HOUSE OF COMMONS

Health and Social Care Committee

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

Tuesday 20 April 2021

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Watch the meeting

Members present: Jeremy Hunt (Chair); Paul Bristow; Rosie Cooper; Dr James Davies; Dr Luke Evans; Barbara Keeley; Taiwo Owatemi; Dean Russell.

Questions 72 - 129

Witnesses

I: Lucas, Activist, YoungMinds; and Hope, Founder of the #DumpTheScales.

II: Professor Pat McGorry, Youth and Mental Health, University of Melbourne, and Director of Orygen Youth Health, Orygen Youth Health Research Centre, Victoria, Australia; and Cassandra Harrison, Chief Executive Officer, Youth Access.

III: Professor Peter Fonagy, Head of the Division of Psychology and Language Sciences, University College London; Dr Aleisha Clarke, Head of Child Mental Health and Wellbeing, Early Intervention Foundation; Tim Bowen, Head, Maple Primary School, St Albans; and Shanti Johnson, Deputy Head, Maple Primary School, St Albans.

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Examination of witnesses

Witnesses: Lucas and Hope.

Chair: Good morning, and welcome to the House of Commons Health and Social Care Select Committee, and our second evidence session for our inquiry into children and young people's mental health. Later on, we are going to hear from those involved in providing mental health services to young people. We are going to hear from one of the main architects of the 2017 Green Paper and from a school that is trailblazing a new approach.

Before that, we are going to hear from two young people who have used mental health services themselves and now campaign to improve them. They are Lucas and Hope. Lucas is 20 years old but first began experiencing mental health issues at the age of 13. He has used both community and in-patient CAMHS services, as well as adult mental health services. He has been an activist for YoungMinds for two years, using his experience to develop their work and help them campaign. You are really welcome, Lucas. Thank you very much for joining us.

Hope is also joining us. She has struggled with anorexia from the age of 12. She was referred to CAMHS but put on a waiting list for treatment, which caused her condition to worsen to the point where she was admitted for in-patient care at the age of 17. She now campaigns on the need for early intervention and prevention with respect to eating disorders. Hope, thank you, too, very much for joining us.

First of all, Taiwo Owatemi is going to ask Lucas a few questions. After that, Dr Luke Evans is going to ask Hope a few questions.

Q72 **Taiwo Owatemi:** Thank you, Chair. Good morning, Lucas. Thank you so much for taking the time to share your experience with the panel. Can you start off by explaining, in as much detail as you are comfortable with, your struggles with mental health?

Lucas: I started experiencing difficulties with my mental health when I was about 13, in year 8 of high school. It started with being quite anxious, but it quickly escalated and I started self-harming. It was not picked up for a little bit, but when it was picked up I was referred to CAMHS. During that time, it escalated and my self-harming got a lot worse, to the point that I was admitted to A&E quite a few times with those difficulties, needing both physical treatment as well as seeing somebody for my mental health.

It kept escalating until I was about 14 or 15, when I got admitted to A&E after very serious self-harm. I then went under the crisis team for CAMHS. Initially, I was told that the waiting list in my trust was about two years long. I didn't have any help before that, so things just kept escalating. I struggled with the self-harm, with anxiety and with intrusive thoughts. Eventually, it escalated to the point that I struggled with suicidal thoughts. I was making plans and things. I was really struggling, and it was just escalating very dramatically.

Q73 **Taiwo Owatemi:** In trying to get access to the support that you needed, do you think you were able to access it early on?

Lucas: No, not at all. As mentioned, I had to go to A&E a number of times. The nurses and the doctors there always got me someone to speak to and all of that, but that was a sticking plaster on a very big wound, in a sense. That was all there was until things got so serious that I had to go under the crisis team because my life was in danger. It should not have had to get to that point for that to happen. That was it.

My school could not offer anything. My GP could only try to push the CAMHS referral. There weren't any other services around at the time that could do anything. A lot of the charities, which are very good, said, "Because you have a referral to CAMHS, we can't see you." There wasn't anything until things got so dire that it was the crisis team. If I had had that a bit before, in school, or something like that, it hopefully would not have got to that point.

Q74 **Taiwo Owatemi:** You were not able to get any support from charities due to the two-year CAMHS waiting list that you were on. What other barriers would you say you had to experience in order for you to get the support that you needed? How do you think those barriers impacted on your mental health?

Lucas: Obviously, the main barrier was the two-year waiting list. A big barrier was also places like school. They thought that because I was on the waiting list that was all that they would concentrate on. When we were talking about difficulties and stuff, they said, "It's okay, we will just wait for CAMHS to come through. You are on that waiting list." But they did not always mention, "Yes, you are on that waiting list but it's two years long." That was quite a barrier.

There were services from the charities that I could not get hold of. It was mainly the waiting list. Obviously, GPs cannot prescribe things like medication or anything like that to people under 18. It has to come from CAMHS. While we knew that that would be useful, nobody could prescribe it because I had to be seen by CAMHS first. The GP could not do anything, so that was quite frustrating as well.

Q75 **Taiwo Owatemi:** How important is it that both GPs and schools are empowered to be able to provide that early intervention support?

Lucas: Massively. As mentioned, if I had had that support a lot earlier, I might not have escalated as much as I did. If I had not escalated as much as I did—I had to have a lot of in-patient treatment before I was 18, and, while that was obviously difficult for me, it was also quite a big intervention. If that big intervention wasn't needed, if we—*[Inaudible.]*

Chair: I think we have lost you, Lucas. We will perhaps come back to you in a few moments. Taiwo, could I ask you to pause your questioning for a moment? We will come back as soon as we have Lucas back. That is a pretty harrowing story.

We will move on, if we may, to Hope. Thank you again for joining us. Dr Luke Evans is going to ask you a few questions.

Q76 **Dr Evans:** Good morning, Hope. Thank you so much for coming along to speak to us. *[Interruption.]* Sorry, my phone decided to answer the questions instead of you. I do apologise. I would much rather hear from you.

Could you tell me a little bit about your story and about how you ended up being in front of the Health Select Committee?

Hope: Yes. I developed anorexia when I was about 12 or 13 years old. Growing up, I had always struggled to deal with emotions and to process things in a healthy way. I have quite a dysfunctional family. My older brother was extremely angry a lot of the time and would run away from home quite a bit. For me, I just put a lot of pressure on myself to try to solve all those issues. A combination of that and the fact that I was also sexually abused for around eight or nine months meant that I had to find another way to cope with what was happening and how I was feeling, and basically try to numb a lot of the emotions and the things that were going on.

I started to restrict my food intake and started to over-exercise as well. I had been quite a good long-distance runner growing up, and pushed myself more and more in that space. People kept complimenting me and telling me that I was training really well and that things were going great, so I just kept doing it.

With my eating disorder, it was like having another voice in my head which gave me real value and purpose. It gave me this sense of control over everything going on around me. With all eating disorders, particularly with mine, I became very secretive. I hid it from everybody. I continued to live with it for the next four years, hiding it from everyone around me.

Eventually, my school got in touch with my mum. I went to my GP. That was my first introduction to health services and the real lack of understanding around anorexia. I remember seeing quite a middle-aged GP. He just did not get eating disorders. He did not understand what it was like or what I was going through. He prescribed me a load of herbal medicine and did a couple of blood tests and things like that, but he wasn’t able to give me any additional support. I kept going back over the next couple of months with my mum, trying to push for support and additional treatment, but because I didn’t think there was anything the matter with me I kept doing what I was doing and kept not really engaging in the conversations with him.

Eventually, my mum drafted a letter for the GP to sign and send to children's mental health services so that I would get an initial assessment at that point. I then got referred to CAMHS and spent the next six months going to weekly appointments. Again, I found it really difficult to engage in the support that was being offered to me. A lot of the way they spoke to me was trying to scare me into eating and trying to shock me.

I remember seeing another therapist who I just couldn't relate to. We did not get along. I didn't really warm to him. I think because I had been sexually abused I really struggled to build up trust with a male figure to then have the space to talk. I just lied every single week. I tricked the system so that my weight would stay the same or it would go up. Over the next six months, I got a lot worse mentally and also physically. Eventually, I had no choice but to be admitted to an in-patient unit, where I then spent the next year trying to recover, learning about food. A big thing for me was exercise, but also learning to talk about things and have space to process in a healthier way.

Q77 **Dr Evans:** That is an incredible story to go through. I wonder if I can take you back to near the start. You highlighted how poor the education was from the medics that you had. What do you think would have made a difference at the time? What could have been said to you that would have cut through? Is there anything? Eating disorders can be very difficult for people to acknowledge, and you mentioned it yourself. You were very clever at being able to convince yourself that there wasn't a problem.

What do you think would have cut through to you then? What could the service look like at the grassroots level for what you experienced? Is there something that we could take away that would make a difference?

Hope: I think it would be if I had had the right questions asked of me. So often with eating disorders, when someone presents at their GP or to any frontline staff, we are often judged on what we look like physically. We are often weighed, and if you do not fit neatly into BMI criteria you are told you are not going to get their support or treatment. While I know that recently they have been looking at scrapping BMI completely, which is amazing, I guess my fear with that is that we are just going to introduce another measurement, whether that is measuring someone's waist or that side of things.

With my eating disorder, and for a lot of other people, it takes time to fall into the underweight category. You are then constantly being pushed back from services. When you are told, in essence, that you are not thin enough for treatment, your brain goes into turmoil. You feel like a fraud and a fake. For me, it would have been having the space to be really heard, to have the space to be listened to.

With all GPs and frontline staff, there should be some kind of screening tool put in place for eating disorders. I know that in some parts of the country we do that with suicide, but with eating disorders we do not do it at all. There should be questions like, "How are you feeling about your body? Are you constantly thinking about food? Are you exercising to lose weight?" Various questions like that would have helped me to open up a little bit and probably to question what was actually going on in my head.

Q78 **Dr Evans:** My experience as a GP was that control is the big thing; I think you hinted at that. Everyone thinks about diet and everything else, and you are rightly pointing out that you do not have to be too thin. There are plenty of people with big BMIs who have eating disorders. It all tends to stem around control.

Is there anything that you think would have made a difference, or could make a difference, to try to address that? Do you get a sense that it is getting worse or getting better? How did you suddenly get control of what you are doing now to be better?

Hope: First, I guess I am still in recovery. It is an ongoing thing for me. I think statistically only 50% of people recover from an eating disorder. Personally, I think that is a huge issue and something that needs to be tackled. We should all have the chance to fully recover.

The thing that helped me to feel like I was more in control and was able to push forward was a number of exercises that I did in hospital. Even when I was admitted for treatment, I still did not think that there was anything the matter with me. I remember on the Friday night, after I had been in treatment for about three days, one of the nurses got me to do this exercise where she marked my head and my feet on a piece of paper. She got me to draw how I thought I looked. I drew an outline. Once I had done that, I lay down on the same piece of paper and she traced around my body. There was such a difference in what I saw and what she showed me. For me, that hit home and that was the evidence I needed.

Quite often with eating disorders—I am sure you know this because you are a doctor—we do a lot of blood tests. We base a lot of it on that, but, when you are in that mindset and are really struggling, you are not going to take the blood tests seriously. Regardless of what my bloods told me and told the GP, I really didn't care. I wanted concrete evidence that I could see right in front of me to open up and help with that.

The thing that makes it really difficult at the moment, arguably more so than when I was an in-patient, is that we get told of really dangerous messaging on social media and online. While eating disorders are not caused by social media, I think that a lot of the messaging out there needs to be unpacked. I know the work that I am doing at the moment with my dietitian is looking at all the rules that I have created in my head that keep me safe and secure. To the outside person looking on, they are quite destructive coping mechanisms and tools, but for me it is getting to the root problem and then unpacking why that is making me feel safe and realising that it is okay to sit with emotion; it is okay not to always be in control, but it has taken me such a long time to get to that point because I did not have immediate intervention when I needed it.

Q79 **Dr Evans:** You mentioned the social media and digital aspect. The Women and Equalities Committee has looked at body image and released a report only 10 days ago. I am not going to ask you to comment on that, but they were concerned about the effect of digital images and social media, particularly on eating disorders.

What are your thoughts on that? Do you have a view on how that affected you? Do you think it is getting worse or getting better? If you cannot comment, that is absolutely fine as well.

Hope: Yes, I think it is definitely getting worse. One of the reasons it is getting worse, and is something I am hearing a lot of at the moment, is that people are getting all their nutritional advice from places like Instagram. Over the last year, we have seen so many of these wellness influencers popping up on Instagram. They have millions of followers and probably a blue tick, so everyone thinks that whatever they say is totally gospel. It really frustrates me because, actually, in a lot of the work I do in schools I am hearing more and more young people who are picking up crazes from these wellness influencers that are really dangerous.

Recently, I have been working with a school in north London. The entirety of their sixth form is now only sucking lollies throughout the whole day because they saw it as a top tip on an Instagram account, and now they are getting more embedded into that mindset. While they will not all go on to develop eating disorders, we are pretty much normalising an unhealthy relationship with food. For me, it is the normalisation of eating disorder culture across our own society that needs to be tackled.

Q80 **Dr Evans:** That is really important. Finally, from my side of things, if we were to widen this back out, one of the biggest problems with eating disorders as an addiction, from my understanding, is that it is not like alcohol or drugs where you can leave it. You always have to eat. We have to eat to survive, and that makes it very difficult because you can never quite get away from that.

If we look at the services as a wider whole, is there anything that you think would have made a difference, or anything you would want to see from the GP or the counsellors, or on the waiting times? We are looking at the strategy behind this. Is there something that would stand out for you, or that you wished someone had reached out to you at this point, or you had different access? The difficulty is that if you do not see that there is a problem it is hard to get to a problem. From your experience, is there anything that you think would have made a difference and that you would like us to take to the Health Secretary about this?

Hope: I totally agree with everything you are saying around relating it to alcoholics. It really frustrates me that people think that eating disorders are a choice. Every morning, I have to get up and choose to eat in order to stay well. The food is like my medication. It is really frustrating because people then assume that you have chosen to be a certain way.

There is still this huge stigma around eating disorders. It is an illness that is massively misunderstood. For me, the thing that needs to happen—obviously, there are funding issues as well, but I am not going to go into that—is looking at whether we can put together some kind of educational strategy that will hit all frontline staff, so that when someone presents at A&E and they have collapsed because they have not eaten for days or something, what is being done in that situation? Normally, that person is fed a little bit, probably for 24 hours, and then discharged back into the community.

Schools have no idea what to do in a lot of cases when it comes to eating disorders. They do not understand it. While it is not their job to fully understand it, again it is looking at what support is out there in those situations. I know that there are school counsellors in certain schools and in certain areas, but they are not experts in eating disorders. They do not have full understanding of them.

More broadly, it is education. It is looking at your GPs and dentists and making sure that everybody knows how to have some kind of conversation around it. I think that, if we do that, we will all begin to learn the signs to spot at the very early intervention phase. I think the education aspect is crucial at the moment. That would probably be my biggest ask of the Government right now.

I won't go off on a tangent, but with psychological support we know that across the country there is very limited psychiatric support when someone has an eating disorder. Again, what are we doing to make it a more attractive thing for people to go into? That is a whole different issue.

Q81 **Dr Evans:** Can I interrupt you on that? You were an in-patient, and we are having a debate on whether or not people should be in-patients or should be in the community. Was it the right thing for you to be an in-patient? Feel free not to answer that question, because it is personal, but at the same time, if you would, it might help us with that assessment. There is debate going on about whether we should be in the community or an in-patient. Should we have more beds or less beds, and what is the choice? Do you have a personal opinion on that?

Hope: Yes, I think I needed to have in-patient treatment. Out-patient support was not working for me. Physically, my body needed it, but I also needed to have that structure and intensive treatment and support. While my family are great, they could not support me. They did not know how to do that and how to have that conversation. It kept me safer and helped me to get well.

The issue that I had was that I spent a year living in hospital, so when I left treatment I was extremely institutionalised. I spent the next four or five years eating my meals at exactly the same time every single day. I had a cereal bowl that I had actually taken from the hospital because I knew exactly how many bran flakes went into that bowl. Yes, I believe that in-patient treatment is really important, and we need more beds for that, particularly with eating disorders, but if we are looking at in-patient treatment, we need to be looking at how we equip someone to go out in the community and start to live a proper life away from it, whether that is doing practice meals out or teaching someone how to clothes shop. It is the little things that seem really easy to everyone else, but when you have had an eating disorder they feel impossible.

I know right now, with regard to beds, that because there are not enough beds a lot of children are being tube-fed at home. We are seeing a lot more of that. It is again just putting more and more strain on families. It is putting a strain on the individual. In some cases, because children are so uncomfortable with having an NG tube, they take it out themselves and the parents have to go backwards and forwards to hospital, making multiple trips a day, to have the tube put back in.

Dr Evans: Thank you so much for speaking so honestly. It has been really helpful to hear. You are very articulate. Best of luck with the campaign that you are running; you really are a spearhead and a figurehead for it. Thank you so much. Back to you, Chair.

Q82 **Chair:** Yes indeed, very articulate evidence. It would not surprise me, Hope, if you are one day in the Houses of Parliament yourself, and maybe even on the Health and Social Care Select Committee.

I have a final question for you, and then we have Lucas back. What message would you give to any young people in a similar situation to yours back in your early teens, who are perhaps hiding from themselves that they might have an eating disorder?

Hope: That is a really good question. For me, it would be to realise that what the eating disorder is doing for you and that voice in your head—what it is telling you and the comfort it is giving you—is so short-lived. It is stopping you living your life; it is stopping you processing things; and it is stopping you going out and doing things. I encourage anyone who is struggling, whether with calorie counting or exercise, not to wait until your BMI gets really low. You deserve treatment and support right now, where you are at.

Chair: Thank you. That is very powerful testimony. Someone else who has been giving us very powerful testimony is Lucas. It is lovely to have you back. I am going to hand back to Taiwo to ask you a few more questions.

Q83 **Taiwo Owatemi:** Lucas, it has been really inspiring to hear your testimony. It is good to have you back.

Previously, you were speaking about the importance of early intervention. Are you able to elaborate more from your own personal experience, and also in your role as a YoungMinds activist, on the importance of early intervention in supporting children and young people like yourself?

Lucas: Yes. Early intervention is so important; I have a strong belief that it can stop things escalating, though not in all cases. In a lot of cases, they might still need specialist support, hospital treatment and things like that. I certainly got to that point, but in a lot of cases I believe it could either reduce the need for that or help to stop things before they escalate. I do not think it even needs to come from one source. It could come from GPs, schools, charities or other groups. To be able to have a breadth of knowledge in different places where people could go would be brilliant. I have a lot of friends, and have talked to and seen a lot of people who would say exactly the same. They have the same story.

For a lot of people, it is not found out. A lot of them finally get the courage to go somewhere like the GP or the school and say, "Do you know what, I am really struggling?" or "I'm self-harming" or "I have suicidal thoughts" or something like that. They are listened to but are then told, "Okay, we need to refer you to mental health services because that is the only place you will get support." That young person might feel, "Okay, I have done the right thing," but then for somebody to turn round and say, "Yes, but you're not going to get any help for months or years" can make people go, "Well, I'm not going to ask for help again because what is the point?" That can make people shut off completely and then things escalate again. We need early intervention and just having a person to talk to.

A lot of the people that I ended up talking to, before I ended up getting under services finally, were people at school. While my teachers were amazing and really listened, they did not have the training or the awareness to be able to talk about it. They listened and stuff, but they always said, "I don't actually know how to advise you or what to say, but I am here to listen." That was very kind, but the training was not there so I did not feel like I had a person I could offload to. That was really difficult.

Q84 **Taiwo Owatemi:** You spoke about how the lack of early intervention has meant that many young people do not feel empowered or confident enough that, when they come out and share the experience, they are going to be listened to. Teachers being able to be trained to provide intermediate support before CAMHS would have helped to make such a massive difference. What areas of specific training would it be important that teachers have? What should that training have in it?

Lucas: I think it should be age specified. I believe that it should come in at early primary school level, at a younger level, teaching about emotions and that this is okay: "You might feel like this." It is the basic emotional-level thing and that it is okay to talk: "If you feel like this, come and tell someone."

At the older level, at secondary school and things like that, I think they should be taught about the signs of self-harm. While people might go, "Oh, I know the signs for self-harm; people will be cutting," it is not always as simple as that. Some people self-harm in very different ways.

It is not always the things that you see in the media or that you see reported. People should be able to see the signs and either open up the conversation or refer somebody appropriately. They should be able to spot the signs—a child being withdrawn and things like that.

Schools get so much training, as they should, about how to spot a child who is being abused at home, yet they are not taught how to spot somebody with mental health problems. I actually have experience of the foster care system myself. The first sign that the school could have picked up on that I was struggling at home was that my mental health was really struggling. If they had picked up on that sooner, they probably would have picked up on the fact that my home life wasn't perfect. Again, that would have helped with that early intervention better.

I think schools should have training on what they should say because a lot of the teachers just sat there silent and went, "I don't know what to say or what is right to say." We should give them some phrases that can help. Some teachers would not know what to say. They would go, "Oh okay, I get how you're feeling. Just keep talking." It's like, "But talking is not doing anything if that's all I am told."

I think schools' mental health awareness training should be national. I know that some schools are starting to do it. I am already hearing great things from the pupils in the schools that are starting to do it. They are feeling listened to and confident. They are talking more. It is even just being able to talk for some people. It is an incredible thing to lift that thing off their shoulders and feel a little bit better, to give themselves a little bit more energy. If people have the confidence to talk, they will keep talking and feel more confident when things get even tougher to be able to do that. I certainly had that. When I started talking, I felt like people were dismissive of me and that people thought I was sometimes faking it or lying, especially when I started talking about it. They went, "You can't be feeling like this." Then I just felt shut off and said, "Okay, I won't talk about it then," until I was made to talk about it. It should not be that way either.

Q85 **Taiwo Owatemi:** No, it should not. Earlier, we spoke about how you have had experience of CAMHS and adult mental health services. How was your experience transitioning between both of those services?

Lucas: My transition was probably a little bit different than for some people because I actually did the transition in in-patient services. I turned 18 whilst in a hospital setting. While the staff at my CAMHS unit were incredible and great, there were already holes in that. I went to the adult unit feeling incredibly terrified. Obviously, in a CAMHS unit you are very much with people of the same age; even though I believe my unit was 13 to 17, the majority of people were 15, 16, or 17, and you feel very safe in that environment. I was suddenly thrown into an adult hospital with people a lot older. I was not told how some of the rules and laws change, because some of them do. I wasn't given any information. The day after my 18th birthday I was driven two hours back to my home county, because I was in CAMHS out of county, and shoved into an adult hospital, feeling absolutely terrified. I did not know what was going on. I was almost feeling like I had to go back all the way to the beginning of the treatment that I had just had. That was my transition within hospital.

When I was discharged, there was a massive difference between community CAMHS and community adults. With the therapy that I finally managed to get, they just went, "Oh, we have to put you back on the list now." That was when I was 18. I turned 21 this year and I still have not had any therapy on the NHS since coming out of hospital. My mental health has worsened. What I am constantly told by adult services and my psychiatrist is, "You need therapy. You cannot rely on meds. We cannot do all of that." I turn round and go, "Okay, give it to me then, please." They still have not. I have been told that I am at least six months off the list, as it is now.

I think the contact is a lot less in adult services. When I was finally under CAMHS community services, I saw them weekly and all of that. Having that regular contact and knowing I had it in the diary was incredibly important. Now it is like, "Phone us when you are in crisis, and then we'll deal with it." It is a very reactive and not proactive service. Having that difference between CAMHS and adults is really difficult, especially at my age. While I was 18 and a legal adult, I still felt very young. I still had not finished my school. I still had not done all of that, yet it was almost like, "You're an adult. Cope on your own. We will just come and help you when you are in crisis again." That approach does not work at all.

Q86 **Chair:** Thank you. I have a quick final question for you, Lucas. How old were you when you were told that you would have to wait two years before your CAMHS treatment would start?

Lucas: Either just when I turned 14 or when I was about to turn 14, so around 14.

Chair: I must say that it is incredibly brave of both you and Hope to say publicly what you have been going through and to speak so openly about your mental health conditions. There is still a lot of stigma around. All of us today are incredibly impressed with both of you, with your courage and how articulate you are. Just the very fact that you are speaking openly about it will give a lot of hope and encouragement to other young people who might be burying these problems.

Thank you very much for joining us. It is really appreciated. Thank you, Hope, who spoke before you, as well. The very best of luck getting your treatment going forward.

Examination of witnesses

Witnesses: Professor McGorry and Cassandra Harrison.

Q87 **Chair:** We move now to our second panel. I think the first panel put things in perspective and showed why it is so important that we are doing this inquiry.

We are going to the other side of the world. We are joined from Melbourne by Professor Pat McGorry. Unfortunately, bookshelves look the same wherever you are in the world, Pat, so we do not have any sense of the magic of Oz, but we know that you have been working some magical things with Headspace. Pat’s work in Australia resulted in the establishment by the Australian Government of the National Youth Mental Health Foundation back in 2005. It was renamed Headspace in 2006. We are going to hear about how that works.

We are also pleased to be joined by Cassandra Harrison, who is the chief executive officer of Youth Access. She is going to talk about the roll-out of some similar services here in the UK.

I would like to start with Professor McGorry. Thank you very much indeed for joining us. Could you talk us through what Headspace does? Perhaps a before and after description: what things were like before for Australian young people like Lucas and Hope, whom we have just been hearing from, and what it is like now.

Professor McGorry: Thank you, Chair, for the privilege of being able to talk to you today. I was also very impressed with Lucas and Hope. One of the key ingredients, if I might say, in the success of mental health reform for young people has been the involvement of young people in both the formulation and the design of youth-friendly mental health care. What you heard today I have heard, I must say, hundreds of times from other young people who have shaped the services that we developed. It is great that you had them on first.

Perhaps I could make a couple of preliminary comments. The scale of mental health investment around the world, as the Lancet global commission in 2018 pointed out, is the problem. Apart from the cultural and structural problems, which we can get into in a second, the underfunding of mental health care compared to the rest of healthcare is a massive structural problem that causes shocking statistics like the one you have just heard: a two-year waiting list to get access to care.

In mental health care, it is the mirror image of what you see in physical health care, where early diagnosis and intervention is privileged and at a premium. If someone has a breast lump, the doors of the health system swing open to welcome the person into care. There is an absolute premium on finding a potentially serious illness at the earliest possible stage. It is the opposite in mental health care.

Coming back to your point about what was happening before youth mental health really became a paradigm shift, not just in Australia but in 11 countries around the world, it will really, I hope, transcend the CAMHS/adult split whose problems Lucas was highlighting. Before that, there was a prototype that was embraced and successfully scaled up across England, at least: the early intervention model for psychosis, which was the first generation of my career in early intervention and youth mental help, focusing on schizophrenia and psychosis. It basically has the same principles. It tries to diagnose potentially serious illness at the earliest possible stage, and then make sure that you manage the early years of illness very intensively and expertly. Then outcomes will improve, and indeed have improved substantially as a result of that approach, where it has been properly funded and implemented.

The lesson from that experience, back in the late 1990s and early 2000s in Australia, made me and my colleagues realise that there was a much bigger fish to fry. Nearly every potentially serious mental illness that affects adult life—whether it is anorexia, as you have heard, mood disorders, anxiety, substance misuse, or personality disorders, especially borderline personality, which is a very destructive illness—begins in the period following puberty, quite often on the back of adverse childhood experiences. The surge of morbidity begins around puberty and peaks not at or before 18 but in the early 20s, and starts to taper off after about 25. That means that if you want to capture the full spectrum of early intervention that is possible, and mitigate the very disabling, destructive and economic effects of poorly treated mental illness across the decades of adult life, you have to focus on the transitional period from puberty through to the mid-20s. That was the main lesson that we tried to learn and implement.

Immediately you look at the epidemiology of the problem and the population health patterns, you realise that you cannot solve the problem with a specialist or secondary/tertiary system alone. Even if you had a decent CAMHS system, or an expanded CAMHS system at the specialist level, you would have to have a primary care portal. You would have to have a high-volume, highly accessible, youth-friendly and stigma-free entry portal. The Youth Access programme could be part of the solution, and I would be interested to hear about that.

The idea was that we were running specialist services in about a quarter of the city of Melbourne for that early intervention model. We had actually managed to get the specialist services to span the teenage to young adults. We broke the mould around the barrier of 18, which Lucas was quite rightly bemoaning, but we had only done it for psychosis. We realised that there were probably tens of thousands of young people in our catchment area who needed access to some kind of mental health care—

Q88 **Chair:** Pat, I am sorry to interrupt. To cut to the chase, you basically moved away from the delivery of specialist services and opened it up so that the offer to young people included GP services, addiction services and other services as well. Is that the basic model?

Professor McGorry: It is, but I would not say that we moved away from the specialist services, because you need a back-up system that is aligned and congruent with a primary care model focused on 12 to 25s. That is what Headspace is. We persuaded the federal Government, which is responsible for primary care. It is a bit weird in Australia. The federal

Government funds primary care and the state Governments fund specialist or tertiary care. There is a bit of a gulf in between.

There was a missing piece to at least make it possible for people to talk to somebody. Standard GPs were no good. Young people did not see—a bit like Lucas was saying—

Q89 **Chair:** Pat, are you confident that the stories we heard from Hope and Lucas would not happen in Melbourne today?

Professor McGorry: No, I think they still would because of the under-resourcing of the specialist system. They had illnesses that needed specialist care and not just primary care, but they might have got a better entry portal. If they had milder or self-limiting illnesses, they probably would have recovered; 60%-plus of the Headspace clients or young people will recover with a primary care level intervention, but there is another 40% who need to graduate to a more specialised model in a seamless sort of way.

It is not a simple matter of just rolling out Headspace across the UK. You have to have a congruent youth mental health system that runs from puberty through to the mid-20s to back it up, so that, if you need in-patient care and more intensive multidisciplinary care, you have a specialist system that is congruent, too. In the study that Swaran Singh did in the UK—the TRACK study—which mirrors what Lucas was saying about the failure to graduate successfully from CAMHS to adult, 95% of those people in the UK failed to make the transition from CAMHS to adult. That is only a small fraction of the people who were in CAMHS in the first place, so you need to do both.

I am sorry that I have not properly answered your first question. Headspace was successfully scaled up. It will be in 150 locations across the whole country by the end of this year. It is currently in 136 locations. It is still a thin green line. It is a great way to enter the system and get to the first port of call. It is very youth friendly and very accessible. It has GPs, and it works with local GPs, but it does not depend on the type of general practitioner that was described by the two young people today; they are very unreliable for young people because young people do not relate to them in the same way, and the GPs often do not have an appetite for working with young people. You need to create a new culture of care that involves GPs but does not depend just on them.

There are other features of the programme—

Q90 **Chair:** I have a question about the numbers that sit behind this. Have you been able to measure the impact? By more early intervention, have you reduced the number of people who are being referred on to specialist services?

Professor McGorry: It is a bit hard to answer that question. There is a thing called the "missing middle". I don't know if you have heard that term. The state services underfund the specialist end of care. We have built a base camp around the primary care model of Headspace, so we are getting a lot more unmet need coming into the system in a timely way. As I say, 40% of it is not able to be taken up by the next tier of care, so I do not think it is possible to say yet, with a partially implemented reform, that you can have the sort of impact you are seeking, but it is definitely achievable. If you look at early psychosis outcomes, and there are 25 years of evidence about early psychosis, we definitely know that you can not just reduce the negative outcomes, especially in the first few years of illness, but you can save a lot of money by doing that too. It is highly cost-effective. Part of that is the reduction in in-patient care that it delivers. There is also better recovery. The kids do not end up on welfare. They get jobs and can function normally.

If we fully implement the youth mental health paradigm, of which Headspace is a key building block, I am sure we will see dramatically improved outcomes in the areas that you are looking at. We have indicative evidence of that, but I would not say that it is conclusive yet.

Q91 **Chair:** Thank you. We will come back to you. Lots of people have questions for you, but I want to move over to Cassandra to tell us about what Youth Access does and how that compares to Headspace. Have you been able to measure any improvements as a result of the services that you are offering here?

Cassandra Harrison: Good morning, and thank you for having me here today. Youth Access is the national membership organisation for youth information, advice and counselling services, YIACS for short. They are also known as one-stop shops or open access hubs. For ease, I will refer to "our members", but those are the services I mean.

These are organisations that are rooted in local communities, providing free, easily accessible, support to young people aged 11 to 25, with a wide range of issues. The pandemic has highlighted for many of us that our mental health does not exist in a vacuum. If a young person is at risk of homelessness, if they are struggling with debt or unemployment, or have relationship problems, all of those things can affect and be affected by their mental health.

Our members provide whole-life support for young people, not just thinking of them as a mental health diagnosis but supporting them with all of the other factors that intersect with their mental health. These community-based holistic services continue to be undervalued. We know that they are effective. We have evidence to show that they achieve clinical outcomes that are comparable to CAMHS and schools-based counselling, and that young people report having better experiences. We know that these open access models reach a more diverse group of young people, including those from marginalised groups, such as young people of colour, LGBTQ young people and, crucially, older young adults as well.

Q92 **Chair:** Cassandra, can I ask you to personalise it a bit? If we think back a bit to those very powerful testimonies we heard from Hope and Lucas, how might their experiences have been different if they had been able to use one of these hubs?

Cassandra Harrison: The open access services that our members provide for young people experiencing the issues that Hope and Lucas have had give a unique combination of prevention, early intervention and crisis support. Hopefully, they would have accessed services earlier, whereby they might have been able to have support with other things. If a young person has anxiety, that might be related to schooling. It might be related to their home life. They could access one-to-one or group counselling, but also the kind of practical advice and support around other aspects in their life that might be affected by their mental health.

Q93 **Chair:** From where you sit and with your experience of youth mental health services, what is the biggest single thing that you would want to change if you were Health Secretary for a day?

Cassandra Harrison: What a lovely magic wand to be given.

Chair: I can assure you that it is not a magic wand, but carry on.

Cassandra Harrison: If I had it, funding is obviously the clearly critical thing. We know that the support our members provide to young people is vitally important. It is really effective. They are filling gaps in the system, but it should not have to be such a battle to keep these vital services running. Our members are having to patchwork together bits of funding, which are often very limited and very short term. That means they are not able to meet the needs of all the young people out there with similar issues to Lucas and Hope, and more broadly as well.

It is a really inefficient way. They cannot plan services. It creates great instability. The services that young people can access depend on where they live. It depends on what is being commissioned and what is being funded. We have had "Future in mind". There is widespread consensus in the sector that investment in these kinds of services is needed, yet the Government have not implemented the recognition that they gave to these services in "Future in mind".

With the right kind of backing, funding and support, these services could play an even greater role in transforming young people's mental health provision and moving things away from crisis to earlier intervention and prevention.

Q94 **Barbara Keeley:** Professor McGorry, I am trying to understand the difference between the model you talked about and where we are in terms of the services we heard about with Lucas and Hope earlier. Does that remodelled service for 12 to 25-year-olds overcome the differences between CAMHS and adult mental health services that we heard about? Lucas talked about how awful the transition was. He has gone from a model where there was regular contact to, "Phone us when you are in crisis." Has that remodelling made the difference there? Would those sort of problems be ironed out with your 12-25 service?

Professor McGorry: Absolutely. There is a qualifier. What I heard from Cassandra were very similar principles to what we have put in place with Headspace, except that there is a fair bit more clinical input, I would say, in Headspace than Cassandra was alluding to. It is still at what we would call enhanced primary care level.

We have youth peer workers. It is very informal in many ways. We also have GPs, psychologists, IPS workers and vocational recovery workers. We have drug and alcohol workers as well in that mix. It is only able to deal with the primary care level of input. In most parts of Australia, if you need to go into the specialist service, it is extremely difficult to get in. That is why I mentioned that point about the "missing middle". We still have the waiting list issues that we heard about.

In the state of Victoria we have just had a royal commission into mental health care at the state Government level because of the very poor quality over the last 10 or 15 years of that service. The Government are now completely transforming the services. They are putting billions of dollars into the services. They are going to restructure and get rid of the CAMHS and adults distinction. They are going to create, essentially, four tiers of care. One is a child focus up to about 11 or 12. Then there is a youth stream, which will be 12 to 25. The specialist services, the secondary/tertiary services, will mirror the primary care platform called Headspace.

In our part of Melbourne, where Orygen is—I work in a medical research institute called Orygen—we already have that, but the rest of the state does not have it yet. The rest of Australia does not, but I think we are going to see a remodelling. I would like to see that happen all around the world actually. There are leaders in many countries working on reform to create a youth mental health system. It can still be linked very closely to children, and to adults too. It has to have nice relationships and boundaries with little children and older adults, but you have to create a space for the young people, and that has to be on the specialist side and not just on the primary care side.

To answer your question, I think we are on the way to solving the problem that Lucas came up against. It is appalling. The TRACK study that was done in the UK, which I am sure you have all read, just highlights in bigger numbers what Lucas was talking about. The experience of young people and parents making that transition is appalling. It is not just about the incidence of the illnesses; it is the developmental period.

The transition to adult is very different from what it was 40 years ago. It takes a longer period of time. It is much more complex and fragile. As he said, you are supposed to be an adult at 18, but you are probably not an adult until you are in your mid to late 20s these days in many respects, especially if you have had mental health problems. You are developmentally delayed as well. You have to have a system that allows you to make the transition in a supportive way across the whole age range from 12 right through, well into the 20s.

I think the problem we have had is that many child psychiatrists do not see that yet. They have not seen the importance of that. We need a new breed of leadership in the psychiatry profession to make this happen.

Q95 **Barbara Keeley:** Cassandra, why do you believe it is crucial that services are open access rather than based on entry thresholds. We hear about people who have gone to GPs or others with mental health problems and been told that their condition is not serious enough. Hope said that she had that experience. How can open access services address that to ensure that everyone who needs help is able to get it?

Cassandra Harrison: How damaging and devastating must that be for young people, when they have been brave enough to ask for help and then to be told that they are not sick enough? Open access services are one of the core principles of Youth Access members. It is about responding to young people, no matter the complexity, severity or nature of the problems that they present with. It is also really important to remember that thresholds do not necessarily equate to level of need.

We have evidence that our members are supporting some young people with a higher level of psychological distress and complexity than those in CAMHS, but they are not accessing CAMHS, for whatever reason. It could be the threshold; they did not feel it was appropriate, or they did not want to go through that route. As Professor McGorry was saying, some young people would not feel comfortable accessing through GPs or schools.

Another important factor is that we know that open access services, like Youth Access members, reach young people who might otherwise be falling through the gaps of statutory services, including those from marginalised groups. There is also the contribution to addressing health inequalities.

Q96 **Barbara Keeley:** Which groups of children and young people are missing out most in access to CAMHS? We heard about the wait, but which groups tend to be affected?

Cassandra Harrison: We know that our members have better reach to young people of colour, LGBTQ young people, young refugees and young people who have experience of the justice system. Those are the groups of young people who access our services. Our services are reaching them to a greater degree than CAMHS.

Of course, there is the issue around need and levels of demand. The Committee will have heard the widespread evidence about the impact of the pandemic on young people's health, and indeed on many of the social determinants of mental health young people have been really affected.

Our members were having high levels of demand even before the pandemic. That has increased even more now.

As I mentioned, we are constantly trying to fight for and patch together bits of funding to keep these vital services going for local communities. What we really need is for the great work they do to be recognised, supported and invested in, so that they can contribute to this transformation in how we address young people's mental health.

Barbara Keeley: Thank you.

Q97 **Dr Davies:** Professor McGorry, we have already heard today about the problems of waiting times, particularly in this country for CAMHS services. In my experience as a GP, it is also rejected referrals, so access to services is a real issue. In terms of early intervention in mental health issues in children, can you emphasise how important that is and the financial benefits that can accrue on a national scale?

Professor McGorry: Thank you so much. I cannot remember whether it was Lucas or Hope who talked about it in the personal sense, but we have extremely good data from particular illnesses, particularly psychotic illnesses. This goes back, as I said earlier, to research that began in the 1990s. The delay in treatment absolutely determines the level of function and recovery that is possible from an illness like schizophrenia or some other psychotic illness.

There is a term called "duration of untreated psychosis". A few years ago, the UK Government brought in a target that you had to treat psychosis, once it was recognised, within either two weeks or four weeks. Jeremy might know the answer to that.

Chair: Two weeks.

Professor McGorry: That dealt with something that probably could have been realised even 10 years earlier, that you had to make special efforts to reduce that DUP. The evidence is really clear. From American research, we know that the early intervention services, like the early psychosis services that I think there still are in most parts of England, do not work if the DUP is longer than a certain period. They do not work any better than standard care, but they work much better if you get the person earlier in the course of the psychosis. That would also be true for anorexia, as in Hope's case. We do not have the data to show it, but it is the same type of illness, which is potentially fatal or very disabling. They all fall into that pattern, but we do not have specific evidence for every single condition yet. We have it from probably one of the most serious sets of illnesses, and the outcome is much better than people think.

The pessimism that is entrenched in psychiatry has to be swept away, but you can see why it is not, because substandard care is mostly what people get. It reinforces the clinician's illusion that the outcomes are poor, but I can totally relate to your frustration as a GP trying to get people into these very tightly managed and gate-kept services. I spent half the week myself this week working in Headspace, trying to get people into the specialist services even as a psychiatrist, because they are still under-resourced. That second tier of care is still under-resourced.

It is absolutely devastating, as Cassandra was saying, for the young people. They have put their hands up and tried to get help, and it is amazingly invalidating to be told that. It is intensely frustrating. It causes a moral injury in the practitioners as well, I think, because they cannot actually do what they know they should do. Other doctors do not have that problem. In cardiovascular and cancer medicine, you do not have that moral injury, but in mental health you do because you cannot do what you know is needed for the patient.

Q98 **Dr Davies:** I have one further question about the set-up of the Headspace network. You say it is funded by the federal Government in Australia as a primary care service. Is it a top-down approach, or do you allow local areas to model the centre according to local need and make-up in terms of the clinicians there?

Professor McGorry: That is a fabulous question. Yes, it was top down. It was centrally commissioned for the first 10 years or so. I have been on the board ever since it was set up. Central commissioning worked very well to make sure that you had the same quality of service, as best you could, across the whole country and the same brand. A trusted brand is incredibly important for young people. Cassandra was referring to that too.

It allowed local tailoring, because local consortia had to bid for the right to run the service. It was locally led and run, but it was franchised, I suppose you could say. Then about three or four years ago, the Government, in their wisdom, decided to devolve the commissioning to 31 local commissioning agents called primary health networks, which put the whole thing at risk. It was under the philosophy, "We must have local tailoring of services." That was already the case, but it was like a political correctness that suddenly crept in and put the whole thing at risk.

We have managed to protect it, but it has taken a lot more effort to do that. I think the devolved commissioning model is a very unwise model. I know you have it in the UK, or you have had it, but you are a smaller country so maybe it is a bit more feasible; I am not sure.

Q99 **Chair:** We have many debates on that, Pat. Let me bring in Cassandra.

Cassandra Harrison: It is important to emphasise that it is great to learn from what has been happening in Australia, but we have services here that have huge expertise and insight into their local communities and have also built trust with those communities, sometimes over decades. What is needed is to ensure that they are properly funded, that there is accountability for that happening, and that they have a seat strategically in shaping what happens in their local area.

One of the reasons that they are so successful in working with young people is that they are not seen as establishment or the same as traditional routes. They work because they are very young person centred and they bring together the skill of youth work expertise and advice and therapeutic and counselling expertise. It is about recognising and building on the fantastic resource that we already have in this country, but enabling those people to do their jobs.

Professor McGorry: I agree with everything you have just said. I think you can still get those outcomes and that local ownership with a central commissioning model, as long as the services are locally run and adapted.

Cassandra Harrison: Absolutely.

Chair: Thank you.

Q100 **Paul Bristow:** You have just touched on what I was going to ask, Professor McGorry. In the UK, one of the challenges that we sometimes have is a cultural resistance to roll out best practice, especially in that devolved system. It is pretty much a not invented here sort of idea. How were you successful in overcoming some of those sorts of challenges to roll out Headspace? It is fantastic to hear that it has been rolled out in other places, but how were you successful in challenging those sorts of barriers and getting buy-in across the entire system.

Professor McGorry: Thanks very much, Paul. That is a great question and how that actually happened is one of the big learning experiences of my professional career. As you say, most of the time it is a combination of not invented here and not in my backyard. People did not want mental health services in their communities.

The way it happened was that the first 10 centres were very carefully selected. They were put into places where the local leadership was great, coming back to Cassandra’s point, and we knew it was going to work. That is where they were commissioned to start off with. Then you had a consumer-driven process. You had people looking at the service in a community down the road and saying, “Why haven’t we got one of these?” It is the first time I have ever seen people competing to get mental health services. The local politician, the local Member of Parliament, was enlisted by the community and became a great supporter. We have had a whole collection of Prime Ministers who are desperate to be associated with the Headspace brand every time there is an election, and even in between. It is a success story that has spread.

The local ownership is important. It really is the fact that we want to have this resource in our community. We will support it. We will sit on the local board of it. It is informal in the way that Cassandra was talking about, but it is a national brand. Everyone wins. The Prime Minister wins, the local MP wins, the local community wins, and the young people win because they have a voice. They are all involved in co-designing and operating the service. The families have somewhere to go.

It is also a blend of health and social care. There is social funding. The vocational recovery services are funded by the Minister of Social Services, but the health system also puts traditional health resources into it. You then have the informality that Cassandra talks about, so it is a winner.

Chair: Thanks, Pat. "Prime Ministers never win" is my motto in politics.

Paul, do you have any further questions? I know Cassandra wants to come in.

Q101 **Paul Bristow:** This is just to Cassandra. I wanted to ask her what her thoughts were on that as well. I have got involved in a local initiative in my constituency, where I talk to local schools about the experiences of young people during Covid and the mental health challenges that they have faced. It is all about accessibility and wanting stigma-free accessibility. Cassandra, I would love to demonstrate what you have achieved to my local CCG and some of the local schools in my constituency. How could we roll out your sort of best practice in other parts of the country?

Cassandra Harrison: What I experience from our members is that they are really keen to share good practice among themselves. The challenge comes when there is local commissioning. In some areas, our members have fantastic relationships with the commissioners. They really recognise the importance that they play. They are very integrated in terms of how they work with schools and with the statutory CAMHS. They are very much part of that strategic planning, but it is really patchy, which means that funding, service delivery and engagement are really patchy.

What we need is central Government commitment. Yes, absolutely, we could have a national programme that provides support, backing and funding but is delivered through local services where they already exist. Thank you for the thumbs up, Professor McGorry. I think that is the solution. Please feel free to get in contact. We are really happy to talk about the work that our members do.

Chair: Thank you very much indeed. The concludes our second panel. Thank you, Pat and Cassandra. That was very interesting testimony. We think it is a very important part of what we do on the Select Committee to look at best practice from around the world and, indeed, around the country. You have really helped us on that.

We wish you every success in your mission to make Prime Ministers happy, Pat. Cassandra, we hear loud and clear what you are saying about funding and the importance of funding local services. Thank you both very much for joining us.

Examination of witnesses

Witnesses: Professor Fonagy, Dr Clarke, Tim Bowen and Shanti Johnson.

Q102 **Chair:** We now move on to our final panel this morning. We are going to look at what has been happening with respect to Government policy in the UK. The 2017 Green Paper on mental health, which I was responsible for, talked about a radical change with two principal elements. First, every school would have a mental health lead who would be able to signpost people to mental health services more quickly as part of an early intervention strategy. Secondly, there would be a new support service that they could direct people to for people with mild to moderate needs, particularly anxiety and depression, so that we avoided the problem of people having to wait until they were sick enough to need to go to CAMHS, but everything is about execution and we want to look very closely at how successful that programme has been since the Green Paper in 2017.

To find out how things are going, we have Tim Bowen and Shanti Johnson, who are the head and deputy head respectively of Maple School in St Albans, one of the trailblazer sites for this new approach. We also have Professor Peter Fonagy, who is the head of the Division of Psychology and Language Services at UCL and helped me write that 2017 Green Paper. Peter will remember that we had many, many meetings to discuss the details of it. We also have Dr Aleisha Clarke from the Early Intervention Foundation. They are a very important group of people who can shed light on what progress is being made.

I want to start by looking very practically at what has been happening in St Albans at Maple School. Tim Bowen, perhaps I could bring you in first. You are one of the trailblazer sites for the mental health support teams. Could you let us know what the progress has been so far? Is it fully operational and has it worked well? What has been happening?

Tim Bowen: We are very appreciative of being one of the pilot schools chosen to be involved. Obviously, when we were chosen to take part it was before any of us had even heard of coronavirus, but to have the additional support both during and coming out of the pandemic has been extremely helpful. It has been beneficial for parents and pupils.

Q103 **Chair:** What happens now that did not happen before, Tim? Explain to people looking at this for the first time.

Tim Bowen: We have a mental health support lead we can contact if we have any concerns about a child or if a parent raises concerns. In the past, we may have said, “You might want to consider going via your GP,” or we had a very limited amount of money for a counselling pot. We now have someone we can go to and who, with the family’s consent, can work with the child and the family at a low level.

Where we are concerned, as you said, with a child who is showing anxiety or depression, or maybe it is the parents struggling at home, and we are not seeing so much in school but the parents have raised a concern, we have someone at the end of an email or at the end of a telephone who, within a week or two, can be working with that family.

Q104 **Chair:** Thank you. Let me bring in Shanti, the deputy head. Thank you for joining us. I think you have had special training as one of the teaching staff in the school to help you to understand who might need to be referred to the mental health support lead. Can you tell us what that training involved, and do you feel better qualified as a result of having had it?

Shanti Johnson: I have had training for a mental health lead, level two, which means that I am able to support children and to help identify where there might be particular needs. I have worked very closely with our EMHP, our emotional and mental health practitioner, to be able to identify needs that we might have in school.

My main priority is to make sure that children in school are very clear that their mental health is just as important as their physical health. We have had a real focus on making sure that children are very clear that wellbeing is important, and that all the children in the school are aware of how they can help to support their own mental health, particularly through being aware of the five ways to wellbeing and just being able to articulate their concerns or their knowledge of how to be aware of their own mental health.

Q105 **Chair:** Shanti, can you talk us through something that has happened with one child, obviously without mentioning the name, just to give us some context of some of the support that is available now that would not have been previously?

Shanti Johnson: Yes. If a child has been struggling, for example, there are two different ways with our emotional and mental health practitioner. There is a way of supporting the parent to support the child, and our EMHP will provide a course of counselling for the particular parent, who is then provided with the strategy to support the child in school. Otherwise, we have support, for example—

Q106 **Chair:** How long has this been up and running?

Shanti Johnson: We have been doing it over the last couple of years.

Q107 **Chair:** How many families do you think it has helped in the school?

Shanti Johnson: It has helped a lot. We have gone through eight different families in terms of individual support over the last year, since it was fully functional. In our groups of children that have been supported, we have about eight per group. A couple of those groups have taken place. Through the time of lockdown, our EMHP has been able to be contacted virtually. She has run groups online as well.

Q108 **Chair:** Let me ask this of both of you. You obviously like the scheme, but is there anything that could be improved in the way it works from what you have seen so far? Back to you, Tim, and then I will bring in Shanti.

Tim Bowen: I am not too sure about improvements to the scheme. One of the slight disappointments I have had on a couple of occasions is that parents have expressed a concern, we have involved the EMHP, but then, when the parents realised that actually they had to take some responsibility and the EMHP was going to be working with them to give strategies to help, they withdrew from the scheme. A few of our parents thought they could pass their concern and problem on to someone else and that the school and the specialist would deal with it. When it came back, "Well, this is what you as parents have to do," sadly in a couple of instances the parents withdrew. That is by no means all, but it was the realisation that they had to take ownership and have skills as parenting.

There was one other case where the family decided to withdraw support because they were concerned, I think incorrectly, that there would be something on the child's record, either going up to secondary school or even on their medical record. It was a child we thought would really have benefited from help, but the parents were concerned that it would somehow be on their record. We reassured them that it would not be, but they withdrew. In other cases, it has been very positive. Shanti may wish to say a little bit more.

Shanti Johnson: It has been very positive. The biggest limit is the fact that we do not have enough time. Our EMHP is with us for half a day a week. It would be really beneficial to have her at school more often. She is on the end of an email, but she only has limited time herself that she can work with us.

Q109 **Chair:** I am sure we will have other questions for you, but I want to bring in Professor Fonagy, if I may. We worked very closely to design the set-up of the mental health support teams. We have now heard that it is happening at one school in St Albans. You are independent of the Government, so perhaps you could give us your view as to whether these reforms are working as you thought they might, or whether you would do anything differently now with the benefit of hindsight.

Professor Fonagy: Hindsight is a wonderful thing, Chair. I have many of those. What I want to say about the scheme—thanks, Tim and Shanti for giving us a good write-up—is that when you had the vision to put mental health into school, and I remember very well the moment you suggested it, we did not quite realise how much good it could do, and how rapidly we could roll it out.

Let me give you some facts and figures. Unfortunately, I cannot say exactly how many children have been seen by the mental health support teams linked directly to schools and providing the educational mental health practitioners that Shanti described. What I can say on a sample that we have followed in London is that it has been exceeding our expectations in terms of outcome. What we found, following 2,300 cases, was that around 60% of the children seen recovered from depression or anxiety. An even larger number felt that they had reached the goal that they wanted to achieve. What we are finding, and I am really delighted about it, is that it is an extremely effective way of intervening that parents like, for the most part, and that children and young people like, and it has been possible to implement it at pace.

If I can give you some figures on that, there are probably around 280 mental health support teams that are either operational or in the process of becoming operational; 180 of them are active. That covers about 15% of pupils and about 3,000 educational settings. About another 100 are in the process of being initiated. That involves training of the staff and recruitment of staff. Another 100 are planned to commence, so we anticipate, and NHS England anticipates, that by April 2023 there will be about 400 operational teams covering about 3 million pupils, about 35%. As a new initiative, we should feel proud of that. It is a remarkable achievement, both in scale and effectiveness.

Q110 **Chair:** Rosie Cooper may come back to you with more questions on that, but I want to put this to you. The major criticism of the White Paper when it was announced was that the pace of the roll-out was unambitious. I do not think anyone questioned that the plans were good, but the commitment was that a quarter of schools would be reached by 2023. That was the end of what we thought was going to be the first Parliament of Theresa May's Government. Obviously, events intervened, but that is why we got to 2023. People said, "Why only a quarter of schools by 2023? Can't we go faster?"

Obviously, the pace of the roll-out is not within your control. You designed the scheme. Do you think it is something that we could be more ambitious about rolling out faster?

Professor Fonagy: I think we are rolling out faster than the figures that you mentioned. Additional funding has helped to accelerate the roll-out. The ambition is going to be achieved a year early. The 20% to 25% ambition is going to be achieved a year early. We think that the 35% ambition by 2023-24 is also going to be achieved.

Of course, it would be fantastic to be able to roll it out faster. It is difficult to say this, but for once money is not everything. Money is important and more resources would help, but we need to train people. The kind of person that Shanti talked about who goes into school and is able to help does not just suddenly pop out of the ground. They have to be trained. What is perhaps currently a rate-limiting factor is the rate at which we can train people.

Q111 **Chair:** I can see that Aleisha wants to come in. I will bring you in, Aleisha, but I want to ask Professor Fonagy a couple of final brief questions. I can sense a non-British accent. Can you give us an international perspective? How do our young people's mental health services and provision compare here to other countries around the world?

Professor Fonagy: I will not give you a comparison with Hungary, which is my place of birth, but I would say that we do as well as many. I deeply respect Professor McGorry's work. He is one of the big heroes in our field.

Just to put the opposite side, another colleague from there, Mark Dadds, has just won a major bid from an Australian medical research fund—the Million Minds Mission—to transform child and youth mental health services. Professor David Clark and I have been invited by Mark Dadds to be chief investigators on that programme because they feel they have something to learn from what we have set up in the IAPT programme, which is really the mental health support teams' intellectual heritage.

Q112 **Chair:** That is very helpful, Peter. On the Australian model, one thing that was very interesting was the idea of splitting CAMHS into an under-12s service and then a 12 to 25 service to try to deal with some of the problems of transition, but also to offer a more holistic service. Do you think that has merit?

Professor Fonagy: From a neuroscience point of view, Chair, it certainly does. I think Professor McGorry pointed out that a young person's brain is developing from about 11 or 12 on a curve up to about 25, and then after 25 there is no merit as far as the brain is concerned. That brain development is important. There are problems wherever you put the cut, but 11 or 12 is a good cut. Continuity is what matters. At the moment, we have a number of disruptions of services that prevent effective integration. I do not know how good the primary care service base or secondary care will be in Australia. That is something to be seen. Is there neuroscience merit in it? Yes, there is. Should it be adopted? It is being adopted in certain parts of the country in zero to 25 services. I do not think that there is any evidence yet that it has sorted out as many of the problems as we had hoped, but it is early days. I hope that I have answered the question.

Q113 **Chair:** Thank you very much. Dr Clarke has been champing at the bit. At the Early Intervention Foundation you have done a review of the value of schools-based interventions, which is what we were just hearing about from Tim and Shanti. Could you tell us some of the highlights?

Dr Clarke: Absolutely. We are in the process of completing a systematic evidence review looking at the effectiveness of early intervention implemented in schools. These are school-based interventions designed to promote positive mental health and reduce symptoms of depression and anxiety in young people, in particular those most at risk.

We have reviewed the evidence across 35 systematic reviews and 98 primary studies over the last 10 years. There is good evidence showing that universal prevention interventions can improve symptoms of depression and anxiety when they are delivered in the school setting. These are universal interventions that are designed to enhance young people's emotional regulation skills, coping skills and conflict resolution skills.

Our second core finding is around targeted interventions. These are interventions designed for those who are more at risk of developing mental health problems. These young people have subclinical symptoms.

The evidence is consistent that cognitive behavioural therapy interventions, when delivered in the school setting by external professionals—psychologists—can have a significant impact in reducing symptoms of depression and anxiety in both the short and the long term.

From my evidence review, some of our key recommendations are focused on the fact that it is not about bringing in an intervention as a one-off event in a school on borrowed time. It is much more about the adoption of a whole-school approach to supporting young people's mental health and wellbeing, so that you have universal interventions that are provided to all young people, and the development of essential life skills, in combination with targeted support for those who are more at risk.

Q114 **Chair:** Aleisha, you have heard what is happening at Tim and Shanti's school. Peter has explained the thinking behind the programme. Marks out of 10 for early intervention for young people in England at the moment?

Dr Clarke: The recommendations in the Green Paper and the actions coming out of it are a huge welcome step forward. It is really important that we are investing in having a senior lead to support mental health support and skills and, in addition, having the mental health support teams. That is particularly important in the context of what we can see from our evidence review, which is a need for professionals to support the delivery of targeted interventions.

There is a need for more training around the implementation of evidence-based interventions in schools. We know that schools are doing an incredible amount to support young people. It is exactly what Shanti was saying. It is great to see five ways to wellbeing. That is part of a whole-school approach.

Q115 **Chair:** What would you improve about what we are currently doing?

Dr Clarke: It would be to look at some of the model programmes across the world. One example would be the Be You education initiative in Australia. This is the first end-to-end initiative that they are implementing right across primary and secondary schools. It is across mental health promotion, prevention and early intervention. There is a need for a joined-up approach, where we look at the development of those life skills right across all pupils. Additional funding for access and making evidence-based interventions available to schools is critically important.

Chair: Lots of people want to ask you questions. I am going to bring in Dean Russell next.

Q116 **Dean Russell:** My first question is to Shanti and Tim. About 10 years ago, I set up the Health and Wellbeing Partnership in St Albans as part of the district council. One of the first projects I was involved in was a review of all the skills by the St Albans Youth Council to ask them about mental health provision. It is great to hear what you are doing.

One of the things that came through in that report, if I recall correctly, was that some schools had provisions and some others did not. In some that had provisions, the pupils did not know to where to go because it was not permeated throughout the school. Some teachers knew it was available and some did not. From your perspective and experience, how do you make sure that you have a whole-school approach and that all the teachers know where to point the pupils, and pupils know where to go? I will go to Tim first, if I may.

Tim Bowen: I hope I can answer your question, and no doubt Shanti will expand. We are a single-form entry primary school with a specialist base. We are not a large school. I have a staff of about 30 or 35 with some part-timers. One of the most positive things in this for me is that the culture in the school over the last couple of years since it became involved in the pilot has changed. We have adopted a whole-school approach to talk positively about children's emotional and mental health and wellbeing, and also that of staff. For me, as a headteacher, that is crucial, although it was set up primarily to support the children. The culture in the school is that it is not just acceptable but a really positive healthy thing to be talking about ways of looking after yourself and your emotional and mental wellbeing.

I gave the example earlier of one or two parents who do not quite see it like that, but for the children it is completely natural. They could list you the five ways to wellbeing and the activities they do, both during lockdown and at school, to support that. Everyone knows now that, if there is a concern about a child, the dialogue and the communication are very open. They would come to speak to either Shanti or myself. Then we put them towards our health worker. It is not that some people have knowledge and some people do not. For me, as head, the biggest and most positive effect of this is that it has raised the profile in a very positive way, and hopefully in a way that will support the children when they leave us, through adolescence into teenage years and beyond. We are laying foundations now that, hopefully, with all the pressures that are going to lie ahead, will stand many of them in good stead.

Q117 **Dean Russell:** Shanti, I will ask you the same question. Could you share any things you have done that perhaps you would have done differently, or areas that were problematic? I know that in some cases engaging with parents was one of those examples.

Shanti Johnson: With parents, at the moment we have been explaining all the things that we are doing. It is just making the parents aware of the different opportunities that we have on offer. The children are very keen to talk about their mental health. As Tim said, they are very aware of their five ways to wellbeing. It boils down to the stigma attached to mental health, and parents perhaps being very concerned that their child might be labelled, or that it might have an effect on their child going forward if they have been identified for any particular anxiety or any other mental health concerns. That is where the biggest hurdle lies with the parents.

On the other side, there are parents who are very quick to say that a child is suffering from anxiety or something a little bit more problematic with their mental health, rather than looking at ways to support emotional regulation and recognising emotion for the sake of emotion. We have the two extremes.

Q118 **Dean Russell:** Dr Aleisha, from your experience, what encourages schools to get involved in this sort of programme? I can imagine that for some schools, if it is more highlighted that there are children with mental wellbeing issues or that there are issues, that might put them off because of the stigma. I am interested in how you break down those barriers to get the first level of engagement.

Dr Clarke: From what we are hearing from schools, mental health is a priority. It is up there as one of the top priorities for schools, but what we are hearing is that schools need more time. Shanti said that time is a big issue; it is a big barrier to supporting mental health and wellbeing. There are other barriers around flexibility and being able to support the implementation and integration of interventions and support within the curriculum as well as in everyday contexts and interactions with young people. Again, the adoption of a whole-school approach can take the pressure away from needing to find just curriculum time to implement the interventions.

Exactly as Tim was saying, it is hugely important that we operate an ethos and environment level in the schools, so that we support young people's mental health and wellbeing through non-curricular ways. When we are operating at the ethos and environment level, we need to ensure that all staff are trained in mental health, so that their everyday interactions with young people support young people's mental health and wellbeing, and it is not just left to a 10-week programme. It is much more about our everyday interactions and how we respond to young people in the corridors, outside the classroom and how they respond to each other. That is really important.

The third part of the whole-school approach, also getting at what Tim and Shanti have been saying, is engagement with parents, so that the work we do in schools is supported and reinforced in the home environment. A way of addressing the stigma around mental health is the need for universal provision. These are not skills that are just for those in particular need of mental health support. They are of universal relevance.

Dean Russell: Thank you.

Q119 **Rosie Cooper:** Professor Fonagy, in response to the Chair's questions you talked about schools' mental health teams reaching about 35%, that is 400 schools, by 2023. Do you accept that that means we are failing 65% of the rest of the pupils? I heard your comments about limitations because of training. What else can we do to accelerate the programme? After all, if, as you described, it is clearly effective and is welcomed by parents, pupils and schools, is this not more than just unambitious? It is a failure. It is failing to help 65%, the majority of children.

Professor Fonagy: To some degree, answering that question is above my pay grade, as it were. I think rolling out a programme too fast, without the learning that is essential in order to make sure that the programme works well, is risky. In the implementation of science, there are many examples that show that, when programmes are simply unleashed, they become ineffective. What is more, they can inoculate the system against them. We must roll things out thoughtfully and deliberately, and make sure that every single mental health support team is properly staffed, and that the staff for it are not drawn from other children and young people's mental health provision. That would destabilise those provisions. First of all, it would be to do no harm.

Fortunately, we have young people—it is largely young people, both undergraduates and graduates—who would like to train as educational mental health practitioners. It is a one-year training that involves being trained in a whole-school approach, alongside other skills like cognitive behaviour therapy for anxiety and low mood. I believe that we need to do things in a way that ensures that this system, which is highly effective and will be another model for the world, as improved psychological therapies have been, should be rolled out in a thoughtful, active learning way, like the IAPT services have been rolled out, which we now feel very proud of.

Q120 **Rosie Cooper:** I hear very much the content of your answer. If this is really good and is seen to be working, and you are recommending that we take a thoughtful approach, could you explain, or help me understand, why we do not collect data nationally from the trailblazer sites? Why aren't we getting behind the detail? If, as you say, we are going to do it thoughtfully and in a measured way, and that is the reason for not accelerating what everyone says is good, the two things seem to be a bit at odds with each other.

Professor Fonagy: If I misled you, I have to apologise. It is not that we are not collecting data. We are collecting data, but at the moment we are not able to see which outcome data is coming from EMHPs, MHSTs and other services. This is something that we will have, and we do have. Let me underscore that it is absolutely a core part of the training for all educational mental health practitioners to collect routine outcome measures, for us to know exactly how effective these interventions are across schools, both in terms of surveys of schools, which they are taught how to do, and in terms of individual interventions. It would not be a proper implementation of the mental health support team concept if routine outcome data were not to be available. I believe that it is, and it will be.

Q121 **Rosie Cooper:** What you are describing is more ad hoc, rather than a national plan to get that information to the centre.

Are we also identifying barriers, be they cultural or religious? Where the trailblazer sites are not reaching certain groups of people, how are you evaluating that? In truth, to come back to the original question, on this basis we are depriving 65% of children the chance to access this. What do you think can be done now to accelerate that programme?

Professor Fonagy: The question about what could be done to accelerate the programme is not one that I can readily answer. What I want to warn you about is that accelerating too fast could be counterproductive, but I believe that you have heard that.

I also want to challenge you when you say that our data on effectiveness are not systematically collected, because they are. It is a new system. We need to improve the way that they are collected. Given that the system has been in place for two years, and that one of those years has been a rather different one from others, I think we have done tremendously well—

Chair: Rosie, what I am going to do is write to the Minister and get that data. We will have that data before we write our report. Do you have any other comments?

Rosie Cooper: No. We all know that 65% of children should have a chance to be helped with their mental health now, safely. We need to do it.

Chair: Thank you. I think that is a fair comment, which does not undermine the progress that has been made in the scheme so far. At the very start of this session we heard some pretty shocking stories of people who were not able to access the care they needed. There is clearly a mismatch, and there are clearly large numbers of people who are not accessing the care they need today. I will bring in Barbara Keeley next and then Luke Evans to wrap up.

Q122 **Barbara Keeley:** I want to ask a question that leads on from what Rosie said about the use of trained counsellors in schools. We heard from Tim and Shanti about how the current scheme was working. There were parents who did not want to take on the role suggested. They did not want to take a course of counselling, and the emotional and mental health practitioner was only there half a day a week, which does not sound like enough.

I have two schools in my constituency with trained counsellors. One is full-time and one is part-time. They are a very effective way of early intervention, too. Given that Rosie has just highlighted that even with the best progress 65% of children are not going to have any support, I want to ask the Professor and Dr Clarke if they think that is something that we should be looking at as well. I think it has worked well in Wales.

Professor Fonagy: I can answer that very quickly to make sure that it is clear that mental health support teams are an addition to existing services. They are not to replace any service. The counsellors who are there should stay there and should be integrated with the NHS services. I think they could become more effective as a consequence.

Q123 **Barbara Keeley:** There is the point though that there is only so much funding to go round. The problem is that a lot of schools do not have a counsellor. It is difficult to find the funding in a school budget to pay for a counsellor. I just wondered if you would comment on the value, but you see a value and you think they should be part of this.

Professor Fonagy: If I could qualify that, the best evidence on it has been collected by my colleague Professor Mick Cooper at Roehampton. The best study on counsellors so far in secondary schools has shown that the size of effect that a counsellor achieves in treating low mood is small. It is an effect size of about 0.2. This relates to what Dr Clarke also alluded to. Cognitive behaviour therapy is the treatment of choice, and counsellors are not routinely trained in that. It is a different orientation, where the best evidence currently is that it is not cost-effective in secondary schools. There is no evidence about primary schools, but Dr Clarke has done a more recent survey of the evidence than I have.

Dr Clarke: I think school counsellors have a role to play as part of a whole-school approach in addressing the needs of individual pupils. There is no silver bullet. There is no one evidence-based intervention or approach that will be the one that we should roll out across all schools. We need a collection of support.

Exactly as Professor Fonagy just said, the evidence shows that for young people in school with subclinical symptoms, minimal but detectable symptoms, cognitive behavioural therapy interventions delivered by external professionals—psychologists, for example—are particularly effective in both short-term and long-term outcomes.

Q124 **Dr Evans:** At the risk of trying to widen this debate even further, we have spent a huge amount of time dealing with treatment and secondary prevention, but, Dr Clarke, I would be grateful for your comments on why we think all this is happening. We know that anxiety is going up. We know that self-harm is going up. We know that anorexia and bulimia are all going up. We know that depression is going up for young people.

We heard in our first session that a lot of it is to do with control, and how people have control of their lives, and what that impact is. Do you have any comments as to why this is happening and what we can do, in potentially influencing Government policy, to try to prevent us getting into the need to have exponential growth in mental health services? What is being missed?

Dr Clarke: That is quite a complex question to answer. We know that there is a range of factors that affect young people's mental health, operating at the individual, community and structural level, interacting in a complex set of ways. If we look at what we are experiencing at the moment in the context of Covid-19, to take that as an example, it has meant significant disruption to the lives of young people in their daily routines, their interactions with other young people and their ability to engage in activities that can support their mental health.

We have also seen, through Covid-19, that many young people have been exposed to loss, adversity, bereavement, domestic abuse and child abuse. All of this has an impact. When we look at the latest data on MHCYP—mental health for children and young people—from last year, when it was collected during lockdown, we see that one in six young adolescents aged between 11 and 16 were identified as having a probable mental disorder. In a class of 30 pupils, that is five pupils. We can see that it is an issue. It is quite difficult to pinpoint one particular issue.

Q125 **Dr Evans:** Let me try to break that down. The NHS White Paper that is being proposed tackles obesity, for example. We are looking at that next time. One argument is that maybe mental wellbeing should be done as a public health issue that would address some of this, and the differentiation that everyone goes through mental anguish but not everyone has a mental health problem.

What are your thoughts on that in relation to early years? I can see that the Professor has put his hand up as well, so I will go straight to him after this. From your side, Dr Clarke, does that strike a chord for young people? Is that something that you think would work?

Dr Clarke: Absolutely. Mental wellbeing is at the heart of this. We know that treatment approaches alone are insufficient to address the burden of mental health. We must promote mental health and wellbeing among children and young people. At the heart of this, we need to put in place universal provision and promotion of wellbeing interventions that are designed to develop essential life skills in children and young people—the ability to identify emotions, to regulate our emotions, to identify negative and unhelpful thinking patterns and to change those to develop coping strategies. I fully agree with you that it is at the heart of a public health approach to supporting mental health and wellbeing and intervening early.

Q126 **Dr Evans:** Thank you. Professor?

Professor Fonagy: I want to make one small point about the risks of some of these things. You mentioned the Government's new obesity strategy, which is enormously positive in terms of avoiding health problems, but there is quite a lot of information that that strategy might inadvertently cause difficulties for people at risk of eating disorders. There is a beautiful paper that came out from my colleagues Francesca Solmi, James Downs and Dasha Nicholls in *The Lancet* just today, indicating that the potential harms of obesity-tackling strategies need to be addressed at the same time as the health benefits.

There is no effect without side effects. I think the focus on mental health has been enormously helpful, but there is a risk now of medicalising anxiety. Some of the spike in the level of anxiety and depression that Dr Clarke pointed to is also part of a change in culture. I am not in a position to say whether it is a good change or a bad change.

Q127 **Dr Evans:** That is why I used the term mental wellbeing and mental health. It is very trendy to talk about mental health, but from a clinician's point of view there is a big difference between mental wellbeing and anguish, and stress and life stress, versus a mental health issue.

I appreciate that we are very tight for time, so do you think you could write to us, Professor, with some evidence of where that definition should be? You have exposure to what it looks like. I think that is at the nub of this. If we medicalise normal stress, that is where there is an overload on the system, and it takes away from the emphasis on people who really need that support, and you get long waiting lists and so on and so forth. Dr Clarke, would you like to come back?

Dr Clarke: I have two very quick points.

Q128 **Chair:** Could we make them brief ones, if that is possible, Aleisha?

Dr Clarke: Absolutely. In relation to over-medicalising the likes of stress, what mental wellbeing and mental health promotion is trying to do is to provide young people with the coping strategies for stress and the inevitable difficulties that we are faced with in life.

The second point is in relation to obesity, which you mentioned. Another area the Government are focusing on is in relation to behaviour and addressing behaviour in schools. That is a very good example of where we should align our strategies in relation to behaviour, to ensure that it supports mental health and wellbeing.

Q129 **Chair:** Thank you. A final brief word from Professor Fonagy.

Professor Fonagy: I think functioning is the important distinction. There is distress and there is functioning. Distress merges with a deficit or a difficulty in normal functioning. That is when you move from a normal to a clinical state. I will send a longer response.

Chair: Thank you very much. We will read it with great interest. The issue of medicalising mental illness is very important. We need to think carefully about that. We have had a fascinating discussion. I thank Tim and Shanti for joining us from St Albans. We are all delighted to hear how well the pilot programme is going.

Thank you, Professor Fonagy, for your helpful evidence, and thank you, Dr Clarke, for your extremely helpful evidence as well. It is really appreciated. Thank you for joining us. That concludes this morning's session.