HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: Children and young people’s mental health, HC 17

Tuesday 25 May 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; Sarah Owen; Dean Russell; Laura Trott.

Questions 130 - 181

Witnesses

I: Dr Bernadka Dubicka, Chair of the Child and Adolescent Faculty, Royal College of Psychiatrists; Saffron Cordery, Deputy Chief Executive and Mental Health Lead, NHS Providers; and Kamena Dorling, Head of Policy and Advocacy, Article 39.

II: Julie Bentley, Chief Executive, Samaritans; Mark Rowland, Chief Executive, Mental Health Foundation; Professor Louis Appleby, Director, National Confidential Inquiry into Suicide and Safety in Mental Health, University of Manchester; and Steve Mallen, Co-Founder, Zero Suicide Alliance.

Examination of witnesses

Witnesses: Dr Dubicka, Saffron Cordery and Kamena Dorling.

Chair: Good morning. Welcome to the House of Commons Health and Social Care Select Committee's third evidence session into children and young people's mental health. Later this morning, we conclude our short inquiry into the treatment of people with dementia and their carers by hearing from the Minister for Social Care, Helen Whately, and the Department of Health and Social Care director of adult social care policy, Tom Surrey.

First, we have two panels that form part of our inquiry into children and young people's mental health. We want to take a deep dive and look, first of all, into issues around in-patient care, and then, in our second panel, at issues around self-harm and suicide.

For the first panel, where we are going to focus on in-patient care, I give a very warm welcome to Kamena Dorling, head of policy and advocacy at the charity Article 39; Saffron Cordery, deputy chief executive and mental health lead at NHS Providers, who has given evidence to us before; and Dr Bernadka Dubicka, who is chair of the children and young people's faculty at the Royal College of Psychiatrists.

Thank you all very much for joining us this morning. It is greatly appreciated. We will start, if we may, by asking Saffron Cordery of NHS Providers to tell us about a survey that she published this morning, looking at the broader pressures on those providing mental health care, including in-patient care. Do you want to talk us through the main findings, Saffron?

Saffron Cordery: Yes, absolutely. Thank you, Jeremy. We commissioned the survey specifically for this evidence session. We surveyed all our mental health trust leaders, and they told us that they were seeing huge pressures on services. Services were overstretched. This was despite significant and welcome support and investment over recent years into mental health.

Of those we surveyed, 100% said that demand for treatment had increased over the last six months, and 84% said that waiting times had worsened. A large majority told us that they could not meet demand for eating disorder services; children and young people needing community support; and in-patient care.

In terms of how those pressures are increasing, the survey showed us that symptoms in young people coming forward were more severe and more complex, meaning that they take longer to address, turning into a greater length of stay or treatment in different settings. There was a lot of Covid-related demand. The pressures were also increasing due to lack of suitable social care provision. Right now, the picture we are seeing is staff shortages, bed shortages and some real concerns about workforce stress and burnout.

We think that is the case for a number of reasons. First is the impact of the pandemic. With schools closing, the broad mosaic of support that they need to catch them before they fall is not available. There are the increased pressures of pandemic life and safeguarding challenges.

There are also structural challenges, and we must not forget those. Despite the welcome focus over recent years, with things like the long-term plan, the mental health investment standard and additional funding, there are some pre-existing structural challenges that mean we are making up for decades of under-investment rather than adding to the pot for providing good services. There are also huge workforce shortages. It is an ongoing issue. We do not have enough suitably trained or experienced staff. The pandemic has taken its toll.

On capacity, we do not think that beds should be the ultimate answer, but currently there are not enough. We have not invested fully enough in community-based services for them to pick up the slack. We need capital investment. Mental health was hugely overlooked when the Government announced their new hospital programme at the end of last year. We need fit-for-purpose buildings, therapeutic environments and better infrastructure. We really need to be able to deal with this big jump in demand and the longer-term issues.

That is just a snapshot of what our survey showed us. I hope it provides a helpful context for what we are discussing today around in-patient care and out-of-area placements. They are all part and parcel of some recent developments, but also some longer-term structural challenges.

If we talk about parity of esteem, what we have not seen in the media is the same level of discussion around backlogs of care and waiting times that we have seen for acute hospitals. All trusts are members of NHS Providers, but one of the things we have seen is a big focus on acute trusts and less focus on mental health trusts and the really severe pressures they are currently facing.

Q130 **Chair:** Thank you. To what extent did your research show that the issues were caused by new problems created by the pandemic, such as children not being able to go to school, lockdown and domestic abuse, and to what extent was it just that people were not able to access the normal mental health provision because hospitals were to a certain extent themselves locked down?

Saffron Cordery: I think it was a mixture of the two. It is hard to disaggregate those elements. One striking feature was that many trusts told us that they were treating children and young people who were entirely new to them. That is a really important point.

Usually, trusts are treating an ongoing case load of children and young people, many of whom are known to them. There has been a significant increase in the number of children and young people who are new presentations. That shines an interesting light.

It is definitely a mixture. What we also saw was the important role of schools in providing support for children and young people, particularly given the fact that there were huge levels of increases in referrals once schools were back. That demonstrates the extent to which schools identify and spot issues, and then put in place the care that is needed.

Q131 **Chair:** Thank you. That is very helpful context for our zoom into the issues for in-patient care, which is what I want to move to. I want to start with Kamena Dorling, who is, as we said, head of policy and advocacy at Article 39.

Kamena, you did a report recently called “A Safe Space? The rights of children in mental health inpatient units”. It painted a pretty stark picture of the problems with some of that care. Children were being kept in hospital for too long, many miles from home. Sometimes they were on adult wards and subject to restraint, seclusion and segregation. Could you outline for us some of the things that are going wrong at the moment?

Kamena Dorling: Yes, of course. Thank you for inviting me to give evidence today in this really important area.

For those who might not know, Article 39 is a very small charity, which fights for the rights of children living in state and privately run institutions, including mental health units. We run a network of children and young people’s advocates, which has around 280 members, including independent mental health advocates.

Last year, we undertook a review looking at children and young people’s experiences of mental health in-patient care. We had originally intended to talk directly to children and young people, but then with the Covid-19 restrictions we decided instead to talk to their advocates and look at the issues that they brought to their advocates and their access to independent advocacy in general.

One of the issues that really came across was access to advocacy. As I am sure you all know, independent mental health advocates have a fundamental role in supporting children in hospital. They can help them understand their rights. They help them participate meaningfully in decision-making processes. They have a key role in supporting children to communicate their wishes and feelings to medical professionals to shape their care and treatment plans, challenge detention and plan for leaving hospital.

Many of the problems we identified during that review reflected many of the long-standing concerns about mental health in-patient care. We have already touched on out-of-area placements. One of the real concerns that came out was about children who are informal patients, in that they are not detained under the Mental Health Act but are there on the basis of their consent or their parents’ consent. They do not have the same rights as children detained under the Mental Health Act. They do not have the right to advocacy, for example, yet many of the people we talked to expressed the point that these young people are living in exactly the same conditions as those who are detained under the Mental Health Act, but they do not understand their rights and have the sense that if they, in some way, break the rules they will end up being sectioned.

There is a real question about whether we have a section of children who are unlawfully deprived of their liberty and are not having the same kinds of protections and safeguards as other children.

Q132 **Chair:** Kamena, to be clear, you are not saying that all in-patient provision is bad. You would accept that some of it is excellent. What is the extent of the problems that you identified?

Kamena Dorling: That is an excellent question. The review was obviously quite short and relatively narrow. I was trying to complement that by looking alongside it at the kind of data that is publicly available on the experiences of children in mental health in-patient care.

One of the significant problems is that we do not know, on a day-to-day basis, what children are experiencing. We do not have clear data on even the number of informal child patients in hospital, for example, so it is very difficult to talk about their experiences. We do not know the basis for their admission. We do not know how many are in different types of hospitals. We do not know how long they are in those hospitals.

One of the areas I want to raise today, because I think it is so important, is that if we do not have that data regularly obtained, collated, published and looked at, we do not know whether the kinds of problems that you hear at the sharp end, of unlawful use of restraint or very long periods in hospital when they should have been discharged, are normal across the board or whether we are hearing the worst examples.

Q133 **Chair:** I want to ask a question of both you and Dr Dubicka. We have heard a lot in our inquiry about the Trieste model in Italy, which, effectively, bans long-term admission to mental health units. It is easy in, easy out. They have in-patient units, but they make it very much harder to have people on a long-term basis. Is that an approach you think we should be adopting here?

Kamena Dorling: We definitely want to see that any child is admitted to in-patient care only as a last resort and for therapeutic benefit, not because there is a lack of appropriate community support. We need a system where children are treated and able to recover in a caring environment that is close to home and appropriate for their age.

I do not know a great deal about the Trieste model, but from what I have read, it seems to be progressing towards a system of community mental health centres, with a very limited number of beds in hospitals for crisis care. That sounds as though it is more likely to deliver what we want to see for all children.

That is systemic change that I think we would want to work towards. In the interim, we actually have existing safeguards in our system that are not working properly. We want to look at how we can improve those existing safeguards while we are trying to make a significant shift towards an increase in community care.

Q134 **Chair:** Thank you. Let me bring in Dr Dubicka from the Royal College of Psychiatrists. We were surprised at how open-minded the RCP has been to the Trieste model in our earlier discussions on it. In this context, what is your view about long-term in-patient care for highly vulnerable people?

Dr Dubicka: Thank you for inviting me to speak again, Jeremy. This is a subject that is very close to my heart because I have been a frontline clinician for over three decades, and 11 of those years were spent in in-patient services. I left my in-patient work in 2018 but have obviously been in very close contact with my colleagues since. There are a few points I would like to make.

I agree with everything that my predecessor has just said. The tragedy is that everything that Saffron said I and my colleagues were saying back in 2018, when I was still working in in-patient care. What we are seeing now, in terms of your question on the impact of Covid, is a crisis on a pre-existing crisis.

It is relevant to say that, in over a decade of in-patient care, the types of admissions we had changed completely. When I started working in in-patient care, we could do planned admissions. I used to go out and do an assessment with a nursing colleague from our intensive support team. We used to try to prevent the majority of admissions, and we did that by providing a six-week package of intensive care. However, some young people still needed to come into hospital.

In what happened over the decade pre-pandemic, and has intensified now, it has been a complete tragedy to see the sorts of young people who are coming in. It was utterly heartbreaking for people like me, who were trying to manage and deal with those young people. We are seeing more and more looked-after children coming in, because of the failures of social care and because of the cuts in social services. There are young people who are incredibly emotionally disturbed and are trying to kill or harm themselves. That was due to the lack of the right support in the community.

The number of young people with autism and learning disability has increased significantly, again because families were not getting the right level of support. I remember one family who were trying to go abroad to Europe to get the right kind of support for their child in the community. Eating disorders have also increased.

What I saw over that decade—my colleagues tell me it is even worse now—were the wrong sorts of young people coming into hospital because of the failures of community care. That is across the board. It is a systemic failure of social care, specialised education and youth justice for young people with neurodevelopmental problems.

On the Trieste model, all my colleagues have been saying the same thing for many years and would say the same thing now. We absolutely need to invest in community provision, not just for mental health but across the board, and particularly for social care. So many young people are failed at that point and need that specialised care.

It would be negligent to eliminate all beds. For example, over the years, and recently, young people who have severe mental health problems, like schizophrenia, bipolar disorder or an eating disorder that has been very resistant to treatment in the community, need to be admitted to save their lives and to be in a safe place. Sometimes those admissions can take a lot more than a few weeks. For example, I have managed many young people with severe psychotic illness. It can sometimes take months to get the right treatment and for their mental state to improve, so that they have the insight to collaborate with treatment.

The other thing I need to point out about what is happening in in-patient units is that when I started working in in-patient care I used to detain one young person under the Mental Health Act per year—one. By the time I finished, the majority of young people in in-patient care were detained under the Mental Health Act. Even more tragic were the ones who were not detained. They were angling to try to get me to detain them because they were just too scared to be discharged; going back to the community was not safe. They were not going to get the right level of support. Things have changed exponentially over the past 10 to 15 years, and that has been highlighted all the more by the pandemic.

We have not been using our resource efficiently. I would love it if far fewer people were falling into crisis and we could give them the right support at the right time. To do that, we have the 10-year plan. What is stated in the plan is completely noble. We very much support it. However, there is no plan alongside that plan as to how we are going to achieve it. Systemic integrated care is essential, but we need to identify where the funding and the resource is going to come from to invest in social care.

Q135 **Chair:** You are saying that investment in social care is essential.

Dr Dubicka: It has been essential for years. That is why we are in the position we are in now. It is absolutely essential. I cannot tell you how heartbreaking it is to look after somebody in an in-patient unit when you cannot find anywhere for them to go in the community. They stay for months on end. They should have been discharged ages ago, but there is a lack of specialised placement. I have known young people go into homeless accommodation through social care. It is a travesty. It is because we do not have specialised provision available. We are spending money on very expensive social care beds for young people who should be properly looked after. That will need significant investment.

In terms of specialised education placements, obviously what is happening with the Green Paper is fantastic but that is only the tip of the iceberg. Some young people need a lot more than that at the moderate to severe end of the spectrum. Similarly, for the youth justice system, we know that many, if not the majority, of young people in the youth justice system also have neuro-disabilities, head injuries and other issues such as that.

Chair: I can see that Saffron wants to come in and we will definitely bring you in, but I am going to go to my colleague James Davies.

Q136 **Dr Davies:** Kamena, you touched previously on the concept of those who are detained informally and the fact that in many respects they have fewer rights than those detained under a section of the Act. Can you explain to what extent you think that is an issue?

Kamena Dorling: As I said, a significant number of children are in in-patient care on the basis of their consent or their parents' consent, and they have a different set of rights from those who are detained under the Mental Health Act. One of the most significant differences is that they do not have an entitlement to independent mental health advocacy.

Some advocacy providers adapt to that and offer a service to informal patients. They might offer a drop-in, but it will depend on the provider and on the institution, so what we have is very patchy provision. We heard from advocates that, first, informal patients are often kept under the same kind of conditions—the same deprivation of liberty, if you like—as those detained under the Mental Health Act, but, secondly, did not have a firm understanding of their rights. They did not have a firm understanding of their right to leave or whether that could be implemented. They felt that there was a threat of being sectioned.

While for some being an informal patient is really important for them to feel that they have control over their life and their treatment, there is a serious question about the inequity of protection for the two groups. It is something that we really want to address. It is something that the Government, in their White Paper on the Mental Health Act reform, acknowledged needs addressing. They recognised the need for all informal patients, not just children and young people, to have access to advocacy. Unfortunately, in that White Paper they do not go so far as to commit to providing that or putting it into legislation when we have a mental health Bill.

Article 39 and other organisations responded to the White Paper to assert that we need two things. We need all advocacy operating on an opt-out basis, such that you are automatically offered advocacy. This is really important for children, if you think about how unwell they might be when going into hospital. You need to repeatedly engage and make sure that they know that that support is available and are given the opportunity to use it. We need it to operate on an opt-out basis, but we also need all those admitted to hospital informally to have that right.

Q137 **Chair:** Could we bring in Saffron, James?

Dr Davies: Of course.

Saffron Cordery: I want to follow up the point around social care. I think this is one of the things that came through in some of the more qualitative responses to our survey. Trust leaders were experiencing pressures because of the pressures in social care.

One particular point that came through was that, as local authorities provide the tier one and tier two support, trust leaders told us that when that was not available, what had to happen was prescribing up rather than providing the right solution. Just as Bernadka said, this is about having to look after young people in a setting that is probably more secure than they actually need because there is nowhere else for them to go.

The point around social care and investment in social care and local authority services is critical. They are in the system as a key part of the delivery structure of mental health services for children and young people, but we have seen ongoing cuts in the public health budget and in services commissioned and delivered by local authorities that focus on prevention. We cannot overstate this: investment in social care and local authority services is absolutely critical.

Q138 **Dr Davies:** Kamena, can you give us an idea of the proportion of those who are in a setting of informal detention, who you think may be affected in this way?

Kamena Dorling: I would love to be able to give you that sense. It brings me back to the point I made earlier. Currently, we do not even have published figures on the number of children who are in mental health in-patient care on an informal basis. We do not have access to information on the grounds for their admission, whether it is by their consent or their parents' consent. I think we should have that data. It should be publicly available.

We also do not have data on access to advocacy services for children and young people in in-patient care. This is something that we tried to obtain at Article 39. The responsibility lies with local authorities to provide advocacy. We sent freedom of information requests. Basically, the majority were not able to give us information on how advocacy was being provided or how many children were accessing it. We had a really worrying figure, which I am trying to find, in a report from the Children's Commissioner for England last year looking at the impact of Covid on children in hospitals. Apologies for not being able to find it; the report found that something like nearly 20% of hospitals had had no advocates visiting prior to March 2020.

The data just is not there. I will sound like a stuck record by the end of this, but I think it needs to be. It is beholden on the Government to try to oversee that, so that we know whether children's rights in hospital are being upheld.

I want to make a quick point about the intersection with—

Chair: Briefly, Kamena, because we have lots of questions to get through. Fire away, but briefly if you would.

Kamena Dorling: I completely agree with what everyone else has said about the importance of looking at both what services are available in the community and when local authorities become involved in a child's case. Under the Children Act there is a duty, when a child is held in a hospital for longer than three months, to visit that child and assess whether they need any kind of further support. This is another area where we are not clear. Advocates told us that that often does not happen, and that can impact discharge planning.

Q139 **Dean Russell:** I will direct my question to Saffron, in light of your report. It is related to the pathway before in-patient care. When I have been speaking to constituents—one in particular recently—their concern is with the ability to do crisis support and the quite traumatic experiences of their children through mental health. They say there is not necessarily the mechanism to support them quickly and get support that will help them in the long term. How much do you think that is playing into the need to have greater in-patient numbers?

Saffron Cordery: It is interesting that the conversations around the Trieste model are about how you do everything you possibly can to make in-patient care a last resort, rather than one of the only options available to you. Your question speaks very much to that agenda.

We know that the availability of crisis support in the community is absolutely critical. We have a really good programme with the long-term plan for mental health, and I wholeheartedly commend it. Trusts up and down the country are working hard to implement it.

The way that the long-term plan has been approached has been to look at investment in a number of specific programmes—eating disorders and early intervention in psychosis. One of the areas where we have only more recently seen greater investment is in community mental health teams. I used to describe it as a bit of a doughnut. There was a lot of intensive support around different programmes, and across mental health, beyond children and young people. With things like perinatal interventions and perinatal mental health, there were very focused work programmes. There seemed to me to be a little bit of a hole in the middle, which was around community mental health teams and their support. That is where we need to focus.

At the beginning of last year, a programme was developed and it started to be rolled out. That is where we need to look. The shortage of community support means that we are unable to provide crisis support. That is not to say that it is not happening. It is happening, and trusts up and down the country have 24/7 crisis lines, but we know that it can be patchy. That is usually due to workforce issues.

Although the numbers of mental health and learning disability nurses and consultants are going up because of investment, what we also know is that demand is going up even faster. Trying to keep up with that is incredibly challenging. Community is absolutely rightly the focus, but there are shortages.

Q140 **Barbara Keeley:** Kamena, can I take you back to the sort of in-patient units with abusive practice that we are so concerned about on this Committee—things like use of restraint and isolation? That is particularly of concern to us for autistic young people and young people with learning disabilities.

The Committee recently heard evidence from a parent of a young person in such a unit. This was followed by the unit removing the rights of the parents to visit. We heard about that from her, after the Committee, on social media. Do you hear from advocates about elements of care and support like visits being withheld as, effectively, a punishment for the family?

Kamena Dorling: That is really shocking and appalling. The withholding of visits is not something that came out of our review last year. What did come out was inappropriate use of restraint, seclusion and segregation, and the failure of units to follow up when complaints were made about that.

I thought it was striking that advocates talked a lot about seclusion and segregation, and about not being told when that was happening and having to fight really hard to make sure that segregation was not used for longer than it needed to be. In one case, we heard of a child who was only supposed to be in segregation for six weeks. I said "only", but six weeks is an incredibly long period of time for a child. It ended up being over four months. During that time, the child's advocate had to argue for them to have access to activities, television and outside space. Again, it goes back to the point that, when you have closed institutions, you need to be able to have external oversight of what is happening so that children's rights are protected.

If I could talk very briefly about restraint more broadly, we have data on this, for which I am very grateful. As of last year we have disaggregated data on under-18s and the use of restraint. In 2019-20, 616 children were subject to restrictive interventions. Significantly, a third of those children were subject to prone, face-down physical restraint, which is particularly harmful and dangerous. NICE guidance emphasises that it should be avoided and states: "This position can, and has, caused death after as little as 10 minutes, by causing a cardiac event." It is completely unclear to me why we are still seeing it used on children. We have got to the stage where the use of restraint is almost seen as the norm in reacting to challenging behaviours, even though our existing guidance talks about not using—

Q141 **Chair:** Could I bring in Dr Dubicka on that point? You worked in an in-patient unit. Is that the case? Do you think there are in-patient units where the use of restraint, and indeed prone restraint, is the norm?

Dr Dubicka: That really shocks me because it should not be happening. It certainly has not happened in the places where I have worked. If it is happening, it is essential that it is completely stamped out. We know from the work programme around restrictive practice and restraint that there are varying practices around the country and that they can, and should, be improved.

Again, if we go back to advocacy, it is so important that we work with young people around restrictive practice. At the unit where I worked, it was by consulting with young people that we were able to identify restrictive practices that staff were not aware they were doing because they had become routine. It is so important that there is co-production and advocacy as well.

Could I go back to the crisis question that was mentioned earlier? I should like to comment on that if it is possible.

Q142 **Chair:** Yes, please do, and then we will go back to Barbara.

Dr Dubicka: I absolutely endorse the need for crisis support. It is improving and NHS England is working hard to do it, but crisis support is still so patchy around the country and is nowhere near on a par with adult mental health, for example.

The other thing that happens is that new services are being set up—for example, where I work crisis services were set up—but then we do not have the specialised staff to support them. All that happens is that specialised staff shift over, for example, from in-patient services—

Q143 **Chair:** So crisis care for young people is patchier than it is for adults.

Dr Dubicka: Correct, yes. We have very patchy crisis care provision and very patchy provision in paediatric wards and in A&E departments for mental health support. We do not have specialised staff stepping forward. Five years ago, we were promised 100 more child psychiatrists. In fact, we have had a reduction of 26 consultants. Across Europe, of 24 countries we are No. 21. We have 4.5 on average per 100,000 of the population, whereas in Finland they have 35 or 36 child psychiatrists. It is similar for mental health nursing as well.

The problem with setting up these new services, which we so badly need, is that we do not have specialised staff with experience. It is fantastic that we are getting in lots of new staff in the Green Paper, but they are not specialised.

Q144 **Barbara Keeley:** You mentioned earlier the appropriateness of in-patient units. You said that admissions were only when necessary and for therapeutic benefit. Basically, we are quite concerned about, and are looking into, the detention of autistic children and young people with learning disabilities. Dr Dubicka talked earlier about an increase in the number of autistic children and children with learning disabilities in those units. Have you seen that increase in the number of children and young people you are working with?

The other question is on ways forward. You have talked about the incidence of informal detention. What changes do you think would be needed to reduce the informal detention issue that you talked about and the consequent lack of human rights for those young people?

Chair: Kamena, do you want to address those points?

Kamena Dorling: On the informal patients' issue, I do not think it is so much a question of reducing the number of informal patients as of ensuring that all children in in-patient care have the same rights and the same protections. That is our focus.

On the point about children with autism and learning disabilities, again from the data, which we have, it is clear that so little progress has been made in this area. I find it staggering. We had a Government commitment to reducing the number of children with learning disabilities and/or autism in in-patient care, yet we have double the number in hospitals at the moment than we had five or six years ago.

Q145 **Barbara Keeley:** It is double the number that it was five or six years ago.

Kamena Dorling: Yes; we have data on that.

Barbara Keeley: Despite Government targets to close those units. It goes back to the question about Trieste. We are in a situation where it has doubled in five or six years.

Q146 **Chair:** Could you send us that data and where you got that data from, Kamena? That would be very helpful for our inquiry.

Kamena Dorling: I can—the whole briefing.

Chair: We do not need it now, but if you could send it to us that would be great.

Q147 **Rosie Cooper:** We have heard some traumatic evidence at the Committee when dealing with this issue. I would like to ask the panel how effective they think the CQC is at tackling poor-quality in-patient providers. There was a worrying story in the *HSJ* last week about it taking many attempts to raise concerns over several years before the CQC rated one such hospital as inadequate.

One parent gave exactly the same evidence to the Committee, saying that they had complained and years later the unit was still rated inadequate. As ever more work is being given to the CQC—more regulation—do you think we can just rely on this one method?

Dr Dubicka: The CQC does a lot of good work. I sat on one of their recent panels regarding how they can improve what they already do. A lot of that focus was around advocacy and working closely with patients.

In terms of safety, there is absolutely no doubt in my mind that the most important thing is to have the right staffing complement, the right number of specialised staff, and trained staff. Unfortunately, in-patient care is the area where we are really struggling. We are struggling across the whole of mental health care to try to get workforce, but in-patient care is the area where it is most difficult. We know that nearly half of in-patient units in a recent survey felt that they did not have the right number of staff. What then happens is that agency staff are brought in—

Q148 **Chair:** Sorry, Dr Dubicka, but the question is whether the CQC is doing a good job in highlighting those problems.

Dr Dubicka: I think it has highlighted them. There was a report in 2018, which was excellent, but I am not sure that the recommendations have been worked on.

Q149 **Chair:** Shall we bring in Saffron and Kamena on that question?

Saffron Cordery: I echo Bernadka's point: the CQC does a lot of really important work. What we have to look at are some fundamental questions around how we actually bring about improvements in safety and quality, not only in in-patient units but across the board. It is important that we have an independent quality regulator like the CQC, but it is also important that we focus on frontline services themselves and what they need to do to improve their quality and safety.

There is an important question around the partnership that can exist between the quality regulator, organisations delivering services and the wider system. What we do not want to see, which we have seen increasingly, are quality and safety issues identified and units closed without any alternatives being put in place. We know that that has, for example, contributed across one region in the country to a reduction of 80 in-patient beds, which is a huge chunk of provision. We need to be really careful—

Q150 **Chair:** I am sorry to interrupt. It is just because of time. Kamena, do you have any comments on the CQC?

Kamena Dorling: Two very short ones. Prior to last year, the CQC did not look at the provision of advocacy in in-patient care. That was something we raised, but they have acknowledged themselves the need to do that as part of improving their work. That is very welcome and it is something to monitor.

One of the issues raised in the reforming the Mental Health Act consultation was about how you can look at the issue of children being placed on adult wards. The independent Mental Health Act review of 2018 recommended that the CQC be notified within 24 hours. The Government rejected that and said that the CQC should be notified within 48 hours, and that was sufficient, and that it would follow up.

Given the very high numbers—592 children were placed on adult wards in 2019-20—that raises questions for me about how that safeguard is working in terms of the CQC following up.

Q151 **Rosie Cooper:** I want to make the point that nobody is questioning the validity of the CQC. What we are saying is that we know the CQC does not investigate individual complaints, but when parents alert the CQC over issues in private homes, it may take two or three years to get action.

My question to you guys is, what can we do together to bridge that gap? Those children are the most important part of this. We can say the CQC is doing a grand job, they're all very busy, and they're not doing individual complaints, but meanwhile children are left helpless in that situation. That is the bit—

Chair: Rosie, we only have time to ask one person to answer that. Who would you like to choose?

Rosie Cooper: Kamena, please.

Kamena Dorling: There needs to be a stronger mechanism for responding to concerns raised by parents and carers of children in in-patient care. We need inspections to be unannounced and we really need to think about how those inspections are prioritised, based on the evidence that is provided, especially if there has already been evidence of malpractice in the past. I am not sure that is very concrete.

Chair: But it is very helpful. Thank you.

Q152 **Sarah Owen:** This question is for Dr Dubicka and possibly Saffron as well. How important is it to have services that reflect community and cultural needs, and breaking additional barriers to access for care, particularly for black, Asian and minority ethnic young people?

Dr Dubicka: That is a really important question. There are a couple of things around that. We have not worked hard enough and we do not have systems in place to reach out to those children and young people. In fact, I am involved in a research project at the moment looking at the needs of Afro-Caribbean children because we know that they are disproportionately represented in in-patient care in particular. It is a really important question. Of course, their experiences of mental health services or social care—whichever service—also need to be considered in the context that they do not always have staff or professionals working with them who might understand their life experience. We need to work really hard to ensure that we are recruiting staff who can understand the issues that these young people are dealing with. It is vitally important, and there has not been enough attention paid to that.

Saffron Cordery: I agree. I think we have seen a bigger focus on this issue in adult mental health services than we have in children and young people's mental health services. There is a whole bundle of issues around over-representation in services, and the corollary, with over-representation in the criminal justice system and in exclusions in schools, which come together to reflect the real need for a more programmatic focus.

The question and Bernadka's responses are absolutely spot-on. We need greater focus on issues around inclusion, diversity and equity.

Sarah Owen: Thank you.

Q153 **Laura Trott:** Bernadka, I want to follow up a comment that you made earlier, which is that we are seeing an increasing number of looked-after children coming into the system. Can you describe the changes that we need to see in the social work system to make sure that we minimise the number of those children coming in?

Dr Dubicka: They are massive. They are absolutely significant, and we have seen that highlighted in recent reports on children's homes, for example, by the previous Children's Commissioner. Again, that is something I see time and time again.

First, the threshold for trying to get support for social care is incredibly high. We know that, if there is an issue for most of the children that I see at the moment in the community, it would be so hard to get support because social care is understaffed and under-resourced. Therefore, that means you cannot get the support early enough.

It is important that we look at the quality of that provision, and that we not only have sufficient social workers but that they are well trained, and that we have the right, specialised placements for these young people. The sorts of young people I see have been extremely traumatised. They need specialist mental health provision in any residential setting. That is really hard to come by. As we know, often the standards of care are not good enough and are failing these children.

One of the reasons why we have such a backlog of young people waiting in tier four, in in-patient beds, is that we cannot identify the right social care provision. Often, these children are shunted around the country, far away from their families. It needs investment across the board.

Q154 **Laura Trott:** How good do you think the training on mental health is currently for social workers? What do we need to change in that area?

Dr Dubicka: It is not enough. We do not pay them as much as some countries, for example, Scandinavia, where it is seen as an important profession. We need to pay people who work in care homes more. We need to give them much more training. It is a very specialised and incredibly difficult and demanding job, looking after some of the riskiest children and young people, who have been so traumatised. No, they do not get enough training. It needs to be regarded as a specialist profession, which is what it actually is.

Chair: Thank you very much indeed. I am afraid that brings us to a close in our first panel, but we had a very good discussion and lots of helpful thoughts.

A very big thank you, Bernadka, Kamena and Saffron, for your evidence this morning. It will really help us to get to the bottom of the question of the right role for in-patient care, and what you need as the alternatives if you are not going to have in-patient care. There were also very important points on advocacy and the use of restraint and seclusion. Thank you very much indeed for joining us.

Examination of witnesses

Witnesses: Julie Bentley, Mark Rowland, Professor Appleby and Steve Mallen.

Q155 **Chair:** We now move to our second panel. We are going to do a deep dive into very challenging issues around self-harm and suicide. In this session we will hear from Julie Bentley, the chief executive of Samaritans; Steve Mallen, co-founder of the Zero Suicide Alliance, which he set up after tragically losing his son Edward to suicide in 2015; Professor Louis Appleby, who is professor of psychiatry at the University of Manchester and director of the National Confidential Inquiry into Suicide and Safety in Mental Health, and is probably the go-to person as far as the NHS and the Department of Health are concerned when it comes to suicide matters; and Mark Rowland, who is the chief executive of the Mental Health Foundation and a member of the National Suicide Prevention Strategy Advisory Group.

A very warm welcome to all of you. Steve, would you provide some context for the discussions this morning? Could you briefly tell us what happened to Edward, and what you think could have prevented it?

Steve Mallen: I lost my son Edward six years ago to suicide. He was 18 at the time, but one of the points to note about Edward is that he was an incredibly capable young man from a good family and a good background. He was not affected by many of the social and economic issues that we know to be drivers of mental illness, suicide and so on.

The first point I want to make is that self-harm and suicide prevention is obviously a pan-society issue. It is everybody’s business. Clearly, the effect on my family was devastating. It is sometimes said that these instances, although rare, are not necessarily that common. What we learnt from Edward’s story, together with many others—I have devoted the past five or six years to researching this sector, as many will know—is that this occurrence happens on a daily basis.

What happened to my son was not a random event. It was not like being struck by lightning or the random act of whatever God you happen to believe in. Unfortunately, he became very ill very quickly, and he was failed by his community, by his school and most especially by the NHS. What we really learnt from that is that self-harm and suicide, as I say, is a serious issue in society now. We have had a lot of evidence this morning about the growing proliferation of these issues. My son is part of that very tragic narrative.

Q156 **Chair:** Thank you. With others, you set up the Zero Suicide Alliance. Some people say that aiming for zero suicide is too ambitious. You obviously do not agree. Tell us your thinking about why we should be aiming for zero.

Steve Mallen: Absolutely. The first philosophy to apply is that we believe that self-harm and suicide are almost always preventable. We must approach them on a preventable basis. It is my understanding, having spent some years researching this sector and so on, that there was always, to a degree, an acceptable level of loss, if I can put it that way, within the system, in that somehow suicide was inevitable in some instances.

It would be naive to think that of course we could eradicate self-harm and suicide from society, but I would ask this question: "If zero isn't the right number, what is?" We must have a zero tolerance approach to suicide. I think that is a very important point.

We have to be careful about using any numbers in the health system, of course. I stress that zero is not a target, but it must surely be an aspiration, particularly with regard to in-patient settings and with regard increasingly to out-patient settings as well. It is predicated on the fact that we believe that most people can be prevented from reaching crisis and that most people, at the point of crisis, can probably be salvaged with appropriate intervention.

Q157 **Chair:** Thank you. We will come back to you, Steve. Professor Appleby, suicide is always preventable and there should never be an acceptable level of loss. That is a big challenge to our system. Do you agree with what Steve is saying?

Professor Appleby: There are always preventable factors—always. I agree with most of what Steve says. Steve and I have talked about these issues many times. It is right to regard no suicide as inevitable. Sometimes in the mental health culture, perhaps as a way of protecting ourselves from the distress that it can cause to staff who do their best but it is not enough, we sometimes get into the language of inevitability. I think that is not correct; we should never regard suicide as inevitable. No suicide is inevitable, and every suicide has preventable elements. That is not the same as saying that we can expect the suicide rate to come to zero. That is not going to happen.

Q158 **Chair:** What is happening to the trends in suicide? There has been a lot of discussion about the impact of the pandemic, but when you look at the overall picture, and for young people, is the trend line going in the right direction or the wrong direction? What is actually happening?

Professor Appleby: The suicide rate for young people in this country is going up. Let's take the under-20s, for example. The rate in the under-20s has been rising for about 10 years. That runs counter to the pattern in the general population, for all ages. It is a distinct pattern in young people.

At the moment, if you take the most recent confirmed figures based on inquest conclusions—these figures are from 2019, so pre-pandemic—they are the highest for young people, broadly speaking, that we have had for about 20 years. They have been rising for about 10 years to a point where the figures are the highest for about 20 years. That is true whether we look at under-20s or under-25s. It is particularly true in females, where the rates are at historical high levels at the moment.

One of the reasons for that is that women have lower suicide rates. The baseline is much lower, so a rise has a bigger effect proportionally. The situation is problematic for young people, to put it mildly. It is reflected also in self-harm rates, which are more difficult to measure because they depend largely on hospital attendance. Those rates are going up in young people as well and have been going up for probably about 20 years.

Q159 **Chair:** Thank you. We had Claire Murdoch giving evidence to the Committee. I asked whether there would be benefit in doing some analysis, a bit like the Hogan and Black analysis of hospital deaths, to try to gauge independently what proportion of suicides really had a 50% or more chance of being preventable. She wrote back to me saying that she felt the numbers for young person suicides were too low to do that kind of analysis. If we were to do it for all suicides, would that be a helpful piece of research to have?

Professor Appleby: I don't think that is the right way to approach it. The issue in that kind of research is whether the care was satisfactory and whether the death was therefore preventable, or whether it reached a certain level of preventability, a 50% likelihood of preventability. I do not think those things are realistic in real lives.

If you accept that all suicides have a degree of preventability, I do not personally like the notion that there is a cut-off—even a 50% cut-off—below which preventability is too low. It is much better to think of what factors apply across those who die that could have been effective. We know quite a bit about how mental health care can be more effective at prevention. Obviously, it is not just a job for mental health care, but we know quite a bit about that. The risk of the style of research that you refer to is that it creates an artificial divide, which I think is not justified.

Q160 **Chair:** What are the best reduction strategies, based on the data that you are looking at in the national confidential inquiry?

Professor Appleby: In relation to mental health services, suicide prevention is never one thing. We need safer wards. There are several elements in what makes a ward safe. We need safer post-discharge care because the peak period of risk is the period immediately after leaving hospital. We need to be able to provide care for people whose mental ill health is complicated by additional problems—so-called comorbidities in the jargon. It is not just a problem of depression, for example, but problems of alcohol, sometimes social problems about housing and family support and so on. It is being able to deal with the breadth of problems that young people have. Every one of those additional problems adds to risk.

There are specific concerns about drugs and alcohol, and about the lack of involvement of families. There is a whole set of measures that our evidence from the confidential inquiry shows are associated with lower patient suicide rates, which are applicable to young people as well as to other age groups. For me, a better study would be to assess how often those proven, evidence-based interventions are applied when people receive care.

Q161 **Chair:** Are we doing that study?

Professor Appleby: We do it in relation to those who die, but it is not being done in a more general sense. I suppose there is an element in which it is. In our work, we publish guidance for the NHS. We publish a self-assessment audit. It may sound like a small measure, but it allows services to assess the configuration of their services against the known suicide preventive interventions. Every mental health trust in the country has taken up that audit tool. There is an opportunity for them to look at their own—

Q162 **Chair:** We know that there are problems with self-assessment. In our maternity safety inquiry lots of trusts said that they were following all the right guidelines on maternity safety, but it turned out that they were not. There may be some value in an independent study to do something like that. We will come back to you, Professor Appleby.

Lots of colleagues want to come in, but because it is such a big issue I want to ask the other panellists whether, in terms of the best reduction strategies, they would add anything to the list that Professor Appleby gave. Julie, why don’t I start with you?

Julie Bentley: One of our key messages from Samaritans would be that we are very concerned about the increasing rates and high levels of self-harm among young people. We know that there is a link to suicidality in relation to that.

Our real concern is that young people are simply not having access to help early enough. We know that they are being moved from pillar to post. They are being ping-ponged. They tell us that themselves. They are not able to get support until they are absolutely at crisis point. We are very much of the view that we need to make sure that services can get to young people much, much sooner and long before they reach crisis. Picking up Steve’s point, we need to get in there much earlier. We need a much more preventive approach so that we do not find young people at crisis.

We did an inquiry through the APPG last year, which looked at testimonies from a number of young people who self-harmed about their access to services and how it was for them. We heard a stream of stories from young people who had not been able to get the help that they needed. They were falling between the gaps because their challenges and problems were considered too serious for some services but not serious enough for others. They were being sent away until their problem got worse and was exacerbated. Then they were coming back in crisis.

The APPG inquiry was told that very often young people were advised to not talk about self-harm because that would, on occasion, exclude them from being able to access support. For example, a young person, Tabby, told us that in group therapy they were not allowed to say the words self-harm. For them, that experience was that it just further stigmatised the issues that they were struggling and dealing with. Another young person told us that their GP was going to try to refer them for CBT, but the GP said to them, "Try not to talk too much about the self-harm or they won't accept you for the service."

We also see that when schools are really struggling with children who are self-harming, they refer them to CAMHS, but when they get to CAMHS the problem is considered not to be important or serious enough at that point for CAMHS, so they are bounced back to the school. From our perspective, much speedier—

Q163 **Chair:** Earlier intervention is the key.

Julie Bentley: Yes.

Q164 **Chair:** Thank you. Let me bring in Mark Rowland from the Mental Health Foundation. Welcome to you, Mark. We have had Professor Appleby's list of reduction strategies, and we have heard from Julie Bentley. What would you add?

Mark Rowland: I have lived the experience of being involved with suicide, with my brother in an in-patient setting in Cardiff. The issues that we are discussing today, as Steve said, are like mirrors shattering in families and communities.

We really welcome this opportunity. The points I want to make are about the two thirds of suicides that happen outside an NHS context or a clinical context. The Mental Health Foundation has been around for 70 years. We have completely pivoted our strategy to focus on public mental health and prevention. The role of treatment is vitally important, but it will not address one of the leading public health concerns of our time.

What I would add to Professor Appleby's list is that we have a suicide prevention plan, but we have falling levels of investment in our local authorities, where the local authority suicide prevention plan sits. When you look at a 15% fall in the public health grant since 2015, that is a problem for suicide prevention. When you look at the amount of money going into public mental health from the public health grant, the number is 1.6%. We are not investing commensurate with the social problem of our time in the communities and localities where people live.

The World Health Organisation is clear that the best investments are in public health approaches in early childhood. We would reap such huge returns if we were investing in the social structures around young people's lives that we know would make a difference. That is around parent/infant support, targeted at people we know are at risk. It is whole school approaches, with proper statutory advice. It is mentoring programmes for young people to have one good adult. Those are the factors. Those are the social support systems that would bring down suicide rates.

I will finish with this, because it is important to understand. If you look at the material deprivation index, suicide increases for every step as you go down the social gradient—every step. That association starts to break down with children and young people aged under 20. Inequality, deprivation and poverty are not necessarily the full picture of what is happening with our young people.

We are at a point now, coming out of Covid, where we have some real choices. Taking a public health approach to the crisis around children and young people over the long term is really difficult, and I understand that, but with the establishment of the new office for health promotion, this Committee could have a powerful role in saying that we need well-resourced, clear, measurable targets for a national public mental health strategy. I think that is doable, but it has not been done. It is about cross-Government commitment in different areas.

Q165 **Chair:** Thank you, Mark. Let me bring in Steve. You have heard a number of people talking about the most effective ways to reduce the number of suicides. Is there anything in particular that you would add?

Steve Mallen: I very much support what Mark was just saying. Obviously, the mantra now is about prevention. I also want to highlight another point that I think is quite important to this narrative.

Since I lost my son, and in recent years, we are all aware that the social narrative relating to mental health and suicide has changed enormously. It is now a much more open subject. We are starting to push back the stigma associated with these issues, at society level, in sport, in the media and so on.

That is a very good thing, because it plays very positively into the prevention agenda, and is particularly relevant for young people. What we are seeing now, as a result of that change in the social narrative, are more young people coming forward and asking for assistance at an earlier stage than they might have done previously. In other words, we are not picking up people when they get to crisis necessarily—although, hopefully, we still are—but actually the change in social narrative means that someone is putting their hand up and asking for help.

We have seen a change in the classroom. We have seen a change in universities and in family settings. One of the strange benefits, if that is the right word, which it probably isn't, of the pandemic, is that children have spent a lot more time with their parents, and their parents have started to understand their needs, their issues, their worries, their concerns and, in many instances, their clinical position.

What we have, Chair, is something of a perfect storm. Obviously, the pandemic has had a serious impact on community and of course health services, but that is being met by burgeoning demand. It is not necessarily burgeoning demand in an absolute sense, as Louis would say, because rates of self-harm and suicide are rising. More people are coming forward earlier and asking for help in a system that is increasingly constrained in capacity and investment. Obviously, we have a serious bottleneck in the system that now needs to be addressed.

Chair: Thank you. I will bring in some of my colleagues now.

Q166 **Dean Russell:** Julie, one of the challenges I have seen in this space—I have been doing a lot of work in the mental health arena since being elected and prior to that—is the impact of suicide and self-harm, not just on the individual or the young person but on their family as well. It feels to me that one of the common threads of the statements just now has been the real need for support in the community, but also in the family and in schools.

From your perspective, what more can be done to help educate families and support them through the process? What I am hearing is that families are incredibly stressed, and parents are incredibly worried about the process. They do not quite know what the next stage is. They do not know how to fight back, as it were, when there is a crisis happening, and they do not feel they are being listened to. I am interested in your view on that from your experience.

Julie Bentley: I think the most important thing when we are dealing with young people's mental health problems, whether it be thoughts of suicide or of self-harm, is that they feel able to talk about that and name it. What we know is that one of the really difficult things, particularly around speaking about feelings of self-harm or suicide, is that they are very stigmatised and very misunderstood. It scares people, particularly if young people start to talk about those feelings, and especially if they talk about them to their nearest and dearest. That often makes young people not want to talk about those things to their families because they do not want to have that impact.

I would like to move on at some point and talk about the online environment. We often hear from young people that they look online for support because they do not feel that they can talk about things to their families. I would say that one of the most important things is continuing to break down the stigma of talking about feelings of mental health challenge, suicide and self-harm, and equipping parents with the skills to know how to talk sensitively to their children about those issues, to help them to navigate them and not to feel alone with those feelings. They are tremendously scary feelings to be alone with. We know from our Samaritans service that one in 12 calls to our helpline last year was around self-harm. It is a really burgeoning issue.

Picking up the point Steve made, there is now more permission to talk about mental health. Young people talk more about it. It is brilliant that young people are feeling more able to talk about it, but we need to not let them down. If they come and say, "I've got a problem, I'm in trouble," but they then find that they are being buffeted around from pillar to post, or being given the message that their issues are not serious enough yet, what we are going to see is young people feeling that they have to have escalated to a point of real crisis before they have permission to ask for help.

As I said before, we need to combine bringing in much more help much sooner, and supporting parents with how to have those really difficult conversations. As colleagues have already said, it is not just about any one place. The answer to this is in our society and in our communities. Some of the major sources of support for young people around mental health are where local authorities find it—for example, in youth services, but of course we have seen youth services decimated. It is in community spaces where young people are known by others, not just their families. It is also in those community spaces that families can get support. We need much more investment at a community level and much earlier.

Q167 **Dean Russell:** If I may, I will address to Mark a similar point to one of the comments you have just made, Julie. From a prevention perspective, one of the things I hear is parents who are worried that their child has to go to almost the extreme level of self-harm or worse before they really get the support that is needed or before they are listened to. My concern is for the child, but also for the families. Would it help if there were clearer pathways and clearer opportunities for parents to be able to flag concerns, without it getting to the point of self-harm having happened for their child?

Mark Rowland: It is really clear that we must take every step we can as preventive action. It is why we are calling for this really ugly term—proportionate universalism. It is important. In order for stigma and for problems to be prevented, and for early intervention, you need mental health literacy. We need to understand our inner worlds much more effectively—our emotions and what triggers them. This is stuff we were not taught at school. It needs to be part of how we educate children and parents.

One of the things that Wales and Scotland are introducing is an independent counsellor in schools, so that there is a reference point for more pastoral care, and training for teachers to be able to have those conversations. We are not going to solve this by clinical response. It is not going to be specialist support. All of us have to be involved in understanding our own mental health and how we share that with others.

To Julie’s point, there is the real paradox that we are building new hospitals and we have waiting lists on CAMHS, and at the same time the YMCA has reported the closing of 750 youth centres. If we are taking away the things that kids need, to be among others, to learn social skills and to get support, we cannot be surprised that we are seeing increasing rates of children’s mental ill health.

In our own study, we have been tracking the mental health of the population. We see thoughts of suicide in our young people at almost double the rate of the adult population, as well as rates of loneliness and hopelessness. The flashing red lights are there; this is a situation that needs attending to.

Q168 **Dean Russell:** Finally, because I am conscious of other colleagues coming in, Professor Appleby, from your professional and academic experience, at what point are children raising concerns with their families and friends? Is it right at the start when they get signs of depression, or is it when it is almost too late and they are starting to self-harm?

Professor Appleby: I don’t think there is a single pattern. There is quite a bit of variation in how readily people talk about their mental health in their families. Some prefer to talk to peers.

There is quite a large group of young people who go on to die by suicide who have never really expressed any warning sign in a conventional sense. This is exceptionally distressing to families because, from their point of view, they see the suicide as having happened out of the blue. They very often use that phrase. When you look back over the history of what happened, there were signs in some cases, but in others it looks as if the young person either kept their distress to themselves or spoke to somebody who was not in a position to support them. Perhaps, and this is a particular worry, for some young people their emotions are quite volatile and brittle, so the process from feeling unhappy to feeling despair may be quite rapid, and the potential for intervention and the gap when something might be done is reduced.

I do not think we have a very good system at the moment for allowing people to seek help. The availability of crisis services when people get into crisis is vital for that. Young people should be aware of their own mental health, as we have mentioned already. We cannot rely on services to pick up the suicide problem. Prevention starts much earlier than that, when young people recognise the difficulties that they themselves are getting into. There is a need for early intervention, which depends on young people themselves to an extent.

Q169 **Dr Evans:** My question is to the Professor, to start with. I am keen to take a canter through some of the factors involved in what is going on. We heard it hinted at, but could you elaborate on how much deliberate self-harm is a gateway to suicide?

Professor Appleby: It is one of the strongest indicators for subsequent suicide. It is a very important risk indication. It is probably the most important statistically.

The list I was giving earlier, by the way, was about mental health services. The prevention task is much broader. There are many services that have a part to play. In my view, the most important is the self-harm service. By that I do not just mean what happens to people when they come to hospital having already self-harmed, but the path young people are on when self-harm is becoming a likelihood. They need services that they can trust and talk to at an early point, when self-harm becomes a possibility, and that is the point at which we need to intervene.

Q170 **Dr Evans:** You have hinted at the fact that the data is not very strong around this, or that we do not know. Should there be legal registration of self-harm? When I was a GP, should I have been tasked in my clinic, if I saw someone who had come in with deliberate self-harm scars that I could deal with in primary care, to report that, and should there be a legal framework to do so? Is that something that would help?

Professor Appleby: I am not sure that is the priority, to be honest. The real gap is what happens to those young people once they present. I did not mean to be too critical of the data. We know that around 21,000 young people self-harm per year and attend services with self-harm. It is probably 10 times as high in the wider community.

Q171 **Dr Evans:** Do you know what the driving factors are behind that? Loss of services has been hinted at. Certainly in my clinical experience the numbers coming through the door, with far more young people with anxiety, stress and self-harm, were radically changing. What do you think are the main driving factors behind that?

Professor Appleby: Behind the rise in self-harm, particularly? Self-harm and suicide are both going up, and the drivers may be slightly different. For self-harm, I think we have to look first of all at what we know about the rise in mental disorder in young people. There is some evidence that the rates have gone up. The differences are not huge over time, if you take the last 20 years, whereas the rise in reported self-harm among young people is threefold in the last 20 years. It far outstrips what we know about rates of mental disorder. You would conclude from that that mental disorder is a little bit more common, but it is certainly more dangerous.

Q172 **Dr Evans:** Does the online world play into that? That has been pointed at as a potential cause.

Professor Appleby: There are risks online. There is no doubt about that, but it is probably one of a number of reasons. If you look at the characteristics of the countries where suicide has risen over the last 10 years, the dominant characteristic is rising income inequality. It is not a change in the online environment. Having said that, it is not easy to have national figures on how much people are online. It is not an easy measurement to make. Even so, when people have tried to do that, it is the socioeconomic context that has got worse for a lot of people.

If you throw into that some very important factors, which are difficult to talk about but are important, one of them is a switch in suicide method in young people to more lethal methods. It is a difficult area and a very sensitive topic for obvious reasons. It is potentially distressing to people. The rise in the use of hanging as a suicide method in young people has been very stark. That is a method much more likely to have a fatal outcome.

There are socioeconomic factors. I would say there is increasing complexity of mental disorder in some young people, so it is depression plus additional problems that add to risk. There is a switch to methods that are more likely to be fatal.

There is also the downside of defeating stigma. Nobody is in favour of stigma, but when stigma goes, people talk about mental health more, and they may talk more about what they do when they are distressed. Some of that may happen, to answer your question, in the online environment. Alongside the rise in self-harm in young people in the last 20 years, there are more young people saying that they self-harm for a particular reason. That reason is to cope with their emotional distress. I suspect that where the online environment plays a part, it is where it reinforces the sense that self-harm can be normalised.

Q173 **Dr Evans:** That is the really important part that I wanted to tease out. There is an argument, usually by the older generations—a gross generalisation but I think it holds some water: “Why don’t you just switch off the online world?”

I am keen to pick up that point, on the basis that some arguments say, “Is this just a snowflake generation that does not have the ability to have the resilience to deal with what is going on?” Maslow suggests that they have gone up near the top, they are on self-actualisation, looking at their friends who are having amazing holidays, taking photos, driving fast cars, having nights out, and you are sat at home still doing your exams and still working, trying to go to your sport. What is the reason why that argument is wrong?

Professor Appleby: I think there are risks in the online environment, as well as protections by the way. Some of the risks come down to comparing yourself with other people. I suppose those who work on eating disorders are particularly concerned about that element. There is online bullying, and, although it is very often an extension of face-to-face bullying, it exists, people are intimidated and it is an environment they may not be able to escape from.

Bear in mind that we did a national study of young suicide across the UK, where we looked at every young person under the age of 20 who died over a three-year period. That was 600 young deaths. About a quarter had used the internet in a way that was suicide related, but much of it was not about social media. It was not even about bullying. The main way in which people used the internet in a suicide-related way was to look for suicide methods. The online environment carries risk. It is not in itself to blame for the rises that we are talking about, but it carries risks. Those risks are not just in social media and what that brings to young people's self-esteem. They are also the direct risks of what is available on the internet and what is relatively unregulated.

Q174 **Dr Evans:** Mark, do you want to come in?

Mark Rowland: In terms of your question—is it a snowflake generation?—when you look at what it is about social inequality that drives rates of poor mental health, there is some association with some of the risks of the online world. We talk about socially evaluative threat. As human beings we do not cope so well, and see it as a threat, when we see other people doing disproportionately better than us. It has an effect on our self-esteem. That is the idea around why inequality is so difficult for us. We are living in the context that human beings have such different lived experiences. I think there is a correlation with the online world. It exacerbates and multiplies our ability to compare and contrast, but it also provides sanctuary in some cases for people to get support, to be able to share their lived experience and find common ground outside their small world.

I think the emerging generation has a greater challenge than has been faced before. We have never faced that degree of social comparison, and that is a legitimate threat to our mental health.

Q175 **Chair:** Let me bring in Julie on this point.

Julie Bentley: I absolutely endorse Mark's point. The generation of young people now are exposed to so much more than previous generations through the fact that we live in a global 24-hour online world. The reality is that that is not going to change, so we need to make sure that our young people are supported and equipped to respond and to deal with it.

On our helpline, self-harm is an issue that comes up tremendously. Certainly in the last year or so, our volunteers tell us that they are seeing an increase in contacts from young people about self-harm as a coping mechanism. We are also hearing from young people who had self-harmed in the past and were returning to it as a result of trying to cope with things. The most common thing we hear from young people who phone us at Samaritans is that they are struggling to get access to mental health services, and that that is causing them increased concern and exacerbation.

I would like to say more about online harms, but I am not sure if you want me to wait, or if you would like me to do that now.

Chair: Julie, we would love you to write to us, if that is possible, and tell us so that we can include your comments in our report. That would be really helpful. I need to move on to my colleagues, Barbara Keeley and Laura Trott.

Q176 **Barbara Keeley:** I think my question follows from what you were saying, Julie, about the increases in the number of people contacting Samaritans around self-harm. Beyond the fact that they are struggling to get access to services, which groups of children and young people do you think are most at risk of self-harm and suicide, and has that changed during Covid? Has it just intensified what we already knew was happening in the groups that were most at risk, or has it actually changed?

Julie Bentley: We were concerned about rising suicide and self-harm rates before the pandemic, but of course the pandemic has had a disproportionate impact on young people through the lens of socioeconomic scenarios. The majority of people who are losing their jobs tend to be younger people because of the industries that they work in, such as hospitality or entertainment. I have a statistic, which is that under-25s account for over half of job losses since March 2020.

As some colleagues have already said, people who are already disadvantaged are more likely to be impacted by suicide and self-harm. There are some specific groups that we know are particularly disadvantaged who are at risk of self-harm. Young men are struggling. As young women have higher rates in relation to self-harm, services are more geared towards young women in the way that they are put together and advertised, and that often stops young men accessing them as freely as they might.

Young people from LGBT communities are struggling to access services and face real barriers around those services. We know that that community of young people are really affected by self-harm. There are higher rates of self-harm, and they often face discrimination, both in their sexuality and in their gender identity. That is a real barrier for them. We already know that structural inequalities in the design of services mean that young people from black, Asian and minority ethnic backgrounds often struggle to access the services, particularly young black men.

We have a huge amount to do to make sure not only that we have the services for all young people, but that we have thought about specific and cultural needs so that no young person is left out in the cold from services. Mark referred earlier to a lot of flashing red lights. I think that is certainly what our view would be about young people and self-harm particularly.

Q177 **Barbara Keeley:** Julie and Mark, what can Government do to target interventions towards the children and young people who are struggling to access support? Julie, you talked about self-harm being a coping mechanism. What should we be seeing now and asking from Government to help with that problem?

Mark Rowland: Thank you for your question. As I said earlier, I think this Committee could have a very useful role in challenging the Government to develop a population public mental health strategy that really looks at what is needed for universal mental health literacy programmes, suicide prevention programmes and training for all of us, particularly those in public service.

In terms of targeted populations, some of the best and most effective targeted work is simple, human accompaniment, peer support programmes for those at risk. I mentioned that there is fantastic evidence about the role of mentoring for young people. We run community programmes in disadvantaged communities, looking at coming alongside and equipping young people with social and psychological skills, and giving them the space themselves to talk about their own mental health.

We would like a really targeted strategy. We need better data. We still do not have ethnicity data on suicide reporting. That needs to be delivered by the ONS so that we can see where the particular risks are. From our own study, the populations particularly at risk are students, young people, single parents and those with existing mental health problems. We know a lot about where the risks are. It is about a tailored approach in communities to really build on the local authority suicide prevention plans to say who and what we can identify and who we can give consolidated support in order to reduce risk and increase the protective factors.

Q178 **Barbara Keeley:** Julie, do you want to add to that?

Julie Bentley: I absolutely support Mark; the answer needs to be much more rooted in the community. In the short term, we would like to see a planned increase in funding for CAMHS and improving access to psychological therapies. We would love to see a network of open access mental health services located in local communities for young people, which young people can access much more quickly.

At the moment, all the attention is focused on crisis because so many people are in crisis. At some point, we have to be able to take a step back in order to put in place longer-term preventive measures, so that we can stem the flow of people who are reaching crisis point.

Q179 **Laura Trott:** I want to follow up something that Julie said about CAMHS. Are the issues with CAMHS simply around funding, or do we need to make reforms as to the type or the quality of the services provided?

Julie Bentley: In the first instance, my answer would be that it is about resource. There is nowhere near enough resource to meet the demand that we have, so really tough decisions need to be made about where the finite resource will be targeted. It is obviously being targeted at the crisis end, which is why we see young people in the revolving scenario where, until they get to a certain point of crisis, they cannot be seen by a service. I would say that resource is the crucial factor.

Q180 **Laura Trott:** The same question to Mark.

Mark Rowland: Resource is an issue, but the struggle at the moment is around workforce. It is being able to get to scale. Up to a quarter of schools will have MHST services. We need them to be available in all schools. We struggle with the model. We are talking about clinical and specialist help. At the moment, finding the people to deliver it is a massive constraint, as Jeremy knows, on the delivery of the long-term plan.

Q181 **Chair:** Thank you. I would like to give the last word to Steve. I know that you very powerfully, at Edward's funeral, made a vow to Edward that you would not stop campaigning until you had put in place all the things necessary to stop stories like Edward's happening again. You said before that a lot of things have changed since then in a positive way. How far are you on the journey to succeeding in that vow?

Steve Mallen: Thank you, Chair, for reminding me of that obviously very poignant punctuation mark in my life. I have devoted the past five or six years to this.

If truth be told, I actually think that we have come quite a long way in the past five or six years. The data has improved. The social narrative has improved. There has been increased investment in mental health. There has been particular attention on children and young people. There have been many reports and many committees. The direction of travel is now decidedly positive.

I often struggle to find out and ask myself whether the glass is half full or half empty. I won't go into my son's case in particular detail because obviously every biography is unique. I am aware of hundreds, if not thousands, of similar stories. The point of the matter is that he was ill served by the system. He should still be alive. He would still have been alive if the system had done what it was able to do.

I have often asked myself when my journey might start to look like it would come to an end. I would need to be convinced that, were my lad to walk into a mental health facility today, the outcome would likely be different. When I sit back and reflect on that, I think the answer is that we are definitely heading in the right direction. Unfortunately, we still have a very long way to go.

I would like to make one or two final points on the issue of prevention, and, very briefly, on the GP sector. Many young people who experience suicide ideation or who are self-harming have exposure to primary care. The data bear that out. We all appreciate the incredible pressures that the GP community is under, particularly heightened by the pandemic, but it remains the case that self-harm literacy and suicide prevention in a large part of the primary care system and in many GP surgeries is very poor. Many things are missed or misdiagnosed. We tend to throw pills at things rather than solutions. Opportunities for creating triangles of care are missed and so on and so forth, as indeed are very simple things like conforming to NICE guidelines.

There are very good NICE guidelines surrounding all aspects of mental health and suicide prevention, increasingly and more especially in relation to young people. I am not quite sure myself why NICE guidelines exist, because they do not seem to permeate through to daily practice and frontline services in many instances.

That is a roundabout way of saying, Chair, that there are actually quite a lot of good things that happen in the system. If we already did what we know to be effective, and we did it well and we did it everywhere, we would effect some change, notwithstanding the monumental size of the problem in front of us.

Chair: That is a good note to end on. Thank you, Professor Appleby and Julie Bentley for giving evidence. Particular thanks to Steve Mallen for your courage in talking about Edward and to Mark for your courage in talking about your brother. Both of you have shown that your campaigning since those terrible events can make an enormous difference, and we have heard some of that this morning. Thank you all very much for joining us. That concludes this panel.