mild to moderate disorders or distress. The whole point is that we work very closely with primary care and schools around youngsters who may not be severe but could become so. In addition, of course, we are expanding the CAMHS offer. We have doubled the amount of CAMHS, both workforce and activity.

Q47 **Dr Evans:** My final question is about the transition for those aged 16 to 18 and going into adult services. There has always been a difficulty. You get to 18, you are deemed to be an adult and the service all changes. It is one of the biggest points that is often raised locally with me as an MP up in Leicestershire. What is being done to address that smoothing between the two and the transition?

Claire Murdoch: We have absolutely identified that 18 to 25-year-old cohort. We are trying to redefine what we mean by young people through the long-term plan. It is unacceptable that because somebody has an 18th birthday all of their care changes. That is not needs led; it is age dictated. Currently, we are working with services across the country to look at how we need to change models of care that do not automatically transition at the age of 18. If necessary, we will keep people until they are 19, 20 or 21, and it will be based on need. We are working with clinicians, including the Royal College of Psychiatrists and others, on what that model of care needs to look like.

We have additional investment that sits behind that. As we have always done, we are doubling down on the quality of transition when it happens. There is no excuse, when a youngster who has been living with complexity and needs to transition at some point to another service, for that to be hurried or for them or their family not to be involved. Indeed, we have issued guidance. We have run webinars and support on best practice.

Chair: I am sorry to interrupt, Claire. I am going to come back to transition issues shortly. I want to bring in Rosie Cooper now, if I may.

Q48 **Rosie Cooper:** Claire, could you indicate why local authorities have been given responsibility for child health visiting, when local authorities are pretty much cutting millions out of all those services? Surely, you should be advocating that services with a mental health component return to

national health service control.

Claire Murdoch: Health visitors and school nurses are a pivotal part of good child health. Health visitors, particularly in the early years, the early start, are pivotal. In whatever model, the fact that they work in an integrated way with CAMHS services and others is essential. I am afraid that it is for Government and others to look at where those services sit.

What I can be absolutely categoric about is that you have to work in an integrated way. I can give the example of our specialist perinatal mental health services. Having embedded health visiting as part of those maternal mental health services is vital.

Q49 **Rosie Cooper:** Where do you think they should sit?

Claire Murdoch: As I said, I think that has to be a matter for the NHS, for local government and for Government, but my own view is—

Q50 **Rosie Cooper:** You are the person who is advocating these services. I am asking you where they fit.

Claire Murdoch: I think that they have to work cheek by jowl in the NHS and as part of the NHS in an integrated team.

Q51 **Rosie Cooper:** That is one of the problems mental health has. We need very strong voices fighting for these services. I know this is a public forum, but we need the people at the helm saying clearly what they believe. Most of your colleagues would surely say that giving more work to local authorities while they do not have the resources is a complete non sequitur. It just doesn't make sense.

Could I address a comment you made earlier? When you were asked about CAMHS beds and the number of beds available, I believe you said that we should reduce CAMHS bed dependency, including for those with eating disorders. There do not seem to be any CAMHS beds nationally available. I appreciate that I am easily confused, but some of these answers do not tally up in my head.

Claire Murdoch: I hoped I was clear that there is definitely pressure on CAMHS beds. I was responding to the "there were no CAMHS beds last week." That was not true. There were CAMHS beds last week. However, there definitely is real pressure on beds. Part of the pressure on beds is because we have yet to build more effective community alternatives. We are well on the way; we have a plan; but we have to have the effective community alternatives in place.

Q52 **Rosie Cooper:** Claire, is it true that you think we should reduce the number of CAMHS beds? These are the conundrums that I cannot follow.

Claire Murdoch: For example, 200 of the CAMHS beds that we use each year are for youngsters with learning disability and autism. We have given a commitment to reduce admissions of young people with learning disability and autism from 200 to a much lower number by 2023. That is because of the evidence, and because parents and the young people

themselves all believe that admission is more harmful than it is beneficial, but it has been necessitated in many cases because of the model of care and lack of investment in the community.

Of the £2.3 billion that we are investing every year by 2023, £904 million of that—a huge percentage—will be for children and young people's community services and community alternatives. The Green Paper is actually coming in at £249 million a year on top of that as well. Professor Kendall talks about this really well. It is about making sure that in the short term we have the resources that we need to care safely and effectively for our young people, but not consigning them to admission if what is required, and it is, are intensive community alternatives.

Q53 **Rosie Cooper:** I have no doubt that we will have to come back to that. Is it true that CAMHS is not in the mental health investment standard?

Claire Murdoch: That is absolutely not true. The mental health investment standard commits to spend recurrently more than the uplift for the whole NHS. Within that, the commitment is that CAMHS growth—child and adolescent mental health investment growth—will grow at a faster rate again. Mental health should grow at a faster rate than all of health, and within that child and adolescent mental health should grow at a faster rate. When we measure that from 2017-18 until today, or this month, we can see that we are fulfilling that commitment and that we are on track with the growth we have promised. In addition, of course, we are very glad to receive the additional £79 million this year, which we very much need to help us recover from the trajectories and the treatment and care from Covid.

Rosie Cooper: Thank you.

Q54 **Chair:** Time is marching on and we have two very important issues that I want to cover with both of you, if I may. The first is about the general use of in-patient units.

Professor Kendall, I know that you have been doing a lot of work to reduce the number of out-of-area placements, and to reduce the use of seclusion and restraint. Could I ask you whether we should consider being even more radical? In other countries, Italy in particular, they have gone even further because of the risks that any in-patient unit ends up, whether you like it or not and even with the very best of intentions, turning back into the old asylums that we have been trying to put behind us for decades. In Italy, it has been illegal to admit people to new mental health institutions since 1978, following pioneering work in Trieste.

We thought we had closed the asylums here, but we still have around 5,000 people in medium to low-secure units, and around 5,000 people in so-called locked rehab. I know that even in Italy they have not succeeded in abolishing secure units for young people, but should we be bold and look at the Trieste model here?

Professor Kendall: I will be completely honest. I am a big fan of the Trieste model. I am a big fan of what they have done in Lille in north-east

France. What they have effectively done is reverse things. If you go back 10 years, we were spending about 20% of our budgets on community services and 80% on in-patient services. They have, effectively, reversed that.

Back in 1978 when they closed the asylums, in places where they had great community services such as Trieste it worked fantastically. But when you looked at other parts of Italy where they did not have great community services, it was quite a disaster. You ended up with what they called "abbandonati", basically people who were let out of the asylum and had nowhere to go.

I think what we are doing for children and adults in the long-term plan—Claire has already referred to it—is making as big an investment as we can to build up our community services. As soon as we can, and as the pressure on beds gets less and less, we should get to the point where we can start to slim down the beds, not entirely but to a very high-quality in-patient service for very risky children, young people and adults. I think much much smaller is the right way to go.

Q55 **Chair:** Barbara Keeley wants to ask about whether we have some structural problems that make that difficult. Let me bring in Claire Murdoch on that point. If you look at that very radical model in Italy, which is, I suppose, a way of putting a straitjacket on the system to force more investment in community facilities, do you think that is something we should consider?

Claire Murdoch: I am certainly a very big fan and advocate. As you may know, I worked in the NHS in mental health for 37 years. I am still a registered nurse. I absolutely believe that in nearly every case it is better to wrap support round an individual at home or in a safe place in the community.

I referred earlier to our promise around children and young people with learning disability and autism. Currently, it is 200 a year, which we want to bring down to maybe fewer than 20 being admitted. If we admit, it should be for a really good reason and a clear purpose. There should be good review before, during and after. We should be putting them back home and supporting them to be with loved ones in their communities much sooner. Everything that we are investing through the long-term plan—it is a significant investment; more than £1 billion to 2023—is about strengthening the community alternatives: the crisis lines, the intensive support teams, looking at respite beds in the community closer to home, and so on. That has to be the right thing going forward.

Chair: Let us go into some of the details. Barbara Keeley wants to talk about some of the issues.

Q56 **Barbara Keeley:** Yes, I do. I am a bit surprised and a bit taken aback. There seems to be just an acceptance of this, which to me is pretty unacceptable. We are talking about 225 children with learning disability

or autism in mental health wards; 81% of those have autism. It is hopeless. It is not the solution, is it?

Whatever you say about feeling comfortable about levels of investment in the long-term plan, we are talking about children with a learning disability and with very long stays in those units. On average, it is 199 days. Only three in 10 have an agreed date for transferring out of the ward. There is a secondary issue of children on adult mental health wards. Children should not be on adult mental health wards. In the statistics I have, 205 children are on adult mental health wards.

Distance from home is another factor. I have met and talked to many parents. In a lot of those cases, 21% are living 50 miles from home; 7% are more than 100 miles from home; and 2% are over 150 miles from home. Some parents, even before Covid, had to make it a day, a week or a month in travelling to get to see their child in those units. I think that is not acceptable.

I want to ask about restrictive interventions first. Not only are those statistics unacceptable, but the level of restrictive interventions has rightly had a lot of attention in Parliament, with 2,500 under-24s subject to restrictive intervention; 616 restrictive interventions are on under-18s. Do we have a picture of fundamental failure to understand the needs of children, particularly autistic children and children with learning disabilities? That is what it seems like to me. I do not accept a picture where we start to talk about 2023 when we are talking about children.

Claire Murdoch: I am so sorry if I have given the impression that I think it is acceptable or desirable that we have those children and young people in hospital. Everything about our plan, with the money we have been given by Government—

Q57 **Barbara Keeley:** What you are talking about is too long term.

Claire Murdoch: We would love to go further faster. We can only operate with the money that we get from Government. We have £2.3 billion for mental health and more than £1 billion of that is for children and young people. We will strain every sinew, and we are doing that. We have seen huge increases. We are seeing a record number of children and young people in the community this year. We can show the growth year on year, and we are making real progress.

However, I do not for one minute defend the fact that children and young people are going into hospital or receiving care that is substandard. I absolutely endorse your point that of the 200 children and young people with learning disability and autism we have admitted, 81% of them have autism. That clearly shows that the plans we have to invest further in things like eight senior children's intervenors whom we have asked to go into hospital and look at—

Q58 **Chair:** Claire, may I interrupt for a moment? I am sorry, Barbara. The thing that is puzzling me is that community treatment is usually cheaper than in-patient care. While I fully accept that resources are often the

issue, the real question we want to know is, with the resources we have, why are we not going faster to reduce the use of in-patient care for people for whom it is clearly not appropriate?

Claire Murdoch: As we said earlier, the numbers of in-patient beds have stayed stable. They have not risen. The reason that we have not opened more beds is that, fundamentally, we want the money we have to go into community alternatives. We have heard here today, and we have all the data that shows it, that there is a big increase in demand. There is a 22% increase in referrals and a doubling of eating disorder referrals. We have absolutely sought not to invest more in in-patient beds but in the community alternatives, in the face of the NHS seeing more children and young people than it has ever seen before.

The proportion of care and treatment, if you like, is visibly growing in the community and not in in-patient services. Our plan is moving very fast and in line with our promises. Yes, of course, if Government could invest more and we could go further faster, we would love to do that, together with our partners in education, local authorities and our third sector partners. Of course, we would like to.

Q59 **Barbara Keeley:** Let me interrupt you. It seems to me, and I have thought around this issue for a while, that we need a system of moving or shifting the funding from the in-patient units to the community. You are talking about £904 million. That is a very substantial amount if you shift it into the community.

When we moved people out of long-stay mental health institutions years ago, there was a system of substantial dowries that attached to the person when they came into a local authority's control, because they needed housing and maybe 20 years of care. Why don't we have a system of shifting the money from the in-patient units, which are not desirable places and where we have those awful restrictive practices and everything I just touched on, into the community? Why do we not have that?

Claire Murdoch: Well, we do—

Q60 **Barbara Keeley:** If we go by what you say is a long-term plan, we are going to be fiddling around with this for years. The numbers of children with autism and learning disabilities have gone up over recent years, not down. We have had targets of reducing the use of those units to nought and it has not happened. What can we do? What mechanism can we develop to make sure it happens?

Claire Murdoch: The mechanism that we have given a lot of time and attention to in the last two or three years is the introduction of provider collaboratives. We can write about what they are, but the whole ethos of them is that in 2012 we saw separate funding streams for specialised in-patient care and community services, run by specialised commissioning in CCGs.

Q61 **Barbara Keeley:** I do not think that is an answer. On the provider collaboratives, you have the very people who are profiting from those units carrying on. Part of the provider collaboratives are the people who are providing those places at a very expensive cost. The Chair might have more questions, but I do not think that provider collaboratives are the answer at all.

Claire Murdoch: I think provider collaboratives will be a really important part of the answer. There is a separate issue, which I hear you on, which is: should the independent sector be part of NHS-led provider collaboratives?

Barbara Keeley: They will want to keep the status quo, and the status quo is that they are making incredibly large profits from this—hundreds of millions of pounds. If you include them in the provider collaboratives, you are not setting up a system that will change anything. I am aware that I am hogging the questions.

Chair: No. The problem we are wrestling with, Claire, and I do not think you are on a different side from us on it, is whether there is a structural impediment to changing to more community care, simply because some providers are making a lot of money from providing in-patient care, and also because some of the community provision has to come through local authorities, which have different funding streams.

We will come back to this, and we may even ask you to come back at the end of our inquiry and ask you the same question again. I might ask you to reflect, when you write back to us, on whether there are structural impediments to speeding up the process. I think the frustration we feel is that we are all agreed on the principle that in-patient care can be very dangerous for people with mental health needs—it can make things worse, not better—but we are worried about the structures that make it difficult to enact the good intentions that I had as Health Secretary when we worked together before, but still seem to take forever.

Barbara, do you mind if I leave it there because I want to bring in Rosie on this point?

Barbara Keeley: We did not hear from Tim.

Chair: I will bring in Tim in a moment, if I may. Let me bring in Rosie first.

Q62 **Rosie Cooper:** Revisiting my confusion again, there is a waiting list but there is no shortage of beds. We need to have young people treated in the community, yet I recently heard of a young person with learning difficulties waiting in an emergency room, not for hours, not for days but for weeks, for an assessment by a CAMHS team. That is getting them out into the community, so they waited weeks.

Claire, how can you say that things are improving if that happens? We are not providing the in-patient service, and we are pretty poor at doing the community stuff too. I am confused. The only people paying the price for this are the young people. We need your help, and we need some

clear thinking on joining up the dots. I am very confused, so God help the people who are desperately in need of your services.

Claire Murdoch: Obviously, what you describe is completely unacceptable.

Rosie Cooper: How can—

Chair: Let Claire answer, Rosie.

Claire Murdoch: I have tried to clearly acknowledge that we have seen a doubling in referrals this year alone. We started from only 35% of children and young people who required treatment receiving it. We have a 10-year plan to turn that round. We have resource to do it for five years, to 2023. To the Chair's point, I think that the NHS can demonstrate at every turn that we are making good progress in the face of considerable pressures. Where we are making a commitment, we are delivering it.

I would like to take this opportunity to thank colleagues across the country who have absolutely strained every sinew to do that. We need our other partners to have the investment and an equivalent plan, whether that is in education, social care, in the third sector and the charitable sector or in community groups, because we know that this requires a fully integrated approach to intervening earlier in the early years, supporting parents and avoiding the point of crisis.

Chair: Thank you. Rosie, I am so sorry. I have to move on because we are running out of time.

Q63 **Rosie Cooper:** All's well, except if you are a child with mental health issues.

Claire Murdoch: I have not said that.

Q64 **Chair:** We understand that. Tim Kendall, do you want to come in on Barbara Keeley's point?

Professor Kendall: There is a structural problem. The structural problem we are trying to solve is that all the in-patient beds are run by specialist commissioning, separate from the local community. The first step of that structural problem, as Claire said, is repatriating those beds to local communities. That is what the provider collaboratives do.

Although I absolutely understand what Barbara was saying, and probably Rosie too, that is not enough. Those beds have to be owned and integrated into community pathways. In the long run, the community pathway should take over, and that should be the prime—

Barbara Keeley: But that is why I raised the question of dowries. This is very important. You are talking about beds. Those young people should not be in beds in units. Those young people should be in a home. They should be in their own home in the community, supported by community resources.

I feel very strongly about this, as I think you can see, but you are accepting very long timescales. We have been struggling with this for 10 years. It is 10 years, for instance, since Winterbourne View, coming up this year. Ten years, and this is all we have achieved: the numbers of children and young people in these units have been increasing.

You can see you have a barrier. I have made the point that provider collaboratives are not dealing with it. You need a different solution, whereby money is transferred. Beds should not be transferred and integrated, but resources to support somebody are transferred. Claire Murdoch is saying that partners need to shape up. Partners have had their funding cut and cut and cut. You cannot expect social care to come up with funding to replace the hundreds of millions on these in-patient units. Let us leave it there, Chair. Thank you.

Q65 **Chair:** It is a very important issue. This is the opening session of the inquiry. What we have done, in a way that is better than I have seen on any other inquiry, is to flesh out the issues. We need some help with the solutions, and I would ask you, Claire and Tim, to consider writing a different type of letter to us from the normal letter, which is, essentially, putting the case for the defence, and to think about those structural impediments. The thing that is worrying us is how long it is taking. I know that because I was a Health Secretary who failed to make rapid progress.

I am going to move on, Claire, because I have to ask you both some final wrap-up questions. They are slightly different from what we have done, but I do not want to close without doing them and we do not have very long.

I have a quick question about transition. We came across a model in Australia called Headspace, in Melbourne, where they have remodelled their CAMHS service into two parts. There is the under-12s part and services for 12 to 25-year-olds, to seek to avoid the cliff-edge transition. It is an integrated service pulling together mental health, general practice, sexual health and addiction services all under one roof, for young people. Do you think there is any potential in looking at something similar here?

Professor Kendall: I absolutely think that we should look at those kinds of things. What we have been saying, throughout the long-term plan particularly, is let's try to find the best way of doing this.

I went up to Birmingham where they have a nought to 25 service. You go in and there is a great chief exec who took me round. I was really impressed with all the stuff they had done. Then she said, "Let me introduce you to the early intervention in psychosis consultants. I did tell you I would show you everything." They were so fed up. They could not have been more fed up.

What they said was, "Look, there is a transition now at 25, where people fall off and there is a problem." I was very much aware that there were

some positive things about the nought to 25 all in one. I know about the Melbourne stuff, where it is nought to 12, and 12 to 25. It also sounds like a smart way of doing it.

Q66 **Chair:** I want to bring in Claire, and then I want to come back with one more point.

Claire Murdoch: I tried to make clear earlier that all the neurodevelopmental evidence, and all the social evidence on development, shows that you are not fully developed as an adult until you are 25. Eighteen is a purely arbitrary historical figure. We have tried to organise services around something that is age based and not needs based. There is a very strong argument that we should be integrating. We have been talking more about 16 to 25-year-olds, but we are inviting different parts of the country to use the new investment moneys to set up radically different services, share the learning and push a different model. I am sure that is right. At the very time when young people experience exam stress, sexual identity and moves into university, college, work or worklessness, that seems to us to be the wrong time to change their care needs. We think that is a very exciting possibility.

May I correct one thing? I absolutely did not mean to give the impression that I am being critical of local authorities for not investing more. I wanted to give the impression that local authorities, education and others need the investment in order to be able to meet the needs.

Q67 **Chair:** Thank you. This is our final question. We have not touched on it today, but it is obviously incredibly important in the mental health world to cover suicide. There is a very specific question I want to ask.

We talk across the NHS about preventable death and avoidable death, but all the statistics about preventable and avoidable deaths do not currently include suicide. To what extent should suicide be considered preventable?

Professor Kendall: I think that in some settings it is better to start with the idea that it is preventable. For example, in any in-patient setting I think we should be saying, "Look, this is preventable." That does not mean to say that it is predictable, and therein lies a bit of a problem for us. If someone is consumed by dreadful feelings and yet is able to plan and execute to kill themselves, sometimes that is not possible to predict. I think that in in-patient settings, in the main, we should be thinking of these as preventable.

There is no doubt that we have reduced the suicide rate in in-patient settings by 50% in the last six years. We have also reduced the suicide rate within mental health services, which would be my next area to look at as preventable.

Q68 **Chair:** My question is this, Tim. We have, when it comes to physical healthcare, very respected studies like the Hogan and Black study, which said that about 4% of hospital deaths have a 50% or more chance of

being preventable. We do not have equivalent studies that I am aware of that look at the 6,000 suicides we have every year and say, "This number of them had a 50% or more chance of being preventable if the care had been as it should." Would there be merit in commissioning such a study?

Professor Kendall: Yes. Currently, we have the national confidential inquiry, which you know about certainly as well as I do. The national confidential inquiry into suicide and safety has identified the key things that underpin deaths that we might have been able to anticipate. We know what the key risks are, and we have built a national suicide reduction programme that uses most of their findings as a way of doing that.

I am guessing that your thought is, should we have a Hogan and Black-type approach to suicides? We could not do it in children. There are two suicides a week in children. That is 100 a year, and the numbers are not there to be able to do a Hogan and Black-type of study. Could you do one for suicides across the board? There are 1,400 suicides of adults and children in mental health services. I do not know if the numbers are there to do that kind of detailed analysis. It is too rare an event, but I think we should be advancing on what the national confidential inquiry has done and looking at those across the board, which we are doing.

Q69 **Chair:** Would you look into that for me? I want to bring in Claire now on this. The issue for me is whether we should be trying to quantify it. If it is a low number, you only need an independent case note review of an even smaller sample size. I think it would be very helpful to have a sense of the total number of suicides we have, and how many we estimate that, with just doing the things we know we should be doing, we could be better at preventing. Claire, is that something you would be willing to look at?

Claire Murdoch: For sure, yes. We have the national child mortality database, where all deaths of children are recorded and reported in real time. We have a group of paediatric mental health and other experts who review that database on a weekly basis, or in fact every day if something comes in that is surprising. It is where we picked up the additional child Covid syndrome.

Part of what those experts look at as they review each of those deaths, including potential suicides that turn out to be actual child suicides, is what the modifiable factors were. What were the things that may have given a different outcome? There is a report coming out in the spring from that group that looks at that. We have a very solid foundation, particularly for children and young people, upon which to build our understanding of each of those terrible deaths.

Q70 **Chair:** I think what I am looking for, Claire—perhaps you could write to me with your thoughts—is whether you would be willing to fund something a bit more like the Hogan and Black analysis, which helps to quantify the whole, because these are such horrific events. Is it 40% or

60% that could have been prevented if the right care had been in place? It has been very helpful in other areas of patient safety as a kind of wake-up call to get everyone rethinking their processes and re-questioning the terrible trap that you can get into of sometimes thinking that these things are inevitable. If you could possibly write to me, that would be very helpful.

Claire Murdoch: Definitely. May I say that we do not think they are inevitable? During particularly this last year, where we have all been so concerned about our young, the group that has looked at the national child mortality database has reported regularly to the mental health team. For example, Professor Kendall, myself and others who are national clinical experts in children and young people's services have convened webinars. We have shared any learning from deaths where we think there may have been factors such as autism that played a part. We have driven hard the ask to the system to identify any child or young person who they think may be particularly vulnerable, and used what we could glean from that mortality database to inform real-time work. We have begun that, and I think your request sounds eminently reasonable.

May I say that Headspace actually began in the UK. It came from us. I am glad that we have exported it. The thing I take from here is that you would be interested in hearing how we are embedding that in what we do and what we offer.

Q71 **Chair:** Maybe it is like vaccine components. We need to export them and then re-import them. The last word to Professor Kendall.

Professor Kendall: You will be relieved to know that Aidan Fowler, Louis Appleby and I are already discussing how we could look at suicides from the sort of angle you are talking about, given that the numbers are on the low side. What is the way that we could do this, so that when someone looks at deaths they can say, "Look, on par we think there are probably too many deaths here and that these could have been avoided."? It is that kind of position we want to get to.

Chair: Thank you very much indeed. It has been a long session. We have fleshed out a lot of ground, but it has been a very positive session and I think you have given us a good start to our inquiry.

Claire Murdoch, Tim Kendall and the earlier witnesses who I can still see are tuned in, Sophie and Emma in particular, thank you very much for joining us this morning for a very thought-provoking session.