HOUSE OF COMMONS

Health and Social Care Committee

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

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Watch the meeting

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

Questions 182 - 272

Witnesses

I: Nadine Dorries MP, Minister of State for Mental Health, Suicide Prevention and Patient Safety, Department of Health and Social Care; Professor Tim Kendall, National Clinical Director for Mental Health, NHS England; and Claire Murdoch, National Mental Health Director, NHS England.

Examination of Witnesses

Witnesses: Nadine Dorries MP, Professor Tim Kendall and Claire Murdoch.

Q182 **Chair:** Good morning. Welcome to the House of Commons Health and Social Care Select Committee's final evidence session in our inquiry into mental health services for children and young people. This morning, we are delighted to have with us Nadine Dorries, the Minister for Patient Safety, Suicide Prevention and Mental Health; Claire Murdoch, NHS England's national boss for mental health; and Professor Tim Kendall, who is the national clinical director at NHS England for mental health.

Welcome to you all. You have all participated in this inquiry before today. This is the final session, when we want to wrap up some of the things that we have discovered and get your views on what the potential recommendations might be.

To start with, we are going to talk about the 2017 Green Paper, in-patient services, suicide prevention and the general model of care that we use. I will go straight to the 2017 Green Paper, if I may. We have heard in the inquiry from schoolteachers about how successful the mental health support teams have been, and from Professor Peter Fonagy, who told us that around 60% of children using the mental health support teams in one study recovered from depression or anxiety, which is obviously encouraging. It is great that we are due to achieve the target of rolling those teams out to 25% of schools a year early. Minister, when do you think that all schools around the country will have access to these mental health support teams?

I was going to give you a chance to do an opening statement. Why don't you answer that question? Then I will pause and allow you to give your opening statement.

Nadine Dorries: Thank you very much. There were a couple of points that I wanted to raise in an opening statement, not least an announcement we have made this morning about additional funding.

We have over 280 mental health support teams in schools at the moment. We are hoping to get another 112 in place. We have around 3,000 schools and colleges covered at the present moment. I have my pack in front of me because we have so much data and so many stats around mental health.

As you may be aware, the original objective was to reach 25% of schools by 2025. I am counting on Claire Murdoch to have my back if I get any of these figures wrong. However, as a result of the pandemic there were some good things that we are clinging on to as we come out of the pandemic. One of them was the fact that we were able to secure an additional £500 million to add to the £2.3 billion that we are putting into mental health. That £500 million was particularly for mental health recovery, focusing particularly on children and young people. Of that £500 million, £79 million is allocated towards additional funding for

mental health support teams. That has enabled us to bring that objective forward to 35% of schools covered, hopefully, by next year.

If you are going to ask me when we are going to get to 100% of schools, I would say that there is a fundamental issue. It is probably best to get this out in the open now. It is to do with training. If you were to look at the number of children who could access mental health services in 2016 via any means—I was not there, but you were the Health Secretary at the time—it may have been this kind of data that prompted you to introduce the Green Paper. Only 25% of young people in 2016 were accessing any kind of mental health support or services. That figure is now up to 40% in just a few years.

The Green Paper has been part of the process of driving that change forward. The reason why we are at 40% now is not the lack of money that has been put into mental health. The Prisons Minister, jealously, often reminds me that my budget for mental health is more than his entire budget for the prisons estate. It is not for lack of funding, but traditionally no one wanted to work in mental health as an area.

I know this from my experience as a nurse. We were all given 12 weeks mid-training to go and work either in midwifery or in mental health. My entire cohort chose midwifery. Not a single person went to mental health. Historically, it is an incredibly challenging area to work in, and it is not one that is attractive to people to work in.

Q183 **Chair:** Cutting to the chase on the recruitment issue, which is where you are going, isn't it—

Nadine Dorries: Yes. We need the people to provide the services.

Chair: The Green Paper said we needed 8,000 staff by 2027-28. So far, we have recruited 1,600 additional staff, which is about 500 a year since the Green Paper was published. At that rate, we are still going to be 3,000 short by 2027-28. Are we upping the pace?

Nadine Dorries: No, that is not true. That is not the case. The reason why it is not the case—to the point that I was just making—is that one of the things that has happened in recent years is that, because of the emphasis on mental health and because more people are talking about mental health, it has become more in the public consciousness. We had over 100 applicants for every training place this year. We have people going through universities now who we are going to have coming out and ready to go and work in our schools with young people.

I think we have seen an increase of 141%—I will go to those figures in a moment—in the number of people we have coming through training and ready to go and work in the mental healthcare space.

Q184 **Chair:** Would you be able to write to us and let us have, for the inquiry, the trajectory of people you are expecting to join, so that we get to that additional 8,000 staff? It would be very reassuring for the inquiry if we

knew that we were on track.

Nadine Dorries: Of course. We will get the data for you from Health Education England. What I would say, though, is that it is impossible to predict how many people will want to work in mental health in 2024. What we know is the number of people who are now applying. As I say, there are over 100 applications for each university place. University courses are a year long and they are designed to get people into mental health support teams, into schools and into our early access units in all areas of the mental health space. It is not just about mental health nurses, doctors and psychiatrists; it is about counsellors and people who can provide a whole range of mental health services.

I imagine they have a trajectory and a prediction. We will make sure that is available for the Committee.

Q185 **Chair:** Is it 30% or 35% of pupils who are going to have access to the mental health support teams?

Nadine Dorries: It is 35% by 2023.

Chair: Excellent.

Nadine Dorries: Actually, it could be by 2022. Claire, is it 35% by 2022?

Claire Murdoch: It is by March 2023, Minister. I would just say that we have a really clear trajectory for the therapists and the training. We have 13 universities undertaking the training. One of the ways we have expanded our ability to train more therapists faster for mental health support teams in schools is by commissioning more university capacity across the country. We are very certain that we will reach those training trajectories. It would be true to say that every post we advertise is hugely oversubscribed, so we know there is an interest in the roles. Therefore, we know there is an interest in working in mental health services, as the Minister said.

Q186 **Chair:** We haven't had any information on the four-week waiting time target pilots. Where are we up to with those? Have they been a success?

Nadine Dorries: They are in the process of evaluation. We have added four more areas—actually, it is two: Liverpool and Sefton, and Nottingham and Nottinghamshire—to those pilots. Again, the pandemic has stalled everything. We are up and running again. I think we are due for an interim report on those pilots shortly.

Work is also being undertaken at the moment on a consensus and how that will look. The data is coming in on the four-week pilots. The work on how we put that into a national standard, how that will look and what the expectations and protocols will be around that is being undertaken at the moment. I am hoping that we will be reporting on that soon.

Chair: Some colleagues want to come in on the points you have raised. Could we wait until after they have spoken before you make your

statement?

Nadine Dorries: Yes. It is not a statement as such. It is just a few little announcements.

Chair: We want to hear about them.

Q187 **Dean Russell:** Thank you, Minister, for joining the session today.

During this inquiry, we have heard that children and young people's mental health services are seeing increased demand and severity of need. Could you outline the current steps to tackle that need?

Nadine Dorries: Thanks very much for that question, Dean. It speaks to an issue that I am concerned about, and we are all working hard on. It mainly involves young women and is something that we need to talk about more because it has not been talked about in the past, and that is eating disorders. We have seen a 22% increase—23%, I heard yesterday—in demand for services just over the past 11 months for eating disorder referrals. That has impacted throughout, as you can imagine.

I should start by saying that eating disorders were on the increase before the pandemic began. We saw an uptick. It is a very complex issue. It surrounds lots of things such as body image and social media. Lockdown brought a particular pressure and strain on young women who had been concealing, managing and living with eating disorders. It came to a crisis point during lockdown.

Dealing with the impact that has had on other services has been a priority. It has been a huge demand. We have seen it not getting to crisis point, but certainly to a point where everybody has been focused. Claire and her team have been incredible. They established rapid-access community eating disorder teams almost overnight. They were aware of what was happening the minute that referrals started to come in, and they put what they needed to do in place almost straightaway in a very impressive way.

That did not mean we did not have pressure on paediatric in-patient beds and adult in-patient beds across the services. Part of the £79 million was to address eating disorders. This morning, there has been an announcement of additional new money—£40 million—added to the £500 million specifically to deal with eating disorders.

I am not going to sit here and say that it has not been our biggest issue recently. It really has been the biggest issue. That £40 million is to help with in-patient treatment for young women. It is also to deal with community access teams. I am sure Claire will elaborate on that further.

In addition, of course, it has been a difficult year for everybody. It has particularly been a difficult year for children and young people. They have not been in school; they have had their routines disrupted; they have been segregated from their friends, their social lives and the normal

everyday that keeps children and young people happy. We saw, particularly early on in lockdown, children and young people reporting low mood, anxiety and poor mental health. I want to talk about that terminology during my opening statement, if I can. Those young people have been incredibly resilient. We have seen young people who said, "On week one, I felt apprehensive, anxious, worried and fearful," but their own resilience brought them through to the other side.

Rather than labelling a generation as a generation experiencing and suffering from mental health issues, we need to acknowledge that we have a very strong, resilient generation that we should be incredibly proud of. They are coming through the lockdown. Some of the main problems we have seen when they have gone back into school and out of lockdown have been in the readjustment.

Q188 **Dean Russell:** Thank you, Minister. That is a really good outline. I am interested in your take on the early-warning signs and the difference between mental wellbeing, mental health and mental illness, and whether there needs to be more in terms of the communication on that. There is also mental health resilience. What is your take on the narrative around that?

Nadine Dorries: Have you seen my opening comments? That is exactly what I say. These are my opening comments, in response to Dean.

I think we need to be really careful about the language we use around children and young people. Sadly, I have seen some unfortunate language being used. I am beginning to feel the kickback on that from stakeholders, the sector and mental health trusts. What we cannot do is hang the label of mental health around everyone's neck. It just is not the case.

What no one is talking about is mental illness. That really concerns me. Bipolar in teenagers, young people and adults, schizophrenia, severe personality disorder and psychosis are the focus of the NHS's main arm of delivery—our in-patient units. They are the lifetime work for our doctors, nurses and psychiatrists. That is the lifeblood of the NHS's mental health delivery.

We are not talking about mental illness. What we are talking about instead is this overarching term, "mental health", when in fact what we have is wellbeing and our early warnings, where we know that almost any mental illness is seen not to be as severe, or can even be prevented from developing, if we have early intervention and get in early enough to detect and work with the early signs, particularly with eating disorders, certainly with schizophrenia and other mental health illnesses. I think Tim will back me up on that.

We talk all the time about mental health. It is important that we are aware of what we are talking about: mental wellbeing, for which we designed, implemented and introduced Every Mind Matters for children

and adults. We know there were over 2 million hits, maybe even 3 million, in a very short space of time. People are going to that website and using the tools to help them to cope and improve their mental wellbeing. Mental illness—

Chair: Minister, I am sorry, but there is so much to do. I know you are enthusiastic, but we need to get through.

Nadine Dorries: I am sorry. Just keep stopping me.

Q189 **Dean Russell:** I have a final point. Would you agree that having a community-based approach to mental wellbeing can be quite supportive in the long run in terms of how we tackle mental health challenges, and ultimately the stigma around mental illness as well?

Nadine Dorries: It is the entire focus of the services that we are delivering in mental health. I must shout out. I know that Dean, in his own constituency, has trained up 100 mental health first-aiders. I cannot remember what your target was.

Dean Russell: It was 1,200, amazingly. Thank you.

Nadine Dorries: That is exactly the focus of our services. I often quote Professor Tim Kendall, who says that almost no mental health service can be better delivered in a hospital bed than it is in the community. He said that to me in one of our very first meetings and I have carried that forward in my mind ever since. Community—close to home, friends, family and work—is where mental health services are better delivered.

Q190 **Chair:** I want to ask you a quick follow-up on your announcement this morning. How do we get girls to come forward more quickly when they have an eating disorder? One of the issues that we know is very serious is people hiding the problem, even from their own family, for a year or 18 months before anything happens.

Nadine Dorries: It is actually much longer. Some report that they were first aware of their eating disorder issue at the age of five, and it may not be discovered until they get into their mid or early teens. They hide it for much longer than a year or 18 months. In fact, Tim Kendall, as our clinical lead, is probably the best person to answer that.

I would say, from a departmental point of view, that this is the point of the mental health support teams in schools; they are there with children in primary school from a very young age. It is part of their training. Picking up eating disorders at an early age is part of what they do.

Professor Kendall: If there were two things that would change this and help people come forward, one is stigma, which I think is gradually being eroded. Our move towards the community is a key part of that. The second thing is access. What we have seen with eating disorders is that the more accessible it has been for young people to come forward and get help, the more people have come forward. We initially thought that we would be able to cover all of our bases and see all the people. As we

opened up eating disorder services for young people, we found more and more people coming forward. Access and stigma are key.

Q191 **Barbara Keeley:** Minister, can I take you back to the question on the coverage of mental health support teams? You have given us the new figure of 35% of children reached by 2023. I am not sure about my calculations with that figure, but there are at least 4 million children without access to support. Given the impact of the pandemic, should we not be accelerating it to cover the entire country as soon as possible?

I am a bit confused by the way you answered some of the questions. You said that the issue is training. That was your initial response, but then you said there was a 141% increase in people coming out of training. If willingness to work in mental health is not the problem, surely there is no barrier to accelerating the programme of getting mental health support teams across the country, reaching all the children, apart from the will and the funding to do it.

Nadine Dorries: I don't think there was anything contradictory in the answer I gave. We have, first of all, the announcement about 35% of schools. That is not new; I have made it in the House before now. I think it was in oral questions. I have certainly made it from the Despatch Box. It is as a result of the pandemic. The first question I asked when I became Minister was, "Can we not get more mental health support teams into schools faster? Can we not have 100% of schools covered by next year?" I think it was the first question I asked both Claire Murdoch and Tim Kendall when I arrived.

The issue is people coming through and training. It is the highlight of the pandemic; it is the discussions around mental health; and it is about mental health becoming a more attractive area for people to work in. In the past year, that is just now bringing people forward who want to work in mental health. Getting those people—

Q192 **Barbara Keeley:** Perhaps I could interrupt you, because we will be short of time if we take so long on each question. Given what you have said about the increased willingness to work in the mental health space, why can't we move ahead? What is stopping you accelerating coverage to get to 100% of schools if we have got rid of or reduced the problem of willingness to work in mental health?

Nadine Dorries: Because it takes time to train people. We want to see 100% of schools covered. We hope that, within 10 years, we will get to 100% of schools, but it's—

Q193 **Barbara Keeley:** But that is 65% of children not covered. It is a very weak ambition to get a service out to only 35% of schools. What about the 65%?

Nadine Dorries: It is not just mental health support teams in schools where we need to put our £2.3 billion. As I said a moment ago, mental

illness is a serious part of our funding within mental health. We need to ensure that all areas of mental health are funded.

Historically, before 2016, there was a huge treatment gap and an underfunding issue. People were not trained. There was no treatment accessible because no treatment was there under any previous Government. We are playing catch-up rapidly, and with £2.3 billion a year, plus £500 million, plus a new £40 million announced this morning, we are pumping the money in. I have no barrier when I request money for mental health from Treasury. This is a problem that the Government want to solve.

We need the people through to deliver the services. That is happening now. It is work in process now. As I said, in 2016 only 25% of children had any access to any mental health services at all. That figure is now 40% and rising. I am proud of that achievement. At that trajectory, I hope we reach 100% sooner rather than later.

Q194 **Chair:** Can I understand this 40% figure, Minister? Are you saying that 40% of young people are currently accessing mental health services, or that 40% have access if they need it?

Nadine Dorries: I will ask Tim Kendall to qualify that statement for me.

Professor Kendall: If you went out into the community and you interviewed kids in 2016, you would have found four times as many kids with a mental health problem as you would in mental health services. That figure has risen to 40%. Now, we are seeing 40%—

Q195 **Chair:** Just under half of the people with mental health problems are accessing mental health services, but that has gone up from just a quarter of equivalent young people. That is what that number means. Thank you.

Professor Kendall: Yes, and an important part of that has been the mental health support teams.

Q196 **Chair:** But it is still the case that more than half of young people with mental health problems are not accessing mental health services.

Professor Kendall: Absolutely.

Q197 **Barbara Keeley:** In fact, this morning *The Telegraph* reported that internal NHS England projections show that an extra 1.5 million children will need mental health support over the next three years. Meeting that would require the capacity of children's mental health services to be three times larger than it is currently. Your existing plans will reach 345,000 children.

Minister, the new announcement today is to provide just 49 in-patient beds. What I am trying to get across to you is the scale of the problem, particularly the increase of the problem as a result of the pandemic, with five-year-olds having panic attacks. With that announcement today, any

funding coming into mental health is a good thing, but it is lacking ambition if we are talking about less than half of children having access to services, only 35% of schools being reached and a new announcement providing just 49 in-patient beds in a couple of parts of the country.

Nadine Dorries: This is the kind of language—five-year-olds having panic attacks—that I think we need to be very careful about. On the data you are quoting, it is an additional 345,000 children. On the in-patient beds that you are speaking about, as I have already said in this session, community services, and providing services close to where someone lives and close to their family, are optimal. We do not want to see children and young people in in-patient beds at all.

Q198 **Barbara Keeley:** I understand that, Minister, but you have announced only 49 in-patient beds.

Nadine Dorries: I was just about to answer your question.

Barbara Keeley: I am an MP in Greater Manchester. There are not extra beds accessible. For a child or young person in my constituency, those 49 in-patient beds are not going to be a help, are they?

Nadine Dorries: We have not reached the situation, even during the pandemic and even with our crisis in eating disorders, where we have not, if required, had an in-patient bed for somebody to be re-fed, or for a young person to be admitted in an emergency for an eating disorder. We have not been in the situation where that person did not have access to a bed. We have people waiting for beds, and we prioritise those who need beds most. Anybody will tell you that, if they had a young person who needed to be re-fed, the community is the best place to do it and not an in-patient bed. Even young adults have to go into a paediatric bed, for a number of reasons.

Q199 **Barbara Keeley:** I think we understand that. My question is about the scale of your ambition. What I said to you is that announcing 49 extra in-patient beds in two parts of the country is not helpful, for instance, to a child in Greater Manchester. Let us leave that there—

Nadine Dorries: The additional beds are Claire's, so I will ask her to piggy-back on my answer, because it is Claire's £40 million and Claire who has identified where we need the beds.

Claire Murdoch: We have invested additionally in all parts of the country. Some of that is for in-patient beds, but some of it is for intensive crisis alternatives. Each region put forward proposals for how it could make the greatest difference for its children and young people at the very top of the crisis pathway. Some of that was additional beds. We looked at that and challenged it, because ultimately we prefer to be closing beds and not opening them. We recognise that we need to rebalance where the beds are across the country in order to localise care. Some of it was the beds, as you quite rightly say, but some of that money was invested in community alternatives to crisis pathways.

What we asked regions to do was to ensure that the additional money was woven through in an integrated offer to the additional £79 million, but also the hundreds of millions that are flowing in this year, next year and the year after. I think it rises to nearly £900 million additionally. We are asking systems to rebalance provision, and the £40 million is designed to help them this year.

Chair: Thank you, Claire. I ask everyone to be quite brief with their answers because we have so much to get through.

Q200 **Barbara Keeley:** I have one more question. Moving on from the report of five-year-old children having panic attacks, I want to talk about access to counselling in schools. Clearly, whatever takes the pressure off CAMHS would be a good thing. Children in Wales, Scotland and Northern Ireland have access to counselling in schools, which means they can access support at a very early stage.

We are looking at a situation where 65% of schools are not going to have mental health support teams supporting them. Would it not be better to have counselling in schools to relieve pressure on CAMHS rather than having to wait until children hit a crisis point? Should we have that in England, as well as in Wales, Scotland and Northern Ireland?

Nadine Dorries: I think we need to look at what is available for children and young people in a community setting in the round. Counselling is part of that. I was just looking for the figure. Many schools have counsellors. I was just looking for the exact figure. I think it could be 60%.

We also have mental health leads, whom we are funding and training in schools. We have counsellors in schools with CCGs and local partners. We have the Link programme. We have the mental health support teams. We have 60 early access—

Q201 **Barbara Keeley:** Could I stop you, Minister? It is not mandated. In Wales, schools have counselling. There are schools in my constituency with counselling, and it really helps children and young people. Given the impact of the pandemic and the reporting of things like panic attacks, which show anxiety, would it not be a good thing to have counselling in schools, particularly at this time, when 65% of schools are not going to be covered by mental health support teams?

We know that counselling in schools in Wales delivers better outcomes. Do you not believe that that is effective and reduces pressure on CAMHS, or do you just not want to take on the cost, which would have to be covered in schools? It is all right saying that some of them have counselling—I know they have counselling—but they are not funded to do that.

Nadine Dorries: We have given additional funding. Again, I was just trying to find the figure. I think it is an additional £15 million to local authorities, including the £8 million wellbeing return to school fund last September, topped up by a further £7 million. It is not lack of money.

Q202 **Barbara Keeley:** Would that cover counselling for all our schools in England? It wouldn't, would it?

Nadine Dorries: Our priority is getting mental health support teams into all schools. Our overarching priority is to make sure that any child who requires mental health services has access to those services. Not all children need a counsellor. Some will do better under a mental health support team. Some will do better with early-access help. Some will do better—

Q203 **Barbara Keeley:** Can we just reflect on the situation that 65% of schools will not have access to mental health support teams? School budgets are stretched, and they do not have the money for counselling unless it is provided to them. The amount you have talked about is not going to provide counselling at all schools in England. It would relieve pressure on CAMHS, because that is what happened in Wales. Why aren't we doing it?

Nadine Dorries: Maybe Claire or Tim can give me the exact figure, but I think 60% of schools have counsellors. They may be schools that do not have mental health support teams. We have also provided £17 million for the training of mental health leads in schools.

There is no one way to skin the cat on this issue. We are trying to get as much mental health support as possible to young people for the purpose of early identification and early intervention, so that they do not go on to have mental health illness. As I have said, it is not a lack of funding. The funding is being pumped into it. Our issue is training and people to deliver those services.

Q204 **Chair:** What we have heard this morning is that 60% of children and young people who need mental health support, because they have a mental health condition, are not accessing it. We have recruited 1,600 of the 8,000 people we need under the Green Paper. The current target is to get to all schools by 2027-28. That is six years away. You told us the good news, which is that now many more people are coming forward wanting to be part of the mental health changes that are happening, and that money is not the issue. Can we bring forward that 2027-28 date, so that, for example, by the end of this Parliament we could say that at least half of schools will have mental health support teams?

Nadine Dorries: That is a question I ask every week. The answer is, how many people have we got going into training; how many new universities have we got offering courses; how many people are we going to get out this June? That is the question I ask all the time—that trajectory.

Q205 **Chair:** When you write to us about that trajectory, it would be really helpful if you could look at the numbers who are now willing to be trained and the funding that is in the system. Can we do something more urgently so that we bring down the 60% of young people who are not getting the help they need?

Nadine Dorries: Some people say to me, "We have a wealth of counsellors in this country," but counselling children and young people is slightly different. We do not have a wealth of counsellors who are trained to work with children and young people. That is the difference.

We will absolutely provide you with the information that you want, but could I just say—just to keep on a positive note—that with what we are doing in a very short space of time, I am incredibly proud of Claire and Tim, and their teams at NHS England? They respond to every request and every issue that arises. Everybody is working. The mental health trusts and people working on the frontline are all aware. All those people working on the frontline are aware—

Q206 **Chair:** I think we recognise the progress that has been made—

Nadine Dorries: Yes, of course. That's our job.

Chair: But we are also all agreed that it is still the case that more than half of young people are not getting help when they need it. What we are asking is, with all that good news about people coming forward for training and about the money being available, can we bring it forward so that, perhaps, at least by the end of this Parliament, more than half of schools have those mental health support teams?

Professor Kendall: When we did the Green Paper, the then Secretary of State—

Chair: Who was he?

Professor Kendall: —and current Chair of this Committee asked Peter Fonagy, Steve Pilling and me to undertake a systematic review of the evidence of what works in schools.

Although counselling may be helpful for some kids, there is a serious absence of evidence about its effectiveness. What we are training the therapists in schools to do is based on the evidence of what is effective. Counselling was not one of those interventions. I just thought I would make that clear.

Chair: That is helpful.

Q207 **Laura Trott:** Thank you, Minister, for coming along today. You talked about your focus on eating disorders and early intervention. Can you tell the Committee how the mental health support teams will be helping with that focus on eating disorders?

Nadine Dorries: On early detection, intervention and escalation of that issue, I would have to ask Tim as a clinician to give you more information on how they intervene and what that intervention looks like. I had some experience, before the pandemic struck, with mental health support teams, talking to them about this very issue, with children as young as five disposing of the contents of their lunch box in the bin, leaving the

wrappers in and telling the teachers that they had eaten what was in the lunch box when they had not.

I am not aware of how they deal with that and escalate it clinically, but the early intervention and the work that they do with those young people is really important. Tim, do you want to add a clinical dimension?

Professor Kendall: The mental health support teams do not directly deal with eating disorders, but they will be aware of being able to detect those kinds of problems. The investment we have in eating disorders is primarily in specialist teams. As I said, they have become much more accessible over the last five years. If they were to find a kid with a significant eating disorder in school, they would be referred very quickly.

Q208 **Laura Trott:** Professor Kendall, we talked about eating disorders being among the most deadly mental health diseases and the fact that early intervention is absolutely crucial. Do you feel that the mental health support teams are sufficiently trained to pick up the early signs of eating disorders? That is going to be the critical period when we can catch people before it becomes a really big problem for them.

Professor Kendall: I do not think you can train in mental health and miss eating disorders. I am pretty sure that the training for mental health support teams will include detection of that kind of problem. In any event, we have another issue, which is detecting that kind of problem—eating disorders—across the whole of the health service. I am not satisfied that we are doing that well enough. That is in primary care, emergency rooms and so on. We have an issue—I am not saying that we do not—but I don't think it is particularly an issue with the mental health support teams.

Q209 **Laura Trott:** In terms of that wider piece—this may be for Professor Kendall or the Minister—what action are you taking to try to increase awareness of early interventions? This is obviously a problem that is rising for many of our young people, mainly women. We know that women's health is something that has been a problem and, thankfully, it is being addressed by the Department now, but it has been overlooked for many years. Is there a real focus on making sure that we have awareness across the system of the urgent need for early intervention for young women and girls when they have signs of eating disorder?

Nadine Dorries: I will take that first from the Department's angle, and then Tim can come in on the clinical angle.

Thank you for mentioning the women's health strategy, Laura. Eating disorders will play a huge role in that. Information is something we are short of in terms of the lifecycle of an eating disorder in a young woman going into an adult woman.

As you know, we launched the call for evidence for the women's health strategy. We had over 112,000 responses. I believe over 70% of those were from individuals, and a proportion were from young women with

eating disorders and older women with eating disorders. It is women's experience in the healthcare setting.

We know from Cumberlege, from Paterson and from the maternity inquiries under my patient safety hub, and inquiries I have had myself, that the constant theme is that women's voices are not listened to. That begs me to ask the question, if strong women's voices are not listened to in healthcare settings, how does a woman suffering from an eating disorder have her voice heard? How is she dealt with in that setting?

I have absolute faith in people like Claire and Tim and our NHS mental health services, in their compassion, responsiveness and how they deal with people coming forward. My particular objective through the women's health strategy is to find out from women what their experiences have been of being identified and diagnosed, and what their treatment course has been like through their life, with eating disorders and other mental health issues, along with the menopause, gynae and lots of other issues. Eating disorders are in there.

The fact that we had—I hate to use the word "explosion"—the rapid increase in referrals of eating disorders came almost at the same time. It was not as a result of the increase in eating disorders that we did this. It ran in tandem. I am really hoping that we get some good information and data from women's lived experiences with eating disorders that will help us to design services in the future.

Professor Kendall: I chair a group that is specifically focused on the recommendations of the Parliamentary and Health Service Ombudsman's report on eating disorders. We have the GMC involved, and Health Education England, the Royal College of GPs, the Royal College of Psychiatrists, the Royal College of Paediatrics and Child Health and the Royal College of Nursing.

Our specific focus is looking at the extent to which practitioners across the health service are aware of and understand eating disorders and what they should be doing about them. We recognise the problem that, when somebody goes into A&E or they go into general practice, we are not yet aware enough. There are training programmes, and work is going on behind the scenes. One that I am very focused on, and where we do not have a solution as yet, is ensuring that all doctors are trained to recognise and deal with eating disorders.

Q210 **Chair:** Can I follow up Laura's point? As you know, the Green Paper is not just the mental health support teams. It is also the mental health leads in schools—teachers who are trained. Could you look into whether that training will help teachers to understand and be aware of issues around eating disorders in the pupils in their classes? That strikes me, as a layman, as a particularly difficult thing to do, to spot as a teacher if someone is not eating properly. It could be very important, and they are more likely to spot it than a GP, who that young person may not be seeing.

Professor Kendall: I will come back to you. I will have a look at the curriculum both for the teacher leads and for the mental health support teams. We will write to you to confirm what I think is the case, which is that it includes training on awareness of eating disorders.

Claire Murdoch: I could not agree more that we need a whole-system approach to raising awareness, early identification and smoothing young women, and in fact everyone, into the treatment that they need. To remind colleagues, mental health support teams in schools have specialist supervision from specialist CAMHS supervisors. There will be additional supervisory expertise reaching into the school.

Why we are so enthusiastic about mental health support teams in schools is that they really should be working with parents, primary care and local community groups. We are working with Beat and other organisations to look at what we can do collectively across the piece to raise awareness. Tim has talked about GP and other mainstream practitioner training. All of that is incredibly important.

I want to say now that I will continue to hold industry's feet to the fire. I think our young people are in the grip of a kind of triple lock. They have sky-high expectations on them. With people pumping notions of shortcuts to health and happiness, whether it is their weight or an idealised lifestyle, there are ever-present pressures. Whether it is *Love Island*, diet products or other social media, it seems to me that we have to drive very hard to support parents, schools and young people themselves and to raise awareness, not only about eating disorders but very significantly so. We have to tackle it in the round.

My final point would be this. Schools that adopt a whole-school approach, where they are training young people and teachers in open-door basic principles of mental health—pastoral care—have great approaches in encouraging pupils to look out for each other, to raise concerns early and training in schools. For me, this requires us to work together as a society in local places and at national level more than ever before.

My very final point is that, in relation to the mental health support team therapists that we have in training—I have just been doing a quick calculation—the cohort that comes into training in 2023-24 will take us to 47% coverage nationally. We do not have a settlement after that. We need to get that pipeline running smoothly, but, by 2023-24, the therapists that come into training for schools will take us to 47%.

Chair: We do, of course, have a spending review later this year. That would be the moment, Claire, to secure some extra funding to make sure that we are reaching well over half of the young people who need help and support. Thank you for that. Laura?

Laura Trott: That is all from me, Chair. Thank you. I would welcome the confirmation from Professor Kendall on support for eating disorders within schools.

Q211 **Dr Davies:** Minister, with regard to access to services for children and young people, we have already touched on the four-week trials. In relation to the pre-existing targets of six weeks and 18 weeks, what was the performance in achieving those prior to the pandemic?

Nadine Dorries: I don't know. I will have to write. I don't have those figures at hand.

Q212 **Dr Davies:** Were we broadly going in the right direction?

Nadine Dorries: Progress? Absolutely. We have been making progress since the long-term plan was first established. We have been making progress since 2016. We have been making progress since the Green Paper was announced and initiatives put into place.

As I said before, we have been working with a treatment gap and a funding gap from successive Governments who never invested in mental health, either in children and young people or in adults. It has been a long-term problem. We have been playing catch-up. When you are playing catch-up, you are constantly on the front foot and moving forward.

I would say that the teams have gone as fast as they can. They have the money. The money is there, but it is getting the services in place and identifying the priorities. It is meeting the acute need of the situation we are in right now, as well as identifying the priorities. Eating disorders are an acute need that blows everything else out of the water. Suddenly that is what you have to focus on. It is the funding, the expertise, the Department and the NHS. That is where you have to focus. Yes, it has been a forward-moving step since 2016.

Q213 **Dr Davies:** How has the pandemic impacted on waiting times, as far as you are aware?

Nadine Dorries: We had an absolute drop in referrals during the pandemic, which is not surprising. Children were not in school. The teachers were not referring. It is interesting; I know the outlook about the pandemic and the impact on mental health, if you read the media, is all doom and gloom. In fact, some people, particularly families, reported an improvement in mental health and wellbeing. Some people, surprisingly, enjoyed lockdown with their children for a year. It was not all doom and gloom.

We had an absolute drop in referrals, but what it enabled us to do was to be really inventive about how we deliver mental health services. I know from my own experience with organisations like Barnardo's, and from young people and care leavers I have spoken to throughout the pandemic, that they were almost demanding that mental health services be delivered to them differently. They were using, without phrasing it as such, the pandemic as a catalyst to change things in their favour. For example, a group of people I spoke to were saying, "We don't want to go and sit in a hospital waiting room. We don't want to go and sit in an

access hub and wait to see somebody face to face. I want my mental health services delivered on my phone or on my iPad." Now, that is not possible for everybody.

What we know is that, for a large number of people, it has been really successful. In fact, Tim did some research on this that showed that when you are delivering digitally to young people —I am not sure what kind of intervention it was, maybe it was IAPT—they have fewer interventions, need less contact and improve quicker. The reason is that they can get the help very rapidly. They do not have to make an appointment and go and travel to an appointment, sit there and wait face to face. They can get what they need much quicker.

I frequently hear that 140,000 children were turned away from CAMHS, which is not true. That metric is calculated on two visits, but we know that a huge number have one visit and have the services that they require. They are given the tools they need, or that their parents, carers or teachers need, and therefore do not need the two visits.

We have a similar rate of success with one to one, but we know that referrals dropped during the pandemic. They are increasing again, obviously, as people are adjusting back to normal life. That is what they are finding difficult. It is the readjustment from lockdown back to normal life. That has put a pressure on us, but we are finding innovative ways to meet those pressures, some of them dictated by young people themselves.

Q214 **Dr Davies:** So it is not all bad news, but as of today are the waiting times going up or down, do you think?

Nadine Dorries: I think they are probably going up with the results of the eating disorders impact that we have had. I think Claire probably has the exact figures.

Claire Murdoch: We can write in with the most up-to-date data, but what we are seeing, broadly speaking, is a pattern of more referrals and more children and young people coming into treatment than ever before. We are seeing more than ever before. For example, with eating disorders we set the one-week and four-week access waiting time standard—one week for urgent and four weeks for routine. We know that, although we have pretty much doubled the number of youngsters coming into treatment, three or four years ago we did not have eating disorder services everywhere by a long shot.

We have come a long way. Before the pandemic, we were meeting those standards, or were really close to meeting those one-week and four-week standards. We are currently at 70.5% for one-week waits and 72% for four-week waits, but we are seeing phenomenally more children and young people in those services. What clinicians are doing, as referrals come in, is making assessments and judgments about how many youngsters they can see, keep safe and intervene with. We have seen a

slight increase in waiting times in the eating disorder field. We can write in with that data for you.

Q215 **Dr Davies:** Thank you. Is there a concern that the data is at national level, and, therefore, if there are local instances of underperformance they can be hidden?

Nadine Dorries: Again, that is over to Claire's team, but I don't think so. I know from the teams that I have met with Claire, and the people who look at the care commissioning groups. The money allocated to care commissioning groups to commission mental health services is ring-fenced, so I know there is a constant eye kept on care commissioning groups to ensure that that money is not filtered off or siphoned off into acute services or somewhere else.

I know there is a very close watch kept on what local care commissioning groups are doing with the money that they are allocated for mental health spending. That is a really important point. I am not sure how many of the funds allocated to care commissioning groups are ring-fenced for a particular area. For children and young people's mental health, it was quite important that they got that money and it was spent on children and young people's mental health. If there are areas where there is a slump, it will be because the care commissioning groups are spending that money somewhere else. That is something we constantly keep an eye on. Occasionally, I hear from MPs in all parts of the House who say to me, "I'm not sure that all the money is being spent." I flag that up to NHS England and they will be straight on to it. We keep a strong eye on it.

Q216 **Dr Davies:** Finally from me, GPs are often concerned about rejected referrals to CAMHS. Is that something you keep a close eye on?

Nadine Dorries: Absolutely. The figure that keeps getting bandied around of 140,000 is actually not true. I know the Chair is concerned about this because I am sure I have heard him mention it in the past. It may be that the metrics are kept on how many young people have two appointments at CAMHS, when actually one suffices, with the tools that they need not to have the second appointment. I think we need to look at how we measure referrals to CAMHS. We need to drill down into the data a bit more in terms of what children are referred for and what they presented with.

One of my concerns around mental illness is that, because of the emphasis on the terminology and this overarching umbrella of mental health, we are seeing young people referred to CAMHS and referred to services, when we have Every Mind Matters for children and young people now. The tools they need to help themselves with their own mental awareness and wellbeing are more easily obtained elsewhere so that we can keep the mental health services that we need for those who have serious lifetime mental illness.

Q217 **Dr Davies:** I think you are right, but I am specifically referring to instances where there is not even a first appointment. There may be alternative services available, but some kind of one-stop shop or a more joined-up system would often—

Nadine Dorries: We have 60 open-access hubs across the UK, but we are using those for a number of things. We are looking at those. I think Peter Fonagy has given evidence here on the Australian model. The jury is out on those at the moment. We know that in Australia they have not answered the problems that they wanted them to answer. They have not delivered in the way that they hoped they would.

We are looking at them. We have 60 in the UK. We are looking at putting out more. We are not just using them for mental health services. We are using them for sexual health and other—

Chair: We are going to talk about that a bit more later.

Q218 **Paul Bristow:** Minister, I was really motivated by what you said about horses for courses and not a one-size-fits-all approach to young people's mental health. I have, very luckily, attended a number of summits in my constituency in Peterborough with a number of young people from different schools. The message they told me, quite clearly, was that there are different avenues for access to mental health support, whether it be CAMHS, a designated mental health support worker, a counsellor in school, or even peer-led support within schools.

There are a number of different avenues. How do we propose to give equitable access to young people to all these available avenues? That is a huge challenge. Secondly, schools are really there to educate our young people. How do we propose to increase awareness of the different things that they may do within the school to support young people?

Nadine Dorries: Thanks, Paul, for highlighting just a few of the services that are available to children and young people. Also on that list are all the stakeholders, charities and support groups who are funded by the Government and who are also out there working in local communities—Young Minds, Mind. I could reel off a list spread across the country. The reason they are there is that we know that services are better delivered in the community.

You are right. One of the problems is that there is so much out there that sometimes people do not know it is there and do not know how to access it. Even education services and the health service do not know what is available. That is why we had Link, which is a programme of interaction between health and education, using online tools to highlight, working between education and health, what services are available.

It is a fact that it is difficult for young people to talk about their mental health issues. It is talking to someone, using a text service, accessing an online service like Every Mind Matters, speaking to someone at Young Minds, or a mental health lead in school or a counsellor or the mental

health support teams. It depends where they feel most comfortable and where they feel they can open up and share what their issues are.

Just going on to the mental health support teams—

Chair: Could you be brief?

Nadine Dorries: I will stop there.

Q219 **Paul Bristow:** The thing I fear is that, obviously, schools are there to educate young people. Traditionally, they were not there to provide mental health support services for young people. How are we going to increase awareness of the different avenues that you eloquently talk about among the schools themselves? Quite often, it is the teacher who is the first point of call when a young person has a mental health problem.

Nadine Dorries: We are nearly five years into providing mental health services for young people in this country. There was almost nothing there before. When I became an MP in 2015, we had what was the early version of CAMHS, which was dealing with just a minority of young people.

We are in an early and, I think, embryonic stage of getting to the point where we are coming through designing and implementing, and young people are accessing services. I think it is going to be a natural process, as we go down the line, of what works best. Will it be the emerging model of early-access hubs? Will that be where we channel all our mental health services for children and young people? Will that be the future prototype and future model?

Chair: We are going to talk about that a bit more later this morning. Paul, can I move on?

Paul Bristow: Yes, of course, Chair.

Q220 **Chair:** We recently had evidence sessions that lasted as long as seven hours. You may have read about some of them in the media. This could, of course, be one of those sessions—

Nadine Dorries: No way. My next meeting is at 11.30.

Chair: If you are hoping that it won't be, I wonder if you could possibly keep your answers brief, although I deeply respect the enthusiasm.

Nadine Dorries: I could talk all day about mental health.

Chair: We still have quite a few other topics to get through. I want to move on to in-patient care. Pretty much every witness that we have heard in this inquiry, including Claire and Tim who are here this morning, has told us that it is better for most young people with mental health needs to be treated in the community rather than in in-patient beds on a long-term basis.

There is a model in Italy known as the Trieste model that effectively bans long-term admissions, although it is for adults and not for children. Why

don't we follow the same approach here? They describe it as easy in, easy out. You have beds and people go in, but they are discharged very quickly. You avoid the problem of people being trapped in in-patient beds for a long time.

Nadine Dorries: Trieste is one town or city in Italy that, before they brought in that model, had well-established community mental health services. I think they had a mental health community-type hub for every 50,000 head of population. I will ask Tim to come in and give you more information, because I know he has studied this far more than I have.

When they brought in this policy in 1980 or 1981, they had already worked to establish—it is not true that they closed down. Each of these hubs had beds in them. They closed down the asylum—

Q221 **Chair:** But they are short stay. It is easy in, easy out. That is the difference. We have young people who are in our in-patient units for years, not just months. That is the difference. You do not have that in Trieste when it comes to adults.

Nadine Dorries: In Trieste, they had in-patient beds. I will ask Tim how the beds were used. They had hubs, one for every 50,000 members of the population. Then they closed down their asylums. Other parts of the country that adopted the Trieste model ended up with people on the streets called "the abandoned" because there were no mental health services and no mental health beds to look after them.

Q222 **Chair:** That is the point I really wanted to make. The constant argument we get is that the reason we cannot do that here is because we have not invested in community services. We are doing another inquiry into people with learning disabilities and autism that Claire has also given evidence to. Again, the reason we still have 2,000 people who are long-term residents of what are supposed to be assessment and treatment units is that we do not have community provision.

Do we need to change the funding flows so that we can make sure community provision is available, if it is funded by local authorities, for example, and not by the NHS?

Nadine Dorries: As I said to Paul, I think that is the place where we will end up. Where we are at the moment is four or five years into the first serious funding we have been allocated for mental health provision. It does not happen overnight. Ideally, that will be where we end up. We are not there at the moment because we are still dealing with catch-up and still trying to train the people to provide the mental health services, but I hope we get there.

Q223 **Chair:** I understand that. I think we all want to go in the same direction, but it is about speed. One reason that some people think we might have a problem is that there is a conflict of interest, which is that if you are providing an in-patient bed you, as a provider, get income from that bed. Therefore, you are reluctant to discharge the person into the community

when you will no longer get the funding.

One possible solution is to say to the people providing those beds, "That funding will stay with you, providing you can re-provide that care for the same person in the community." It may be with crisis care available, but community supervision. Could that be a way that you break down that conflict of interest?

Nadine Dorries: I think it is a really interesting proposition. What I would caveat it with is this. I have visited, as part of my role, mental health hospitals myself. I am aware that there are people in those hospitals for their own wellbeing and safety. They require to be long term in in-patient beds. We have some very serious mental health illnesses and conditions—

Q224 **Chair:** I completely understand that. We understand that. The problem is that we heard from a young lady with autism on this Committee, and she—

Nadine Dorries: Learning disabilities and autism are something completely different.

Chair: They are different, and you are right to say that, but the point she made, which is relevant to this, is that being put in an institution where the doors were locked actually made her mental health a lot worse. It potentially made her dangerous, so it ended up being a self-fulfilling prophecy.

Let me ask you about this conflict of interest. The other issue that has come up is with, often independent sector, providers offering assessment and treatment units, who have their own doctors signing off that it is not safe for someone to be sent back into the community. Is there not a conflict of interest? Obviously, if they said they should be released, that organisation would lose money.

Nadine Dorries: I think that is an interesting point. I cannot answer that in the affirmative. What I will say is that, wearing my patient safety hat, we have the CQC watching all units and all mental health provider in-patient beds very carefully. In fact, one of our main problems is that they frequently close down those beds. I had one this week. It is then up to Claire and her team to find alternative provision.

Q225 **Chair:** I am going to take the phrase "interesting" to be Minister-speak for "I agree with you but can't quite say so," and move on, because I want to ask—

Nadine Dorries: Claire wants to come in on that.

Chair: I will bring in Claire and Tim in a moment, but the other issue—

Nadine Dorries: Chair, can I just say that it is important not to conflate learning disabilities and autism with serious mental health illness? Those two need to be kept completely separately.

Q226 **Chair:** Of course, and that is why we are doing separate inquiries. There is one issue that is the same, which is that someone who could be better treated in the community can find their mental health deteriorating, whether they have a learning disability, autism or not, to the extent that they then cannot be put back into the community because of the conditions and because they are so stressed by their long-term admission.

Nadine Dorries: Can I take you back to my initial point and one of the first things I said? The first thing that Tim Kendall told me when I came into this post was that almost no mental health condition can be better treated in a hospital bed than in the community.

Q227 **Chair:** Thank you. We have Tim here, who can make his own comments. I want to make another point, which has been raised by NHS Providers. Part of the issue sometimes with offering community alternatives is lack of capital. There was obviously disappointment about the absence of mental health trusts in the initial 40 trusts that were allocated capital under the Government's 40 new hospitals programme.

Are you confident that mental health trusts are getting enough capital to make the transition to set up community hubs as an alternative to in-patient admission?

Nadine Dorries: Yes, because we want to close down in-patient beds, not open them.

Q228 **Chair:** But you still need capital for some of the community provision, because you are setting up—

Nadine Dorries: We do. Absolutely. And that is why we were given the £2.3 billion, the extra £500 million, and the extra £40 million today. Capital is coming into mental health community provision. I am not sure that mental health hospitals is where we want to go.

Chair: I am talking about capital for community provision, but perhaps you could—

Nadine Dorries: That is a conversation I am having with Minister Argar. With the early-access hubs, there are other ways of providing infrastructure in communities to provide mental health services.

Q229 **Chair:** Could you write to us and tell us what capital is going in to help the transition from in-patient care to community care?

Nadine Dorries: Claire will have to write to you with that, because she gets the budget.

Q230 **Chair:** A lot of community provision is provided by local authorities, which are funded through the social care system. You know that yesterday a crucial meeting between the Health Secretary, the Chancellor and the Prime Minister to resolve the future of the social care system was postponed. We do not know why. Should people worry that that meeting did not happen?

Nadine Dorries: No. The Prime Minister and this Government are committed to providing reform to social care before the end of this year. By the end of 2021, the answers to the questions will be there and the reforms will be there.

Chair, as you know from when you were Secretary of State for Health, I am sure you lost count of the number of meetings in your diary that you had to postpone for various reasons, such as the data not being available, or you did not have the information you wanted to make a good judgment. I do not know what the reason was, but I know that the absolute commitment by the end of this year is there to introduce social care reforms. It will happen.

Claire Murdoch: I won't talk to the Trieste model because Tim will do that. He is very expert in that area. I have a few things, very briefly.

First, I know there are mixed views on the provider collaboratives, but can I say again that they are NHS led? What we are trying to do is give the NHS, as the lead in local areas, the money we currently spend on in-patient beds to repurpose, reprofile and set that alongside the long-term plan investment, and transform care. Areas that have gone early with that transformation—we would happily give more information or arrange for MPs to visit—have made drastic reductions in the need for in-patient beds. South London and Maudsley partnership, which is three mental health trusts across south London, have reduced the need for in-patient beds, since they took on responsibility for the budget, by 32%. They have done that by looking at their local need, looking at what the gaps were in the community provision and combining the bed money with the new money we are putting in, and changing models of care. That is a huge reduction in the need for beds. They are also focusing on dramatically shortening length of stay.

Northumberland and Tyne and Wear have done something very similar, where they have managed to reduce their need for beds by 42%. In a way, we are taking the principle, "This is the money. There isn't more. If you spend it on really high-cost, in-patient care far from home and long lengths of stay, we are not here to help you. If you reinvest it, we will give you all the support, the clinical leadership and the models of care, and we know that you will do something much better for children, young people and their families."

That is why we are excited about the collaboratives. I make that point. I make the point as well that I welcomed the review that was announced earlier this week into local authorities, looking at children and young people's crisis placements and care homes. I think that NHS-led provider collaboratives need to work locally with their local authority to localise care as much as possible in the future.

The third thing I would say is, yes, I think a free market has led to some perverse incentives. We know the independent sector has greater access

to capital and can open units more quickly. We have been very grateful, on occasion, for their support. For those who do a good job, great.

We know that is different from a really planned market of care that is local and is NHS and public sector driven, even if it is provided by a group in the third sector, the NHS and other partners. It is really important that we anchor those services locally and work closely with local authorities, and that it is NHS-led. Where we do that, we will transform care.

Chair: Thank you, Claire. I am sorry to hurry you, but we have a lot to get through.

Professor Kendall: In answer to your question, I think in-patient care is extraordinarily expensive. It is often harmful, not always. It is all too often the last ditch because there is not a community service. When you think about what we are currently spending on eating disorder beds for young people, it is £250,000 a year. That is four people taking £1 million.

My view is that you could spend that better. The evidence is there. There is randomised controlled trial evidence that shows that community-based treatments are superior in that context. We could provide fantastic community-based care with that kind of money.

The final bit is that people get stuck. They stay in those beds for long periods of time. I would welcome an evolutionary approach to reducing our bed base and increasing our community services, as we are doing, in much the way that Trieste has done, but for children as well as adults. They have only done it for adults.

Q231 **Chair:** Do you like the idea of telling NHS trusts that they can keep the funding, provided that they re-provide those services in the community?

Professor Kendall: We did this in Sheffield. We brought back all the people out of area in locked rehab. This is adults. We brought them all back and reinvested that in the community. Our CCG agreed for us to keep all the money. It has basically meant that we have an absolutely top-notch, community-based rehab service. I think it is a workable model, yes.

Q232 **Barbara Keeley:** I have a question for the Minister about access to advocacy. The recent White Paper on mental health does not guarantee advocacy for informally admitted patients, despite the recommendation of the 2018 independent review. Why has it been excluded?

Nadine Dorries: I have no idea that it has been excluded. I will have to write to you on the details of that. I am not aware that it was specifically excluded. I assume that you are talking in the context of children and young people. We are committed to safeguarding the rights of children and young people who are admitted to in-patient care, and ensuring that they have the right access to treatment and support. I cannot really answer your question more fully than that, but I can certainly write to you on that point.

Q233 **Barbara Keeley:** That would be helpful. There is a supplementary question. I do not know if Tim and Claire can add anything. Without guaranteed access to advocacy, there is a risk that children and young people, and their families, where children are in in-patient units, are not fully aware of their rights. There is a question about how we can safeguard them and ensure that families understand what their rights are, if they do not have access to advocacy. It ought to be an opt-in and it definitely ought to be there.

Nadine Dorries: I think we have a responsibility at the Bill stage to possibly update the code of practice. I share your concerns. I think we need to take that away and look at it. I am sorry, Barbara, but I cannot give you a fuller answer now. I do not know if Claire or Tim can.

Claire Murdoch: The vast majority of children and young people who are in hospital will be there under legal powers that, therefore, would trigger the right to formal advocacy. I think we need to go away and really get under the numbers of how many children and young people we are talking about, and write to you about that.

Secondly, I would agree with you that it is a serious step when a child or young person is admitted to an in-patient unit. The best ones will always have independent advocates available to give feedback about everything, from culture and quality of care to things that the individual particularly wants fed into their plan of care.

Perhaps we can take that away and look at how many children and young people under the Act are there under legal powers—I think it would be virtually all, or the vast majority—and they would also set out that, whenever a child or young person is in an in-patient unit, we would expect it to be good practice that advocacy is available. We will definitely get back to you on that.

Q234 **Barbara Keeley:** It is worth saying, Claire, that you have just said that the best ones will have access to advocacy. It is perhaps not the best ones that we are worried about, is it? It is the worst ones that we are worried about, and if the worst ones are not allowing access to advocacy—

Claire Murdoch: No. I was trying to make the point that it is possible and affordable, and we should see it universally. We will look at it, but what I do not know is the link with the Mental Health Act and the numbers. We will write, with the Department of Health and Social Care, to clarify all of that.

Q235 **Barbara Keeley:** I think, Minister, it has been asked whether the upcoming reform of the Mental Health Act will move advocacy for anyone detained under the Act to an opt-out. It should not be an opt-in system, which seems to be the way it works. It is not very open access. That is going to be an important question for the Mental Health Act.

Nadine Dorries: We will look at that. Perhaps Claire can give a more detailed answer about the legal powers automatically triggering that right. This is something to do with the passage of the Bill. We will look at what is in the Bill in the code of practice and maybe, Barbara, you can push this again as the Bill passes through the House.

Barbara Keeley: I am sure that many people will.

Claire Murdoch: Just to be clear, we are introducing family ambassador roles to all—

Chair: Hold on, Claire. We will come back to you.

Q236 **Barbara Keeley:** We have heard during this inquiry that the use of restraint is almost seen as the norm. I think that is very disturbing. Minister, how concerned are you about the use of restraint in mental health in-patient units?

Nadine Dorries: A really interesting question. I am not sure if you are aware, but last week, or on 25 May I think it was, we opened the consultation on the Mental Health Units (Use of Force) Act that received Royal Assent in 2018. I think Steve Reed MP brought that forward in a private Member's Bill.

Q237 **Barbara Keeley:** It was Steve. Why has it taken three years to get through?

Nadine Dorries: Covid. It received Royal Assent in 2018. We were at the point of going out to consultation when, sadly, Covid struck. There is a particular family who have been the genesis behind this.

Barbara Keeley: I am familiar with it. You do not need to explain it.

Nadine Dorries: I have met them and they are really happy that we have finally gone out to consultation. That will be a 12-week process. I do not have the date that the consultation is due to finish. It will be important because it will certainly establish the protocol and the processes around restraint.

Interestingly, I was visited yesterday by the European Commission, who had taken a tour of our mental health facilities in the UK, looking particularly at how restraint is used in a number of mental health settings, and—

Q238 **Barbara Keeley:** My question was, are you concerned about the levels of restraint? Could you answer that question first? Are you concerned about it?

Nadine Dorries: I am looking forward to the results of the consultation and the input to the consultation. I no longer work in the NHS. I am no longer in mental health facilities where restraint is used, but I know that there are times when our NHS staff need to protect the safety of the patient and their own safety, too. Restraint is something we will never be able to do without.

Q239 **Chair:** Minister, could I jump in to support Barbara's point? The issue is that there are some places in the NHS that are brilliant at only using restraint in the exceptional situations when it is needed. There are other places where it has become normalised.

We all understand that there are situations in which staff have to take action they do not want to take in order to protect their safety and the safety of patients, but could you look into the question of variation? We have heard evidence that suggests there are too many places where it has become a normal part of how they interact with patients.

Nadine Dorries: The consultation will be a body of evidence when it reports. That is why I am looking forward to seeing who responded and what the responses have been. I would be really interested. For example, prone restraint is difficult and not something anybody should be doing.

Chair: We should never do it.

Nadine Dorries: Never.

Q240 **Barbara Keeley:** Should it actually be banned? You are not giving us an opinion about restraint generally, apart from the fact that you are looking forward to the consultation. Should it be banned, particularly for children and young people?

Nadine Dorries: I want to see what the responses are from NHS staff, workers, organisations, stakeholders and patients. I do not have enough evidence or feedback from patients. I believe prone restraint may actually be illegal. I do not know if Tim can come in on that. He will. Nobody should ever be prone restrained. Having spoken to the family of the unfortunate and poor man who was behind the introduction of Seni's law, there may be incidents when police are called to hospitals and healthcare settings when they should not be, and when there would be no requirement if people were properly trained to deal with patients who are in a state of distress, mental distress or whatever the situation, and better training was required.

Is restraint used too often? I think the evidence we have heard so far is that it is. That is why we have brought in the use of force Act. That is why we have gone out to consultation. That is why this Government supported an Opposition private Member's Bill through the House, to make it law so that we could do something about restraint. I am looking forward to the responses.

Q241 **Barbara Keeley:** The final thing that might be useful around that consultation is that the data on children and young people's experiences in in-patient units is poor, even the data about the use of restraint. We heard from organisations advocating for children, who found that the data was not very good. It might help you, Minister, if you can, to improve the data around the use of restraint because it is incredibly partial. That is not helpful. There is no way to address this unless you understand the extent of it.

Nadine Dorries: Understanding the extent of it is part of what the consultation is about. Tim, particularly, is on the frontline. Claire, do you want to come in on this?

Chair: Let me bring in Tim on this one, not that I don't want to hear from Claire, but I know that Tim has done a lot of work on restraint.

Professor Kendall: The real problem with prone restraint is that it is associated with death. With prolonged prone restraint, once you have gone past 10 minutes, your risk of dying is really significant. Yes, we should be saying that prone restraint should not be happening, but—this is why banning it is a problem—there are times when people who have been sexually assaulted, particularly in a prone position, find it unbearable to be restrained in that way. That is not that uncommon in some areas. I would be very cautious about having a blanket ban on this kind of thing.

Far better is what we are doing with the quality taskforce by rolling out training in human rights so that everyone who is working in an in-patient unit is trained in human rights. We are going to introduce family ambassadors across the entire estate. A safe wards programme is a good evidence-based approach to reducing the use of restraint, predominantly by focusing on the individual from the moment they come into the unit, engaging with them personally and so on. There is quite a lot going on in this area.

Q242 **Barbara Keeley:** There is an interesting point, though. We have just been through the 10-year anniversary of Winterbourne View. In the worst cases, it is not a question of training in human rights. Some of the private mental health in-patient units hardly train staff at all. The reason things like that have been exposed is that journalists can get in there with no experience or training whatsoever. There are still organisations, as we found with Whorlton Hall, that do that. That is why talk of banning is more important, because people who are not trained will fall back on violent restraint as all they can do if they are not properly trained.

Professor Kendall: In the long run, the right solution is to provide alternatives to admission. In the meantime, the really important step that we are taking in introducing provider collaboratives means that the NHS will be leading those collaboratives and will be commissioning all the private units that provide in-patient care. To my mind, that gives us influence over those kinds of units.

I absolutely agree with you that there is far too much restraint, particularly among children. That is a cause of real concern. Claire and I, and the Minister, all see this as a really important issue that we have to deal with.

Barbara Keeley: I am glad it is seen as important, but I would hope to see more than a feeling of influence over provider collaboratives. The Government have the strength of the law in dealing with prone restraint.

Commissioners can do more than just try to influence the poor providers or the bad providers where violent restraint is going on.

Chair: I think it is also a mistake to say that it is just an issue in independent sector providers, although I am sure it happens there.

Q243 **Rosie Cooper:** Most of the questions I was going to ask have been asked. Minister, I would like to understand the potential conflicts of interest that you described as "interesting" in your replies to the Chair. For all our benefit, would you undertake to investigate conflicts of interest as an interesting situation and come back to the Committee? It could be a significant and important way forward if we deal with potential conflicts of interest.

Nadine Dorries: I want to make one point on Barbara's question. We have just talked about restraint, particularly about prone restraint, which some feel should be banned. I also regard segregation and isolation as a form of restraint. When we talk about restraint, all we talk about is people lying on the floor. In fact, there are other forms of restraint that last for much longer and need as much attention and as much review. We see people segregated and isolated for long periods of time.

Chair: Again, I think that is where the variation is interesting. There are trusts, I think in Gloucestershire, where Tim and I found that they have completely eliminated the use of seclusion. They ran out of space and they had to find other ways of doing it. That goes to the variation point. Rosie, do you have any other points you want to ask about?

Nadine Dorries: I did not actually understand Rosie's question on conflicts of interest.

Q244 **Rosie Cooper:** First off, Minister, could you answer the bit about conflicts of interest and whether you will investigate that and come back to us? I would quickly like to pick up your answer on restraint and how it can be used differently, and go on to ask Claire and Tim whether staff are effectively trained in de-escalation techniques and given the time to do that. It is a two-parter: conflicts of interest that could affect everything we do, and then, to go back to your question about restraint, are staff trained properly in different ways of handling it?

Chair: Rosie, are the conflicts of interest to do with independent sector providers not wanting to release people into the community?

Rosie Cooper: Absolutely, yes.

Nadine Dorries: I am sorry, Rosie. I was not sure which particular answer you were referring to. It needs to be looked at, and I think both Claire and Tim are looking at how those models operate. Training, which you have just discussed, is very important.

What I would say—Claire may have touched on this—is that, in those models of care, the NHS is always the lead. On boards of collaboration where you see collaboration between the NHS and the private sector, it is always the NHS on the board and always the NHS leading those

provisions. We already agreed in the previous answer that we will get back to you with more information on that.

What was your question on restraint, Rosie?

Q245 **Rosie Cooper:** In essence, following your answer to Barbara, there are different types of restraint—isolation, as against physically being put down on the floor. I asked whether staff were getting proper training in de-escalation techniques, and do they have time to use them?

Nadine Dorries: That is one for Claire to answer, I am afraid, because that is an on-the-frontline situation, but I totally get where you are coming from. I have been learning a lot recently about de-escalation and how to talk people down and calm them in a situation of high anxiety and high stress. I will bring in Claire to answer in detail, because the science of it is really fascinating.

Claire Murdoch: The variation is unacceptable, and we need clinical networks to support learning and spread practice. Certainly, under the new legislation, we will be requiring all providers who receive NHS funds—including IS—to publish an annual report on restrictive intervention to make it more public.

On the training of staff, if staff are going to undertake restrictive intervention or restraint, they are expected to undertake a five-day training in how to do that safely. A big part of that training, which has to be repeated every three years as a minimum, is on de-escalation. I think it is critical that you have that.

Tim mentioned the taskforce. We are spending more than £5 million on rolling out training at the moment. In addition, there is human rights training and training for healthcare assistants. We are introducing certification of healthcare assistants because very often, particularly in the private sector more than the NHS, but in both sectors, they are on the absolute frontline. We have to have well-trained healthcare assistants where we are using them, so we are introducing certification there. We are working with the British Council for Human Rights on human rights training. All provider collaboratives have to have parent and family ambassadors and ambassadors for human rights.

For me, it boils down to culture and proper board leadership, whoever is providing a service. Barbara Keeley mentioned abuse earlier. I just want to say right here, right now, that that is a case for prosecution. It is criminal activity, and it is for the police. We always have to be alert to that.

The piece of work that we try to lead in the NHS is obviously alert to that, but a whole tranche of training, support and recruitment should drive up care where it happens. That is the aim. There needs to be much more transparency around publication of data on restrictive interventions, where they are used.

Rosie Cooper: The evidence we have heard from young people would indicate that this is not really felt by them on the ground, and that things are not de-escalated before getting into interventions. The theory and the evidence we have heard do not quite tally.

Chair: That is something for us to come to in the report, I think

Q246 **Dr Evans:** My question is for the Minister, to start with, and it returns to some of the earlier themes. I am particularly keen on prevention. We have talked a lot about dealing with people who start to have problems, but prevention is so important. You mentioned the distinction between mental wellbeing and mental health. Could you clarify what you mean by that?

Nadine Dorries: Sure. My main distinction is between wellbeing and mental illness, and the fact that we are not talking about mental illness any more. There are people who suffer, who really need services, and have their condition sometimes for all of their life, though not always. We have people who have suffered from schizophrenia who, after a number of years, never have a reoccurrence and live a normal life. Mental illness is something that we are not talking about.

I am trying to give you an example. There is the situational weaponising of emotions that we would regard as everyday situations in which we would normally draw on our own resilience to come through. For example, somebody spoke to me who is divorced from his wife. He did not have the children for Christmas. He told me that it really affected his mental health. I asked why, and he said it was because he was angry, even though it was his turn next year as part of the separation agreement.

He was using what had happened to him over Christmas to describe it as a mental health situation, when in fact he was angry, upset and annoyed. By the time he came to talk to me about it he was completely out the other side, and he was fine.

Q247 **Dr Evans:** My interpretation would be that every one of us has problems with our mental wellbeing. Stress comes along, exams, lockdown and losing your job—all those kinds of things—but not everyone has mental health. I draw a parallel in what we do with, for example, obesity. We have an obesity strategy that looks at it as a public health issue first. Not everyone is fat, but everyone could get fat if they carried on not exercising and became overweight.

What do you think of the merits of turning mental wellbeing into a public health issue, in the same vein as obesity? What would that do to change it? Everyone suffers with their mental wellbeing and the stress and strain of everyday living. How do you think that would work as a policy?

Nadine Dorries: I think Public Health England has already taken this on board in the introduction of the Every Mind Matters website and the new Every Mind young people's website. We have had millions of hits on there, where people have used it and used the tools tab.

You are absolutely right, and you are taking me on to a slightly bigger point and a bit of a bugbear of mine. I do not think that mental wellbeing should sit within the Department of Health. There, I have said it. I think it is cross-governmental. I think it belongs to DCMS as well. I think it belongs to the Department for Work and Pensions. Of course, it belongs in Health too and in Education.

One of the good things about the pandemic is that I found it easier to get other Departments to engage on this. Wellbeing is wellbeing, and across Government and Public Health England—I have forgotten what the new name is now—we can take wellbeing as an issue and educate people on it. We have almost talked the nation into believing that they have mental health problems when, in fact, what they may have is just a low level of anxiety because, as you have quite rightly said, people lose jobs, move jobs and move home. We lose people and people die. We suffer from grief.

All those things should not go into the category of mental health. When we talk about all those things under the category of mental health, we do not talk about mental illness. We do not talk about the 20-year-old woman with bipolar who is suffering and on whom we should be educating people. We do not talk about learning disabilities and autism and other things—

Q248 **Dr Evans:** You are right. You have hinted at joining the Departments. You mentioned Education, and we have heard about that so I am not going to go back there. You mentioned DCMS. I have a personal interest in that side. To what extent do you think the online world has an influence on eating disorders, anxiety, depression and self-harm?

Nadine Dorries: Huge. I recently saw a supermodel, who had given birth 48 hours previously, sat in a bikini by a swimming-pool. That was not her body. That was absolutely touched-up and enhanced, whatever they do to photographs. That was it. I could not help but think that any pregnant woman or a woman about to give birth who is looking at social media accounts, or Instagram, and sees that will believe that that is what she should look like 48 hours after she gives birth.

I think there is an impact for young women particularly. I know there is no evidence to prove a causal link yet. That work is going on, and there is a huge amount of research going on into it. I do not think you can blame social media per se, but it would be absolutely naive to say that there is no link between the eating disorder crisis that we have, and that we saw happening before the pandemic even struck. It was not a crisis at that time, but we certainly saw the uptick and the escalation. It would be naive to say that there is no causal link between the number of young people using Instagram and other social media accounts, looking at perfect body images, and believing that is what their body should look like.

Q249 **Dr Evans:** On that basis, is the Department advocating a precautionary

principle and stepping in on the basis that it looks reasonable to draw some policy lines on this, or is it waiting for the hard evidence that there could be a problem stored up down the road?

Nadine Dorries: As you know, the online harms Bill is about to come before Parliament very soon. I believe you will have had more discussions than me. I hope there will be some lines, some movement, towards recognising this in the online harms Bill. I don't know.

That is what I mean when I say that I do not believe mental wellbeing is just a Department of Health issue. I think it is a cross-governmental issue. All policies that we look at—

Chair: Thank you. We got that loud and clear. Any final points from you, Luke?

Dr Evans: No. Thank you very much, Chair.

Q250 **Paul Bristow:** Minister, I would like to move on to whether you feel we have the right models of care for young people. We heard from experts in Australia, where mental health provision has been remodelled with CAMHS split in two. One section is for under-12s and the other is part of an integrated service with general practice, sexual health clinics and even employment support for 12 to 25-year-olds. Do you think that is something that you may consider?

Nadine Dorries: I think you are talking about Headspace and the open-access hub models.

Paul Bristow: Yes, that's right.

Nadine Dorries: Not only do we consider it, we invented Headspace. Headspace was here in the UK before it went to Australia. It has just been rebranded with a different name in Australia. Yes, we are looking at that all the time. In fact, we have rolled out 60 early-access hubs. As you have just said, they integrate sexual health and even careers advice into some of them, along with mental health support.

I cannot help but think that in my day, when God was a boy, we called those youth clubs. I come from quite a deprived area of Liverpool. We had people attending our youth clubs who were doing just that kind of thing. There is nothing new in this world. Everything comes around in a different form. I think the open-access hubs are something that we will be keeping a very close eye on.

Sadly, in Australia they are yet to conclude that they work. The evidence is that they have not solved the problems that Australia wanted them to solve. They have not dealt with the issues that they wanted them to deal with. We are taking our evidence from our own experience and seeing how they work in the UK.

As I said earlier, this is a process. We are four years into serious funding and serious consideration of mental health in children and young people.

It has not been done by any previous Government, and we are four years in. We are on a journey. I would like to imagine that, 10 years from now, all our mental health services will be delivered via an infrastructure in the community and looking something like an open-access hub, where young people can just walk in. They will not need to be referred. They can just walk in off the street and receive the support and mental health support they need.

Q251 **Paul Bristow:** You said that in Australia it has not had the results that they had hoped for. Is that a review that your Department has led or looked at? That is not what we heard from our evidence.

Nadine Dorries: I think Peter Fonagy's words to you were that the open-access hubs had not solved the problems that they hoped they would solve, and that the jury was still out. I don't know where you had your evidence from, but I am getting it from Peter Fonagy. Tim may know more about the evidence.

Chair: We heard some very compelling evidence from Australia about how it had worked there. I think you are saying that the jury is still out in terms of effectiveness.

Nadine Dorries: And we are doing it anyway. We have opened 60. We are not waiting for Australia's evidence.

Chair: We heard from people doing it in the UK. In fairness, even if it was invented here, it seemed to be more extensive in Australia, particularly in Melbourne. They seem to have taken it a bit further.

Paul, do you have any more questions?

Paul Bristow: No; that is fine. Thanks, Chair.

Q252 **Chair:** I want to move on to the horrible issue of suicide. If the right care is in place, should we consider the vast majority of suicides to be preventable?

Nadine Dorries: That is a very difficult question. I think probably the politically correct answer for me is to say to you that every suicide is preventable, but if I am being absolutely realistic, I am not sure that every suicide is. I have experienced it in my own family. Having first-hand experience, I am not sure that, realistically, every one is preventable. That is my short answer.

Q253 **Chair:** We heard very powerful evidence from Steve Mallen, who tragically lost his son, Edward, to suicide. He set up the Zero Suicide Alliance. His very strong view is that we should be aiming for zero suicide, not as a target but that should be our aim. Do you agree with that?

Nadine Dorries: Yes, absolutely. Zero suicide should be the goal. But practically and realistically, is that achievable? I don't know. My common-sense hat tells me, from my own personal experience, that it may not be. It absolutely should be the goal. Part of that goal is training people how

to identify, how to intervene and how to talk to somebody, as well as how to refer somebody on for further help. All that is part of it.

Q254 **Chair:** One of the issues that I think you would agree with is that there are many cases when a suicide could have been prevented. When Steve Mallen talks about Edward, it is very clear that, if Edward had been able to access the mental health support that he needed at the right moment, Edward would still be alive. Do you think there is value in doing a study that tries to look at precisely how many suicides were preventable had the care been in place, so that we can see much more precisely what needs to change?

Nadine Dorries: I co-chair the National Suicide Prevention Committee with Professor Louis Appleby. I do not know if that is work that Louis Appleby is undertaking at the moment. What I do know he is undertaking at the moment is real-time suicide surveillance across the UK. I think he is on 14 STPs now and hoping to finish on 16 STPs.

One thing I can say to reassure the Committee is that there is no evidence of any increase in suicide over the last year. In fact, in some areas suicide has gone down. Contrary to some of the inflamed rhetoric that we had at the beginning of the pandemic, the facts are that suicides have not increased this year.

Q255 **Chair:** Professor Appleby gave evidence to the Committee, and we have talked to him about this. We had a letter from Claire and Tim saying that, if you tried to do a study into what proportion of young people's suicide was preventable, it would be difficult because the sample size is too small.

Nadine Dorries: It is 100 a year, I think.

Q256 **Chair:** The question I want to ask is, could we do a bigger study on suicide looking at a larger sample size and not just younger people, to try to get to the bottom of the proportion of suicides? It would not be the same as the Hogan and Black study into broader patient safety in hospital. There would be a different set of questions. Professor Appleby seemed to think that it might be possible to find a different set of questions that would give us the answer we are looking for. Is that something you would be open to?

Nadine Dorries: I would defer to Professor Louis Appleby on that point. What I would say is that I almost always receive, when there has been a suicide of a young person, a prevention of future deaths report from the coroner when the coroner reports.

I am very careful. I never, ever discuss the means by which young people take their own life. Just recently, I have been aware that there are certain situations where we may see a cluster of suicides, and where we would know the means by which those young people took their life. What can we do to prevent that? I would probably go to my comments earlier about cross-departmental working.

Even if there are deaths that we can prevent—Tim will know the percentage—I think I am correct in saying that a large number of suicides are people no one is aware of. They have never approached anyone or reached out. They have never even been to see their GP.

Q257 **Chair:** Tim, I want to bring you in to answer the point on whether we could do some kind of study to establish what proportion of suicides we have confidence that we could have prevented, so that we can really make sure the lessons are learned. Is that something you think we could pursue?

Professor Kendall: It depends on what we want to achieve. The number of suicides in children and young people is sufficiently low that, even if we looked at it over several years, it might be difficult to get anything meaningful out of it.

If our aim is to try to identify when a trust, for example, is outside the norm and having more suicides than it should, which was the point of the Hogan and Black study, there may be a way of doing that that could help alert us at national and regional level. Roughly, an average trust will have 25 suicides per year. The question is, if they reached up to 35, would that make us think there is something wrong? Equally, if their suicides went down to 15, is it possible that they are turning away all the wrong people and that they are not getting into services?

This is important. If you look at the suicide rate in trusts, remembering, as you know, that about 28% of suicides happen when people are in mental health services, it has actually fallen over the last three or four years. Part of that is because we have expanded the number of people coming in, but I think there are some real, genuine falls, particularly on in-patient units.

It is an important issue, but I am not sure that the Hogan and Black study could do it. If we got Louis and his group to look back over the last 10 years and say, "What is the standard deviation for each trust over 10 years, and could we identify when a trust has gone outside, say, two standard deviations?" is that a point at which we could then intervene? I am talking to him about that, but we have not come to a conclusion.

Chair: Perhaps you could write when you have concluded what you decide.

Nadine Dorries: Could I just make one burning point on what Tim said, and on the issue of preventable deaths? You spoke about the Zero Suicide Alliance, which was funded by the Department.

It is very difficult to collate the evidence from large initiatives, which cost a lot of money, into how many deaths they have prevented. I have met so many charities—I spoke to one on Friday night—who are small groups of people across the country. They go out at peak times on Friday, Saturday and Sunday nights. They take two or three-hour shifts and stand on railway bridges and local bridges. They talk people down and

phone the police. We do not fund those people, and no one speaks about them. They do not come into the Department or have a high profile, but they are saving people's lives every day.

What I think we need to do as a Department is drill down to those smaller organisations across the country, and perhaps assist them with greater funding and training. They are already saving two, three or five lives a week. We need to assist them to save more.

Q258 **Dr Evans:** I have a follow-up question for the professor. I agree that when you are dealing with such small numbers it is quite difficult. Self-harm is an important point. It is a halfway point and can be an indicator for suicidal intentions or, indeed, attempts. What are your thoughts on how we deal with that? There is no recorded register of deliberate self-harm, so it is quite difficult to understand the problem. It is quite difficult to get the reporting mechanisms right, yet it may well be a good indicator when it comes to preventing suicides, by taking one step above the problem and the flow.

What are your thoughts on that, and whether it is indeed a valid way of dealing with it, or something that may fall apart because of a technical point that you know far more about than I do?

Professor Kendall: First, you are quite right to say that self-harm has a very important link with later suicide. It is probably the most important link we have. If people self-harm and they come to the attention of services, we need to take it very seriously. I think that message is understood across mental health for both children's and adults' mental health.

That is very important, but self-harm is incredibly common, especially among the young, so much so that I have a worry that it has become almost normalised in young people. The vast majority of self-harm never comes anywhere near mental health services. As I say, when it does, it is taken pretty seriously.

It is also true that it is very difficult to predict. If you take studies following up people who have self-harmed, and then you think, "Well, what are the characteristics that might determine later suicide?", they tend to be things like being male, having depressive symptoms or having an existing physical health problem. Those are all things that are incredibly common. While I think we should take self-harm as very important, and we do, it is very difficult to find what factors turn it into a later suicide.

Q259 **Dr Evans:** Rather than suicide, then, how about the indication of diagnosed mental health problems such as anxiety, depression or eating disorders? How strong is the link between self-harm and those conditions?

Professor Kendall: If you follow up, in big prospective studies, people who have self-harmed, having a mental illness does not predict later

suicide. Having said that, 28% of suicides occur in adult services. In children, it is higher, at about 40%. Among people who have mental health problems, we need to take this very seriously, and I think we do.

Q260 **Dr Evans:** Would you advocate a forced register of reporting those incidents, as we have with knife incidents that turn up to A&E? Should primary care, secondary care and educational establishments be reporting the numbers to the Department of Health so that we have some idea of how widespread deliberate self-harm is?

Professor Kendall: As I say, we would not possibly know how widespread self-harm is without doing community-based studies. Where they have been done, we are talking about much bigger numbers than we find in mental health services. Within mental health services, it has to be seen as a safety issue. Absolutely.

Q261 **Dr Evans:** Minister, we have heard that there is a lot of this going on and it has almost been normalised. At the same time, we are hearing that we do not have a way of really knowing how much is going on unless there is contact. Is that something that the Department should be working on, as primary prevention almost, to stop people getting into that or alerting people very quickly when it is happening?

Chair: We have to make that the final question, Luke, I am afraid.

Nadine Dorries: We take that guidance from Claire and Tim, because they get the referrals. They are on the ground and know what is happening in emerging situations such as self-harm, and whether it is an issue.

I think I am right in saying, though, that during the pandemic there were very few incidents of self-harm. It was one of those issues that went down and did not turn up at A&E, but it is on the increase since, as a result of young people going back to school and coping with getting back into that routine. I am going to hand over to Claire because—

Q262 **Chair:** Actually, we have to move on. I am so sorry. We will bring Claire in before the end. Time is running short and I have a few other really important questions that I can, hopefully, cover quickly.

First, one of the big worries in the mental health world is that the backlog created by the pandemic might end up using some of the resources that have been put aside for the mental health long-term plan. Are you going to make sure there is enough money in the system to deal with the backlog, on top of what is already needed to deal with the long-term reforms?

Nadine Dorries: It is already happening. There is the mental health recovery plan and the £500 million, with the additional £40 million that we have announced today and the £79 million that we have put into the mental health support teams. It is already happening.

Chair: We understand that more money is going in—

Nadine Dorries: We need the money to pay for the services—

Q263 **Chair:** We understand that the money is going in, but we do not know if it is enough. What we are trying to check with you today is that you will make sure there is enough there to deal with the backlog so that the reform plans do not get put on hold.

Nadine Dorries: I work very hard to ensure that the funding comes through, and continues to come through, to mental health.

Q264 **Chair:** On workforce, obviously the pressures have changed a lot since the long-term plan. We have the Covid backlog. There is also the Mental Health Act White Paper. Are you going to revise the numbers that were set out in the NHS mental health implementation plan in 2019-20, which was done before the pandemic?

Nadine Dorries: There are no plans to do that at the moment, but I think it is possibly work in progress. We are still dealing with the pandemic, sadly, in the Department. We are dealing with, as you say, the referrals that we have had and the backlog. I think that will certainly be part of the process over the next year, because it is important that we know the numbers that are coming down the line towards us.

Q265 **Chair:** More broadly, do you think workforce issues would be helped if Health Education England had a statutory responsibility to publish independent projections of what they thought the workforce need was in every specialty, including mental health, so that the public could be absolutely certain that we were training enough doctors, nurses, allied health professionals and so on?

Nadine Dorries: Chair, I am not going to be able to answer that in the way you want me to. I know, as you do, that it is a very complex issue. In my own area, of mental health—I deal with a number, as you know, in maternity and others—it has been a learning experience to go from where we were when I first took up this job two years ago to where we are now with the number of people who want to work in mental health. As Claire said, there are over 100 applications for each university place. There are universities coming forward and offering places. The Department is reacting and the public have reacted to suddenly wanting to work in mental health. I go back to the days of Winwick Hospital and never having wanted to work there.

Q266 **Chair:** I suppose the issue is that Health Education England has those projections, but they are not allowed to—

Nadine Dorries: But they could not have predicted this. Whatever projections they had would have been completely wrong.

Q267 **Chair:** No one could have predicted the pandemic. They have projections now, but they are not allowed to publish them by the Treasury. This is negotiated in the spending review. My question is, should they publish their projections independently every year, a bit like the OBR does for

Budget forecasts, so that we can all be confident that we are training enough people for the future?

Nadine Dorries: I think you need to get someone from the Treasury and ask them that question. I do not know the answer.

Q268 **Chair:** Fair enough. I have a final couple of questions, and Laura wants to ask you a question on patient safety issues. I want to give Tim and Claire a chance to come in a final time. Is there anything you want to pick up from the issues that we have covered so far? Claire, was there anything you wanted to wrap up with?

Claire Murdoch: Thank you very much. I have a few things, and I will do them very quickly.

On Headspace, Australia have been in contact with the Royal College of Psychiatrists to register some concerns. I am sure they could help, or we could find more information about that.

Secondly, on suicides, obviously each death that is reported to any of us at NHS England or, in fact, across Government is seen as a catastrophic and devastating incident. It is always important that we give hope to young people and their families, and that we are here. We have the 24/7 crisis lines in place now in every NHS trust, in every area of the country. It could not be more important that people pick up the phone and seek help.

We know that 40% of suicides in children and young people are not known to the NHS. I want to take that as an example—there are so many—as to why everything about our strategy and long-term plans is around integrating care locally, localising in-patient care, reducing it and looking at earlier intervention. The mental health support teams in schools are an exciting bridge in trying to close the gap between raising awareness, early intervention and treatment for mental illness.

If I might, very briefly, I want to thank Simon Stevens. He has been insistent that, within the NHS budget for health, mental health has had a ring-fenced budget. Within that, he has been insistent and steadfast that the ring fence for children and young people's mental health should grow at a faster rate than all health investment. I think that is why we are seeing a doubling in the numbers of children and young people who we are treating.

I want to end, if I might, with the point that the NHS cannot do this alone, and wider society must step up and work alongside teachers and parents for our young.

Q269 **Chair:** Thank you, Claire. Tim, do you have any final points?

Professor Kendall: No, I am fine. I think it has all been covered.

Chair: I am sorry to cut you off, but I know the Minister has another appointment. There are a couple of final things on patient safety, as we

have you here. Laura Trott has the first question.

Q270 **Laura Trott:** Minister, we have raised the issue of women's health today and the historical lack of focus on this particular issue. At the weekend, *The Times* raised a very important point about the lack of pain relief for women undergoing IUD insertion. Since then, we have had horrific experiences of women shared across social media. I have certainly had a number of people come forward in my own constituency. Can you commit today to look at that specific issue as part of the women's health work and the consultation that you are doing at the moment?

Nadine Dorries: Yes, absolutely. No woman should suffer pain as a result of having an IUD or a scope procedure, such as laparoscopies. I believe there are scope procedures where no pain relief is offered. I do not have words that I can use while I am sat here to describe just how appalling that is.

I am constantly given the line that most women do not feel pain; that many women go through this; that it is explained to women; that they are given a leaflet and are told that they can have pain relief. In fact, I hear that they are told, "Oh no, you'll be just fine." I hope we can use the women's health strategy to reverse the assumption that because you are a woman and might have been through labour, or because you are going to go through labour, pain is a part of your existence. I hope we can use the women's health strategy to totally reverse the wrong thinking that takes place today.

Laura Trott: Thank you very much.

Q271 **Chair:** Thank you very much, Laura. What is your response to Cumberlege, Minister?

Nadine Dorries: We have tabled the WMS. That is coming soon, before the end of the year. I think it is coming in September or October time, but we are on track with that.

Q272 **Chair:** A final question from me. We heard today that Henrietta Hughes is stepping down as the national guardian responsible for the reforms to make whistleblowing easier across the system. I hope it is not out of place for me to say, as Chair, that when, as Health Secretary, I worked with her, I thought she was absolutely excellent. I want to put on record my thanks to her for her work. I wondered whether you had any comments.

Nadine Dorries: Can I do the same? Henrietta has been in the post five years. I was kind of expecting it, but it is devastating. She has overseen the introduction of over 700 lanyard-wearing, speak-up guardians across 400 hospitals in the UK. It is work in progress. She has never taken her eye off the ball. It has constantly been her mission to improve patient safety by having speak-up guardians who others can go to, to talk about their experience of treatment or their experience of healthcare that has been administered. She will be a huge loss. I am hoping that we can persuade her to continue working with us in other roles, because she is

inspirational. Yes, it is very sad news, but we thought it might be coming after five years.

Chair: Thank you. You have all been very generous with your time this morning. Claire, Tim and Minister, thank you very much. That concludes the session.