HOUSE OF LORDS

Select Committee on Science and Technology

Corrected oral evidence: The Science of Covid-19

Tuesday 22 September 2020

10 am

Watch the meeting

Members present: Lord Patel (The Chair); Baroness Blackwood of North Oxford; Lord Borwick; Lord Browne of Ladyton; Baroness Hilton of Eggardon; Lord Hollick; Lord Mair; Viscount Ridley; Baroness Rock; Baroness Sheehan; Baroness Walmsley; Baroness Young of Old Scone.

Evidence Session No. 19 Virtual Proceeding Questions 202 - 209

Witnesses

Dr Michael Bloomfield, Principal Clinical Research Fellow and Head of the Translational Psychiatry Research Group, UCL; Convener, Covid Trauma Response Working Group; and Honorary Consultant Psychiatrist, Camden and Islington NHS Foundation Trust and University College London Hospitals NHS Foundation Trust; **Professor Matthew Hotopf CBE FMedSci**, Vice-Dean of Research, Institute of Psychiatry, Psychology and Neuroscience, King's College London; **Professor Nichola Rooney**, Consultant Clinical Psychologist; Professor, Queen's University Belfast; and Northern Ireland Chair of Division of Clinical Psychology, British Psychology Society.

USE OF THE TRANSCRIPT

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Examination of witnesses

Dr Michael Bloomfield, Professor Matthew Hotopf and Professor Nichola Rooney.

Q202 **The Chair:** Good morning to our witnesses. This session is being recorded and you will get the transcript to check. If you have any further evidence after the session that you wish to send in, please feel free to do so. First, I am going to welcome Dr Bloomfield, Professor Hotopf and Professor Rooney. I know each of you in turn is going to do a short presentation and then my colleagues will ask the appropriate questions. Thank you all for coming today and helping us with our inquiry.

Dr Michael Bloomfield: Good morning. Thank you for inviting me to give evidence today. Among my roles, I am a consultant psychiatrist at the Traumatic Stress Clinic, a specialist NHS clinic for post-traumatic stress disorder. I am also a principal clinical research fellow at University College London.

Psychological trauma is defined, according to internationally agreed medical criteria, as being the experience of a very stressful event such as actual or threatened loss of life or serious injury. This could be direct trauma to an individual, witnessing a traumatic event or learning of a loved one’s experiences of a traumatic event. While it is important not to pathologise normal psychological reactions—and by this I mean unduly attributing reactions that many of us have as being due to disease states—experiencing psychological trauma none the less increases the risk of a range of mental illnesses, including depression, anxiety disorders and post-traumatic stress disorders. In addition, experiencing psychological trauma can exacerbate existing illnesses, such as psychosis.

After a traumatic event, it is normal for many of us to feel a heightened sense of threat and experience intrusive memories of the event in the form of flashbacks and nightmares. These experiences typically resolve over a few weeks. In post-traumatic stress disorders, a heightened sense of threat in the here and now, alongside intrusive memories of the traumatic event, can become persistent and are associated with a state of hypervigilance and avoiding triggers that remind the individual of the traumatic event. Untreated, post-traumatic stress disorders are potentially debilitating conditions.

As the Covid pandemic raced towards the UK, I, together with colleagues at University College London and the Traumatic Stress Clinic, realised that we were about to face a mass casualty event that would, by its very nature, expose many millions of people all over the world to psychological trauma. We were also aware that the necessary infection control measures for the pandemic would interfere with healthy resilience and recovery processes through a range of factors, including reduced social contact. We therefore convened a multidisciplinary working group of experts, psychological trauma specialists and researchers to co-ordinate evidence-based clinical and academic responses to the Covid pandemic.

Through this work, we have identified five groups of people as being at high risk of traumatisation and other adverse mental health outcomes through Covid: patients who have survived serious Covid illness; health and social care workers witnessing the actual or threatened death of high numbers of patients and also having a threat to their own lives through the risk of infection; people who are bereaved, as a result of Covid and in the context of Covid, who are at risk of a range of traumatic bereavement reactions; people who already have experiences of trauma or who are at increased risk of traumatisation indirectly, in the context of trauma, including, for example, children who are being abused in their homes, victims of domestic violence and survivors of torture, such as refugees; and finally, patients with existing severe mental illnesses who would be receiving less support now from services that had already been overstretched before Covid.

Through this work, we supported our acute general hospitals in our region in providing helpful support for NHS staff and issued expert guidance relevant to psychological trauma and the pandemic. We have been contacted by clinicians, both here in the UK and overseas, who have found our work to be helpful.

In terms of both health and social care workers and survivors of severe Covid, our research, based on previous epidemics and current survey data, has found approximate rates of over 20% for PTSDs and over 30% for anxiety disorders and depression. While there might be some selection bias in these prevalence rates and so they may be overestimates, they are still significantly over the expected rates of these disorders. We believe them to be indicative of suffering and urgent clinical need. The available data indicates that the risk of PTSD among health and social care workers and patients who have survived severe Covid is of a similar magnitude to those surviving other mass casualty events, such as terrorist attacks, or as is seen in military personnel who have returned from war.

We have a range of effective treatments for PTSDs and other mental health problems at our disposal, which can include treatment in or with guidance from specialist trauma clinics where this is necessary—for example, due to clinical complexity. There is therefore an imminent need to both detect and treat these survivors of psychological trauma. Without targeted screening programmes, as have been used following terrorist attacks and other major disasters, detection is challenging for a number of reasons, partly because avoidance is a core symptom of PTSD, which therefore interferes with helpful treatment-seeking behaviours.

We also believe that treatment will be challenging because these clinical services have already been under-resourced prior to Covid and additional resources have yet to be made available. We believe that the situation is compounded by an ongoing challenging funding landscape for research into mental illnesses. In conclusion, we urgently need our repeated pleas for parity of esteem between the mind and the brain, and other parts of the human body, to be quickly translated into proper resources for both clinical care and medical research.

Professor Matthew Hotopf: Thanks for the invitation to speak. I am a psychiatrist and epidemiologist based at the Institute of Psychiatry, Psychology and Neuroscience, King’s College London. I direct the National Institute for Health Research biomedical research centre at the Maudsley.

Earlier this year, I was one of a group of mental health researchers convened by the Academy of Medical Sciences and the mental health research charity MQ. We wrote a call to action paper, which was subsequently published in *Lancet Psychiatry*, exploring what the mental health science response to the pandemic should be. The paper anticipated many of the mental health consequences of Covid that we are seeing now.

In order to understand the mental health impact of the pandemic, one needs to consider two distinct types of question: the impact of the pandemic on patients who have experienced Covid themselves and the impact on the mental health of the wider population. Starting with the wider population, we know that public health restrictions, uncertainty about the future, economic downturn and disruption in the workplace and education have profound impacts on people’s lives. What we have not known until more recently, with robust data, is what impact that is having on mental health.

However, there have now been some pretty good studies that have actually been able to follow people from before the pandemic—existing cohorts. Then they have sampled them during the pandemic and looked at change in mental health symptoms. In one study I was an author on, we found an increase in clinically significant distress in the general population, going from about 18% up to about 27%, so a 50% increase in people experiencing clinically significant symptoms of distress.

Worryingly, this has particularly affected young people. In the UK, we were already seeing an increase in mental disorders among young people, particularly young women, and Covid seems to have amplified that trend. The groups most affected are young women, in the age group between about 16 and 25, and people living with children at home. In a sense, there is a disconnect here. The group that is at least risk of mortality is actually paying the greatest price, potentially, in terms of social, economic and educational impacts. That is being seen in the mental health consequences.

I want to say a bit about the NHS. Michael has touched on this. Many surveys are showing considerable distress in healthcare workers. There have been a couple of big systematic reviews on this. Our own research across a number of NHS trusts is beginning to show something similar, with up to 60% of people in NHS employment showing clinically significant symptoms of distress. One has to put a level of caution on this. We do not know quite what these symptoms represent. When you dig down with further questionnaires, it is a combination of anxiety, depression and post-traumatic stress symptoms, which Michael has alluded to. There is clearly a signal here that one needs to take account of.

The second area I wanted to develop was the mental health of those directly affected or infected by the virus. Acutely, from surveillance studies of acute neurological and psychiatric presentations, we know that there can be some fairly unusual presentations, such as acute psychosis or catatonia and encephalopathies. In more chronic terms, we are seeing an accumulation of physical, cognitive and mental health symptoms, which are being characterised as long Covid and seem to be affecting people, not only those who have been admitted to hospital with respiratory failure but also those in the community who never made it to hospital and maybe never got a test for the virus in the first place.

It is highly likely that there will be a complex interaction between mental and physical symptoms. The mental and cognitive component of long Covid will be disabling in its own right. I can say more about the work that colleagues have done in terms of long-term follow-up of people who have been critically ill and how important that mental-physical health interface is.

In our position paper, we called on funders to support programmatic research, which would not just describe the problems but help us to understand mechanisms and develop treatments and preventive strategies. The Academy of Medical Sciences and MQ put out a statement yesterday calling for this to be seen through by research funders. To reiterate Dr Bloomfield’s point, there is a long history of underfunding of mental health research. Many of the funders have realised this and written strategies, but there has not been as compelling a response to that as one would like to see. I suppose there is a risk that Covid amplifies this gap. Instead, it is critical that we use this as an opportunity to integrate research on mind, brain and body.

Professor Nichola Rooney: Good morning and thank you very much for the invitation. We are very pleased that mental health is in your sight and thoughts. I am a clinical psychologist by background. I am currently chair of the Division of Clinical Psychology in Northern Ireland, which you will have gathered. I am here representing the British Psychological Society. I also have experience of working in the psychological aftermath of Covid-19 from a devolved nation perspective, which may be of interest to you. As a society, Northern Ireland has had its experience of trauma, not one-off lone events but long-term trauma. Some of our learning is based on our own experiences in Northern Ireland.

In relation to the current pandemic, I sit on the British Psychological Society Covid-19 response co-ordinating group, and I chair the workstream on bereavement care, which I am happy to talk more about today. This group has developed a toolkit of resources—I hope they have been sent to you—for adults, children and staff, providing advice for the public and professionals on dealing with bereavement during this pandemic. Within Northern Ireland, I have also chaired a task group aimed at developing resources and a pathway and model for bereavement care of the pandemic.

I come from a perspective of considering the psychological impact of the pandemic, not only for those who have contracted the virus but for us, the general population, who have been affected by the restrictions and the impact of the virus. Within Northern Ireland, I have also been on the group that has developed the emotional and well-being framework for staff and guidance for the psychological follow-up of patients who have suffered and been hospitalised with Covid-19.

My viewpoint in responding to all these populations that have been mentioned is that we need to ensure that people can access the appropriate support at the right time. It has already been said that first and foremost, as mental health professionals, we must be careful not to stigmatise people or pathologise what they are going through, which can often be normal reactions to very abnormal situations. We have to say it is normal to have been stressed. I am sure that during this pandemic we have all experienced elements of stress and maybe now, as we head towards a long winter, some low mood. These are all perfectly normal reactions; they do not mean that we are suffering from a mental illness.

As with grief, most people will manage without specialist support. However, according to my findings on Covid pandemic bereavement needs in Northern Ireland, there are normally 16,000 deaths in Northern Ireland every year. Since the end of March, 6,999 people had died, so over 7,000 by now, and over 880 deaths were attributed directly to Covid-19 on their death certificates. Compared to a five-year average, we will have seen 1,120 excess deaths.

How do we manage bereavement care for this population? As a rule of thumb, we will imagine that at least five people will have suffered grief because of their bereavement. When we look at those figures, for England the total number of bereaved since the beginning of April would be 1.5 million. For approximately 250,000, that is directly due to Covid, but the rest have faced the restrictions in place around the time of the bereavement. For Great Britain as a whole, that would be 1,667,250 people, so we have to think of how we are going to meet the needs of people bereaved during this time. They are difficult numbers to take in.

The normal experiences we have in place, particularly in Northern Ireland, where we are big into our wakes, and have huge funerals and community responses to death, have been stopped at a time when we most need support. Some of the biggest stress buffers are our social supports. At the time we need people most, we have been unable to access them. There have been some very moving stories, as you have probably heard on the news. Behind these statistics, we have to remember, are people and devastated families. We have to ensure that we have appropriate resources in place.

As the BPS stated in response to the House of Lords “Life beyond Covid” call for evidence, we are conscious that this pandemic has not been experienced equally. We are concerned that people on the margins will be even more vulnerable to the virus. We need to ensure that people at the margins are not forgotten about but can avail of the treatments and support available. Many of these may be now inaccessible due to technological needs as we turn to remote working.

We need a stepped approach to managing the psychological aftermath of Covid. We need timely access to evidence-based, appropriate psychological interventions where necessary—and I hope, in relation to people who have had the Covid virus, within multidisciplinary rehabilitation teams, provided alongside the physical health rehabilitation. All this is predicated on having a sufficiently trained and supervised workforce.

In mental health services, because of austerity and cuts, we have had very little extra funding and resource and staff development. We have managed so far by redeploying a lot of our services when things have closed down, but we are concerned that we will not have the resources necessary to face the challenges ahead. We also need a population health approach to increasing psychological resilience, and supporting and empowering people to manage their own health and well-being and to understand the difference between normal and abnormal responses.

The Chair: Thank you very much to all three of you for those excellent presentations. I have about 40 minutes for my colleagues to ask questions. There are usually lots of questions, so I will ask colleagues to keep them brief and the witnesses to answer as briefly as you can.

Q203 **Baroness Walmsley:** I would like to explore a little further the actual effects on the lives of those people who have experienced what I believe is called complicated grief. That is hardly surprising, when people have seen their loved ones gasping for breath, being put on a ventilator in hospital and eventually dying, when they are unable to hold their hand, reassure them, have that connection and say goodbye, which is so important to many people. First, I wonder what the actual effects are on people’s lives.

Secondly, what can we learn from the families who have been bereaved by other traumatic events, such as the Manchester bombing or the Grenfell Tower fire? There is a big difference. Those people have had the community around them who have had the same experience. They have formed groups and clearly got a lot of comfort from that. They have had what they call closure. They have been able to find out what happened, why it happened and all those things. Because of the restrictions and the vast numbers, that is not possible for the millions of people who have suffered bereavement over the last six months because of Covid.

What are the actual effects on people’s lives and what can we learn from these other groups that I have just mentioned? Professor Rooney has had a lot of experience of that in Northern Ireland, so perhaps she could start.

Professor Nichola Rooney: They are very important questions. Any of us who have been bereaved knows how difficult it is. Even though I am saying grief is a normal process, how difficult it is should not be underestimated.

One thing we have learned in Northern Ireland, in relation to traumatic bereavement and death during trauma, is that we really need to be able to process the trauma before we can begin to grieve. A lot of what you have described of what people will have experienced during the death of a loved one really interferes with what would have been a normal grieving process. It can often delay the ability to start to grieve and come to terms with loss, because we are actually experiencing flashbacks to witnessing the types of things you are talking about. It can delay the process and make it difficult. It increases feelings of guilt and anger, which are particularly difficult to process and deal with.

As for the restrictions on social support, you are right: the community plays a massive part in recovery. One of the strengths of what we have learned about our population in the midst of this pandemic is how communities have come together. There are fantastic community, voluntary and other third sector organisations that are well placed to support people in the community who do not need to access specialist psychological services. Ultimately, part of our recovery is having opportunities to remember, to share memories, to integrate learning from that person’s life into our own lives and to come to terms with how they have impacted on others. All those things are what we normally do.

We have developed resources. The British Psychological Society has developed a lovely resource called “continuing bonds”, which draws on experiences from around the world, following other pandemics, of different ways to remember loved ones. We need to put those things in place now. Ultimately, there has to be a government-led commemoration and opportunity to remember our loved ones in the long term.

Baroness Walmsley: Do people know about the existence of those resources?

Professor Nichola Rooney: We try to advertise them, through Twitter and social media, and they go out to professionals. Our data on who accesses them would suggest that they are known, but certainly we need to extend that and make them further known. If you have the opportunity, please tell people to go to the website of the British Psychological Society.

Professor Matthew Hotopf: On the point about affecting lives, for many years I have been running a clinic in St Christopher’s Hospice in south-east London. Some of that is seeing people with complex grief reactions, under normal circumstances, when people have died of cancer or other long-term conditions. I cannot put a figure on this—I am not going to give a very researched answer—but the group of people I see with complicated grief are some of the most difficult to be with in the same room as, because the psychic pain they experience is so challenging.

Particularly challenging is the re-experiencing of grief. It seems they are stuck in a closed loop. It is as though the grief does not stop being raw. That can continue for many months, or even years, as a process. It takes a very long time, with a lot of support, to get to a stage where, as Professor Rooney was describing, people can start moving on and come to some form of closure. They usually do, but it is quite an extraordinary experience just being in the room. Their lives are completely impacted, in their ability, occupationally and socially, to form new connections and do the very practical things they need to do, in the context of grief.

Q204 **Baroness Sheehan:** May I put this question to all three of our expert witnesses? First, as we head into winter, longer evenings and facing tightening restrictions, how concerned are you about the impact that shorter daylight hours will have on the country’s mental health? Could you reflect on which groups may be more greatly impacted? Secondly, what part do you think alcohol has played to date during this crisis? Is there a public health message that policymakers need to think about delivering, particularly focusing on the recent announcement about the curfew and the concern some publicans have expressed that drinking will then move indoors?

Dr Michael Bloomfield: There is increased confidence among some members of the community that, having been through the first wave of Covid, we know what to expect now from the second wave of Covid. However, that is mixed with quite significant anticipatory anxiety about what will happen next. In terms of the effects of reduced daylight, there is evidence of an increase in depressive symptoms associated with the winter months, which may exacerbate other mental health disorders as well.

Regarding alcohol, we know that alcohol use has been on the rise and people have been using more alcohol. That is an additional public health concern. To go back to my earlier points about psychological trauma, that also increases the risk of substance use disorders, including alcohol use disorders.

Professor Matthew Hotopf: The buffering effect of being able to socialise is very important. In times of stress, that is what we do. We are social animals. Although you can go so far with platforms like this one (i.e. Zoom), you can only go so far. One can anticipate that, if you reduce people’s capacity to socialise, the effect of shorter daylight hours, poorer weather, less access to outdoor space and less inclination to access outdoor space will have an impact, in terms of population mental health. You cannot put a particularly precise figure on any of that.

In terms of alcohol, I agree. Alcohol is clearly a concern, as an adverse coping strategy. Substance use services for the last decade or so have been fractured by changes in commissioning structures and so on. That has had a very significant impact. It means that access to services for those with complex problems with alcohol has been much harder. There has been a loss of expertise because of the commissioning going to local authorities as opposed to the health service.

Professor Nichola Rooney: I agree with everything that has been said. We know that there was increased alcohol consumption from the off licence reports. Northern Ireland has the highest rates of death from drug and alcohol misuse and we have very poor specialist resources. Again, community groups are probably carrying the bulk of the pressures. We certainly need to think in the future about increasing our community addiction services. We also need good public messages and we need them to be delivered. We see now difficulties with young people and social distancing. We have to have behaviour change experts behind these messages; they need to be delivered by people from within that population. We need to be agile in how we get the messages across.

Q205 **Baroness Rock:** Professor Rooney has picked up a very interesting point about public messaging. I would like to focus a little more on the communications during the pandemic, the concern and fear that some people feel, how we should look at the tone of public messaging and what we have learned from the past on public messaging.

I would also like to ask about the shielding programme for the vulnerable and elderly. Is there anything different that we should do, learning from the past couple of months, particularly as we go into the autumn and winter months and it looks as though we will be coming back to more severe restrictions, about the loneliness that the vulnerable and elderly feel? That has certainly come through over the past couple of months. There are two questions really. Professor Rooney, perhaps you could start on the wider issue of communication and the tone of public messaging about mental health concerns.

Professor Nichola Rooney: At the start, the messaging was very clear and people knew what to do. We are finding it more difficult. I am trying to be polite about this, but it can be confusing and sometimes the messages are a little difficult to follow. We have to bear in mind what we want from messaging. People need to know why they are doing it; they need to have a clear understanding of why they have to do something. They need to have a motivation themselves for doing it and they need to understand clearly what they have to do.

Those are the key components and sometimes that has been a little confused. We need to have messages delivered by appropriate role models or people we can relate to, and not just the same message for all our populations. We probably have different messaging in Northern Ireland from some of the rest of the UK. I know that is one thing we are struggling with now, but clear communications and campaigns are paramount.

In relation to the second point, you are right. One of the learnings we have got from Covid is that there was, understandably, a strong focus on acute physical health. We very quickly learned about care homes and the difficulties facing the elderly, people rendered vulnerable because of their conditions, shielding families and children who are carers. It took us a while to realise: "Oh my goodness, we really need to attend here."

In Northern Ireland, we have integrated health and social care, which may make it a little easier, but we are now turning our attention to supporting staff delivering social care packages. We need to identify much more quickly—we are probably better placed to do that now—the most vulnerable people in health and social care, and reach out to them, ensuring they have the necessary support and not expecting them to come to us.

Baroness Rock: Dr Bloomfield, do you have anything to add on communication about mental health? What can we do to focus on the mental health aspects of it as well as the physical issues?

Dr Michael Bloomfield: Consistent explicit and implicit messages need to be given about the importance of the interventions that are happening for both our physical and our mental health. Specifically on mental health, one of the most useful messages to give would be to maintain as much social contact as possible within infection control restrictions. Although meeting over Zoom for lots of people is not as nice as meeting face to face, it is better than nothing. If that is not possible, there are telephone calls.

In the virtual world that we live in at the moment, we can have an illusion of feeling connected to other people through Twitter and email, but we lose the interpersonal buffering effects of a conversation. It is having the conversations that can be most helpful. Any possible ways to boost social interactions and conversations will probably have the strongest effect. That is based on my clinical judgment though, not on research.

Baroness Rock: Professor Hotopf, are there any self-help techniques that we should be talking about in terms of mental health?

Professor Matthew Hotopf: I agree with what has been said about the things we know are beneficial: maintaining social contact, connectedness, sleep hygiene—there is a lot that could be done for that—and avoiding harmful coping strategies such as resorting to alcohol and substances. Those are, essentially, the key messages one wants to convey. It is not that there is a shortage of that sort of messaging. Maybe it is sometimes a bit confusing to find your way around all the advice that is being given.

The challenge is how one does that when the population as a whole is rather divided in its overall sense of what is being done regarding lockdown. In fact, it is not just the population but the scientific community as well. We saw different opinions from two eminent colleagues from Oxford University just yesterday. Colleagues of mine have done research showing that, when coming out of lockdown, about a third of the population felt more needed to be done in terms of protection, about a quarter felt we should just be getting on with it and the remainder felt it was just about right. That kind of disparity makes the broader messaging quite difficult, in terms of how one conveys what healthy things to be doing are. At the start of lockdown, there was much more of a sense that we were all in it together. Everyone agreed that this was necessary, and there were not many dissenting voices. In a way, that is almost a greater challenge than the specific mental health messaging.

Q206 **Viscount Ridley:** I am glad Professor Hotopf has raised lockdown, because I want to follow up on that point. He said that the group at least risk of mortality has the highest mental impact, or at least that was what the evidence might suggest—in other words, young people. Young people have been hit much harder by the lockdown than by the virus. We can probably agree with that. If we are to ask the question, "Has the lockdown had greater mental impact than the virus?" are there ways to look into that? In particular, can we look at Sweden, which has had slightly higher levels of infection throughout but much less of a lockdown, particularly for young people? People have been able to go to funerals and things like that. Could that be a case you can look at to try to tease out whether lockdown or the virus is causing most of this mental anguish?

Professor Matthew Hotopf: The short answer is yes. It is a good idea, which had not occurred to me, actually. Making international comparisons of population mental health is always quite challenging; there are lots of extraneous factors that you need to take account of. There are all sorts of subtle differences between different states in the United States or countries in Europe that would allow those sorts of comparisons to be made. It comes down to having decent population data, which is not a given. That comes back to my point about significant research investment.

Viscount Ridley: I do not know whether Professor Rooney would like to comment on that point about countries or states where funerals have been allowed. Could you pick up an impact there on mental health that is nothing to do with the virus but to do with the lockdown?

Professor Nichola Rooney: I agree. We have data from other pandemics in the past and the impact of restrictions of grief that we can look at. That is how we know that this is going to have an impact. As Matthew has said, it is difficult to have international comparisons because the psyche can be different in different countries as well. To the question on adolescents and young people, peer interaction is really important for their mental health. So we cannot have one size that fits all. We have to think of different ways of managing the virus within different populations.

Dr Michael Bloomfield: I agree with the other witnesses. It highlights the need for joined-up psychological and psychiatric input into the strategy to deal with Covid.

Q207 **Baroness Young of Old Scone:** I was staggered by Professor Hotopf's statistic of 60% of staff showing clinically significant symptoms of distress and by the emphasis that came out in several of the presentations on screening programmes. Can we focus on NHS staff and social care staff? Are these screening programmes beginning to emerge? Are a range of support services in place for staff as we go into the second wave, first in the NHS and secondly in social care?

Professor Matthew Hotopf: I said there was a health warning with this. If you ask people on a questionnaire that is designed to screen for mental disorders about symptoms of distress at a time when they are under considerable stress, they are likely to come out positive. You pick up a lot of people who are stressed and to some extent distressed, but do not necessarily have a mental disorder.

The critical point is to see whether these symptoms continue and are maintained, and to dig deeper by asking people in more depth what is going on. We are running a study that does exactly that at King's College London. That is going across a number of NHS trusts, with the hope that we can understand better what these experiences come down to.

The question of screening is a bit more challenging. There has been a debate about screening for psychological distress in all sorts of exposed populations, including the military. Colleagues of mine at King's did a major evaluation of the idea that you should be screening veterans as they come back from warzones and found that it made no difference. It may actually cause harms because you may be medicalising a lot of healthy distress. Healthy distress is a bad term—I mean normal reactions to stressful situations. It is not a question of screening; it is a question of the level of health surveillance that needs to happen. As I say, that is taking place. I am less clear about what is taking place in social care, but that is vital.

The mental health of the NHS workforce was a source of concern for some years before Covid. Yes, there are experiences of day-to-day clinical practice that are distressing and disturbing, but the greatest driver of mental illness in the population of people caring in NHS settings comes not from day-to-day experiences of caring for people with distressing disease but from the structures you put around them, particularly access to all the things one would want in a decent place of work: support from colleagues, decent accommodation and places to rest, and shift patterns that are civilised and not absurd, as some shift patterns for junior doctors have been. Those structural things, particularly the support of people within the organisation and the feeling that concerns are taken seriously and contained, really matter. That was rather a long answer, but I hope it sheds some light.

Dr Michael Bloomfield: There is a difference between having a mass screening programme for the general population, which is the kind of screening programme used in the military, and very targeted screening programmes, which can be helpful, as our experience of other mass casualty events shows. Quite often, symptoms of post-traumatic stress disorder tend not to be picked up through traditional routes. They tend to be missed in primary care. There are quite a few studies showing that post-traumatic stress disorder can be missed even in psychiatric clinics.

There is a need for some sort of programme to detect those cases—and there are different names for this, such as screen and treat or targeted screening. As Professor Hotopf's answer alluded to, there is controversy in the field about exactly how that should work. Research is needed into that. None the less, there is urgent need that warrants an approach to detection and treatment sooner rather than later i.e. before research further research is conducted in this area.

Baroness Young of Old Scone: Could I press you a bit further? In your judgment, are there mechanisms at all in place to enable staff who are feeling particularly stressed or challenged to get support?

Dr Michael Bloomfield: There are mechanisms in place. I am aware of national mechanisms in England, through NHS England, and in the other countries of the United Kingdom. There is huge regional variation in what is on offer. In our region of London, staff support has been offered, and some of that has been taken up. The feedback from our research is that take-up of staff support has been quite low. Often healthcare workers can be ambivalent about taking up formal psychological support.[1]

We have heard consistently that psychological support needs to be offered by people who know the local context and have existing relationships with staff members. Any screen and treat programme or targeted screening programme could work through those staff support mechanisms. A distressed member of staff, for example, might be able to complete a brief screening tool to detect PTSD when they take part in routine staff support. If they score positive on that, they might have further more detailed screening and assessment as appropriate. However, at the moment, we do not have resources to roll that out.

Baroness Young of Old Scone: Are you aware of any similar mechanisms in care settings, in care homes, social care and domiciliary care particularly?

Dr Michael Bloomfield: The situation in social care and in care homes is even more challenging than in the health service.

Professor Nichola Rooney: One of the first things that were done, in acknowledging the pressures that staff were under, was to develop a staff well-being framework and to quickly set up helplines, support rooms and teams around staff. The framework in Northern Ireland was launched by the Minister of Health in April, based on the British Psychological Society guidance on staff support.

The difficulty is that, in the acute stages, people are very reluctant to seek help. We learned quickly that we did not have things in place for social care, so we opened helplines and support to care home staff, ambulance staff and anybody working in health and social care. We developed rooms and safe spaces for staff. In that state of high anxiety and overwork, you cannot really access your own emotions and avail of psychological support. The next phase, when people begin to feel tired, burned out and maybe slightly disillusioned, is the most dangerous point for staff.

I want to pick up on what Matthew said. Rather than place the difficulties within the person and talk about building a resilient member of staff, we have to look at resilient teams and communities, and we have to look at the psychological context of the organisations. That has seemed lacking in the past within healthcare. We need psychologically safe, robust

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[1] Subsequent private communications from Dr Bloomfield: "The feedback from our research is that take-up of staff support has been quite low from nationally deployed schemes, compared to locally arranged schemes which have seen higher take-up. Often healthcare workers can be ambivalent about taking up formal psychological support as individuals, rather than taking part in support targeted at teams and organisational systems."

organisations. We are seeing more use of reflective practice spaces, Schwartz rounds, where staff can share their experiences with colleagues. We have psychologists integrated into physical multidisciplinary teams, as Michael talked about. It is much easier to support staff if you are integrated, but to ask staff to seek help individually is challenging; there is often poor uptake and it is not appropriate.

Q208 **Baroness Sheehan:** I am very aware that all three of you brought up the need for robust data so that we can have evidence-based interventions. Professor Hotopf, you spoke about the mental-physical health interface, which you hoped you might be able to expand on later. Professor Rooney, you talked about unequal experiences and multidisciplinary teams. We need data to inform all that. Can you say where the remit for that lies and how we can drive this forward? Where are the gaps that we need to fill?

Professor Matthew Hotopf: It is quite a broad question. There is a question about where the data is available. The gap is in having proper mental health surveillance, which I was talking about in the context of NHS staff. We need that more broadly, with population surveillance—we are piecing together bits of evidence, but not at the scale needed to inform policymakers—and surveillance of the mental health of people who have experienced the infection. That falls between research and clinical services. I am a great believer in clinical services integrating mental and physical healthcare. We have had a programme running for many years that does that and ensures that people coming to general hospitals have mental health measured as they come through. That sort of pattern is the way forward.

Q209 **The Chair:** My question follows on quite well from that, which mostly relates to research. Are there relevant cohort studies in place to gain long-term insights? Are the interventions that have been applied being adequately evaluated, and by whom?

Professor Matthew Hotopf: That is a very big question, but you are absolutely right. There are a number of existing cohort studies that have already produced some data: the one I was referring to, called Understanding Society; the ALSPAC study run out of Bristol University; and Generation Scotland. There are existing cohort studies giving insights into the population impact of the pandemic. However, these go only so far. As I was saying about NHS staff, it is not really sufficient just to send out a questionnaire and identify that there is a bit of a signal. One wants to have in-depth understanding of what it means. That is where there is a gap in our data and understanding.

There is also a gap in the follow-up of people who have experienced Covid. There is a large platform study, and you heard last week from Professor Chris Brightling. There is mental health embedded within that to some extent, although, again, it is to the extent of asking some fairly simple questions of participants. One really needs something that goes beyond identifying a problem to explore the mechanisms and reasons for that problem and, in the case of people who have come out of Covid with mental health difficulties, to understand whether there are brain mechanisms that are responsible, immune mechanisms and so forth.

The evaluation of treatments is a huge question. There are disappointingly few novel studies looking at the capacity, for example, of digital interventions to improve population mental health. That is an obvious opportunity, given the need to do simple things at scale, and that is an area that our report, from the Academy of Medical Sciences, drew attention to. I am not aware of research funding in that field; it could certainly be developed.

Professor Nichola Rooney: If you have been hospitalised, we are putting teams in place so you can access evidence-based therapies. The rehabilitation package is developed with a research base underpinning it. We are not so clear about the population that has not been hospitalised. There is a group that is looking at long Covid, which you may wish to speak to. At this time, they are a difficult population for us to access in a meaningful way.

The Chair: Last week, we heard a lot about the effects of Covid on the brain and nervous system. Is there any evidence that that has led to any systemic effects, in terms of mental health issues? Answer quickly: yes or no?

Professor Matthew Hotopf: Yes.

Dr Michael Bloomfield: Yes.

The Chair: What?

Professor Matthew Hotopf: You get some fairly extreme acute reactions, which can include psychosis and catatonia, about which we know relatively little. Chronically, we do not really understand what long Covid is. It is almost certainly a combination of being physically deconditioned and very unwell for a long time, underlying physical health problems that persist and the impact of that on your cognitive state and mental health. It is a complex interaction.

The Chair: What I have heard from all of you and the evidence we had yesterday suggests that not only are there existing mental health problems that Covid has affected and exaggerated, but there are now bigger and newer issues related to mental health because of Covid. This affects large cohorts of the population: the young, the sick, the old et cetera. I acknowledge that there cannot be a short answer, but is there not an opportunity now for a reset in the way in which we do research and deliver care in mental health? If the answer is yes, who should do it? Professor Hotopf, you are raising your hand.

Professor Matthew Hotopf: I am raising my hand because this is what I am passionate about. The problem is that for too long mental health has been somewhat siloed. A huge amount of benefit would come from a much more systematic approach by which research funding insisted on a mental health component as the norm and you had to explain why you were not doing that, if you were investing in major health infrastructure, for example. That has not been the case and it could make a substantial difference.

In healthcare, it boils down to having proper integration as much as possible. That involves access to mental health services within general hospital settings and permeable access to mental health expertise within primary care. If you are coming out of intensive care, having been really ill for four to six weeks, and you are just about getting back on your feet and sent home, you need a package of care that takes account of brain, mind and body. Unfortunately, during Covid, a lot of those community resources, physio, occupational therapy and so on, which are absolutely critical, have been harder to access because of restrictions and the disruption within local services.

The Chair: Thank you very much. I am sorry that we have run out of time because I know there are other people with questions. Thank you very much indeed, all three of you. If, on reflection, you find there are points on which you have more detail, please feel free to write to us.