HOUSE OF LORDS

Select Committee on Science and Technology

Corrected oral evidence: The Science of Covid-19

Tuesday 22 September 2020

11 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; Lord Winston; Baroness Young of Old Scone.

Evidence Session No. 20 Virtual Proceeding Questions 210 - 218

Witnesses

Caroline Abrahams, Charity Director, Age UK; **Professor Tamsin Ford CBE**, Professor of Child and Adolescent Psychiatry, University of Cambridge; **Professor Sonia Johnson**, Professor of Social and Community Psychiatry, UCL.

USE OF THE TRANSCRIPT

Examination of witnesses

Caroline Abrahams, Professor Tamsin Ford CBE and Professor Sonia Johnson.

Q210 **The Chair:** Welcome to our next witnesses, Professor Abrahams, Professor Ford and Professor Johnson. Thank you very much for coming today to help us with the inquiry. We look forward to hearing from you. Can I ask Professor Abrahams to start off, please?

Caroline Abrahams: I should point out that I am not a professor. I am afraid I am mere layperson.

The Chair: You have just been made one. We are all professors.

Caroline Abrahams: I will take that any day. Good morning, everybody. I am the charity director of Age UK. We are the largest charity for older people in this country. Obviously, we have been having a pretty busy time. It is very interesting for us to take part in your session today. I will start by saying that this is a crucial issue for older people. We have been doing some research on it, so I have some evidence to share with you. I am afraid it will not be very cheerful.

We have not published this research yet, but we have done some polling. One in three of the older people we polled agreed that they felt more anxious since the start of the pandemic, which is not very surprising. People living with long-term health conditions were more likely to be feeling anxious. Over a third of the older people who took part agreed that they were feeling less motivated to do the things they used to enjoy.

The general sense that we get, and we get this picture as well from local Age UK branches that are working on the front line with older people, is that this is an incredibly challenging time. We did this research a few weeks ago. Our worry, of course, is how things will be over the next few weeks and through winter. It is always a difficult time for older people: it gets dark and cold; it is harder to get out and about. Particularly, it is the anxiety of knowing that there is a virus out there and, if you are a very old person who has other health conditions and you catch it, that might well be the end of it. Living with that month after month, day after day, and with the isolation and loneliness that many are feeling, is a horrible cocktail of issues for older people. We are very seriously concerned.

Professor Tamsin Ford: Good morning and thank you for inviting me. I am a professor of child and adolescent psychiatry at the University of Cambridge. My clinical background is obvious. My research background has been about tracking access to mental health and well-being services across the range of the population, from those who are thriving to those who are really struggling, rather than just clinic-based mental health, and about optimising service organisation and intervention delivery, to maximise children's developmental potential.

I would start by saying that children, and certainly those under 10 or 11, seem very unlikely to catch the infection. If they are less susceptible, that means there are fewer opportunities for transmission. The evidence is less clear among teenagers, but children have been notably absent from

policy considerations in a way that I think is very foolish. Children obviously are our future. The pandemic hit against a background where consistent evidence from various surveys and some longitudinal data demonstrated that young people's mental health was deteriorating. Between 2004 and 2017, our national surveys, which we should be tremendously proud of, because they are probably the biggest and best in the word, demonstrated an increase from one in 10 school-aged children having a clinically impairing mental health condition, to one in eight.

This latest survey in 2017 included 17 to 19 year-olds, and is one of a number of studies suggesting that young women in their later teens and early 20s are a particularly vulnerable group. This survey shows that nearly a quarter of them had a mental health condition. Half of those had more than one mental health condition, and approximately half of them were self-harming regularly.

Right from the outset of Covid, because of the huge disruption to everybody's lives, the disappearance of vulnerable children from normal support systems that would keep them on the radar and the lack of uptake for vulnerable children going into schools, there have been real worries about children's mental health. There are lots of signal-to-noise problems with the research. A fantastic living systematic review is being done by McGill in Canada; I can send a link to anyone who is interested. I checked this morning and this amazing team of people have now screened 23,500 abstracts of papers relating to mental health, in response to Covid, but fewer than 100 studies have been included as sufficiently rigorous. This means there is a lot of disinformation, a lot of time being wasted for respondents and perhaps fatigue creeping in.

There is a tension between getting good data and needing data quickly, because we want to act now. The problem with these convenience samples is that weighting back to the population only partly reduces bias. Large is not necessarily good; large and biased is biased, and there is no theoretical basis for statistical analysis in a sample where you do not have a sample frame.

However, what can we learn from the only 14 studies that have pre-existing data before Covid? Those in students suggest an increase in depression and anxiety. For most, it was depression more than anxiety. More relevant to our context in the UK, there was a study from the UK Longitudinal Survey, which I do not know if Matthew Hotopf mentioned. This showed an acceleration of the deterioration of mental health, which has been slowly deteriorating over the last decade. It accelerated in all groups, but particularly in the young. It was evident particularly in 16 to 24 year-olds, and to a lesser extent in older young adults, if that makes sense. Women were vulnerable, particularly young women. A new vulnerability emerged, which will not surprise anybody, and that was adults with children under five.

There are some really good cross-sectional studies, but there is a real data gap for children. Of those pertaining to children, there is one from Bristol, which you might have seen, on 17 schools. They have data from

October last year, pre-dating the pandemic, and they went back in May. These youngsters were in year 9, so they are 13 to 14 years old. There were very interesting findings. The well-being of those who were struggling before Covid and lockdown has increased, and they have fewer symptoms of depression and anxiety. We need to think very much about the way we support children, if being on lockdown makes your mental health better for a sizeable chunk of the population.

Last week, a survey of 19,000 children, aged eight to 18, from 237 schools in the south-east of England, suggested that 10% of 12 to 18 year-olds have self-harmed at least once; 2% reported feeling unsafe at home, which is deeply worrying; and 4% felt unsafe at school. They only had a well-being measure, not an anxiety or depression measure. This has decreased in all age groups but is worst among older teenagers. There is a lot of sleep disruption, which has implications for mental health, and more loneliness.

Another study you might have heard of is Co-SPACE. This is a convenience sample recruited by social media. They are relatively white and affluent. The parents have reported increased restlessness and inattentiveness and sleep disruption across the age range. The mental health of younger children, aged 10 and under, has deteriorated across the board but particularly in behavioural problems. If that translates into problems on the return to school, the potential costs of this cohort going forward are huge. Behavioural problems that impact your development are seriously bad news. It will not surprise anyone that parents reported a huge amount of stress trying to juggle work with home schooling.

One last study I want to mention, conducted by a colleague, Helen Minnis, in Scotland, is particularly interesting. It is very small. Just under 50 parents and professionals working with children and young people were interviewed right at the beginning of lockdown, in April, and then again in July. That showed that families fell into either a virtuous or a vicious circle. Somebody has beautifully described the pandemic by saying, "We might all be in the same storm but we are not in the same boat". In thinking of a response for children and young people, and I suspect other vulnerable groups, this is really key.

Where there were adequate resources, and the youngsters were old enough to access online education and had the kit and the space to do so, initial anxieties had decreased. The families were often valuing additional time with each other, could see benefits and were coping. Where there was overcrowding, lack of access and financial worries, there was a spike in domestic violence, which we all anticipated, and substance misuse. Some families were in a very nasty, vicious and deteriorating circle.

Helen and her team have co-produced an idea to try to mitigate this, should we have to lock down again, which is really worth considering. The ideal is that children are at school. If we can keep the schools open, we really need to try to do so, because children are least at risk from the virus, they are probably less involved in the transmission, and the health,

education and social consequences of shutting down schools are immense. They will suffer more and they are bearing the cost for us.

If we cannot keep the schools open, can we have part-time schooling, so that parts of the year group go in on some days? Can we stagger times for arriving and going home? If that is not possible, can we congregate families around a trusted adult or grandparent, or group families together so it is not families living in overcrowded situations, desperately trying to cope with this all on their own? Can we mitigate it? That said, there will be some very vulnerable older family members, or children themselves, who have long-term conditions, where that is not possible. We need to think about how to support them.

Professor Sonia Johnson: Thank you very much for inviting me. Good morning. I am the director of the NIHR Mental Health Policy Research Unit. We have a role delivering evidence to inform policy. I am also a professor at UCL and a practising psychiatrist in the London Borough of Islington. In the Mental Health Policy Research Unit, we have been conducting rapid studies focused on experiences in the mental health care system during the pandemic. We have been looking at staff and service user experiences in the UK of people living with mental health conditions already, particularly people living with relatively severe conditions. We have also done an evidence synthesis of what has been written around the world about these experiences.

I will give you a few key findings, first about the experiences of people already living with longer-term mental health conditions, such as psychosis or depression, during the pandemic. Unsurprisingly, most of the reports are of deterioration, both qualitatively and quantitatively, although that is not uniform. There are a number of problems that people are recurrently reporting in their lives. These include exacerbation of loneliness and social isolation, and greater risk of family conflict and domestic violence. A lot of people are reporting on loss of routines, coping strategies and the contacts and services that usually enable them to self-manage and cope with their mental health conditions. The economic impact of the pandemic, as well as the social impact, seems to be magnified for people living with mental health conditions.

Tamsin has it exactly right for this group too. They are in the same storm but not in the same boat. Many of the problems and inequalities are potentially exacerbated. Having said that, it is not a uniform picture. From talking to people about their experiences, some people with mental health conditions seem to have done relatively well in the pandemic. People reported that it provided a respite or that they are already used to living with social isolation and adversity. They have found that maybe not much has changed or they can draw on reserves of resilience from that. Some people find that they have more contact with others in their communities, and that they feel less socially excluded. It is a mainly but not entirely negative picture of experiences during the pandemic.

Looking at what has happened in mental health care, in terms of service use, a similar pattern is being reported from quite a few developed countries. Early in the pandemic, the use of the statutory mental health

services tended to drop. Perhaps because people were avoiding services or services were just not functioning or responding, there was less use of most types of service in many countries. The reports seem to suggest that that is now rebounding and that services have subsequently begun to be very busy, both with seeing previous clients who have been out of contact and with new presentation.

Looking specifically at the challenges faced by different services, in in-patient and residential services, such as hostels for people with long-term mental health conditions, unsurprisingly there has been a very big challenge of infection control. There are specific issues, such as managing infection control with people who are unwell or have cognitive problems, which mean they find it difficult to follow guidance. In our staff survey, people repeatedly wrote about how the layout of wards and residential accommodation was not conducive to socially consistent care.

There is a big concern in both in-patient and residential services about what they can provide being very much impoverished, and about people becoming quite lonely and isolated in those settings. Because of quarantine regulations or closure of communal areas, people are being admitted to hospitals and then not much is actually happening in terms of the usual therapeutic and activity programmes. There is a lack of visits from relatives, and a lack of the usual contact with and trips to the outside world. There are ethical dilemmas, where people are detained under the Mental Health Act but then receive reduced therapeutic input when they are in hospital. Ethical dilemmas also arise in relation to control and restraint procedures where they involve added risk of infection, as well as the usual risks.

Looking at the community, crisis services have tended to keep doing a reasonable amount of face-to-face contact, but to switch partially to phone and video calls. Again, there are considerable infection control challenges, such as in paying home visits to people who are in quite a disturbed state of mind. Following infection control procedures in that situation is pretty tough. There are also some very interesting and rapid innovations in crisis care, such as new services being set up to avoid people going to A&E, providing new forms of walk-in crisis care and new hotlines. These are innovations that some people are saying they would like to keep longer-term.

Finally, looking at community mental health services, psychological treatment services have tended to be entirely online during the pandemic, while community mental health teams have provided a mixture of face-to-face, but mostly remote care. It has been a very rapid transition, in that before the pandemic there was quite a bit of research evidence suggesting that telemental health methods were useful and video calls could be used to deliver good care, but we were not doing much of it. It has been adopted very quickly. However, how successfully this seems to have been done and how much trusts and services are managing to use video calls, rather than just making quick phone calls to people as a form of contact, is very variable.

The things that are hampering it being done better include a lack of clear protocols. There are lots of variations between services in what is thought to be acceptable, in terms of the video platforms used. Both staff and service users often lack equipment and good connections. There are also concerns about digital exclusion potentially exacerbating the exclusion of some people who do not have the skills and who face cognitive difficulties, resource barriers and cultural barriers to engaging in digital care. There are concerns about whether therapeutic relationships can be the same on a video call.

Finally, there are concerns about people having the privacy to conduct a call, about who may overhear them and about people finding it intrusive to talk about these very intimate matters in their bedroom, which they cannot get away from. Those are my main points. There is lots of change but much still to resolve.

The Chair: Thank you very much to all three of you for your presentations. I have less than 40 minutes and lots of Committee members wanting to ask questions. Can I ask Committee members to be brief in their questions and witnesses to keep your answers brief and to the point? I am sorry about that.

Q211 **Lord Winston:** Professor Tamsin Ford, your stuff on children is really important to us. I am trying to separate the issues here. One issue is that children of all ages are often very frightened by what they see around them, and they are clearly having a great deal of that distress communicated from parents and adults.

The other issue is quite different, and I wonder if you would focus on this a little. It is their isolation and therefore their lack of development in play and other aspects with other kids. If you have time, differentiate between younger, primary school children and adolescents, who are facing very different problems.

Professor Tamsin Ford: We need to be careful not to pathologise the adjustment that we have all had to make. A large chunk of the population will do fine. As ever, the social, emotional and financial resources of families and other key adults will mitigate it. This is where Helen's work on virtuous versus vicious cycles is so instructive. Teachers and teaching assistants in schools should encourage children who are frightened to think about the controllable things. "Yes, there is a scary virus out there, but you can wear a mask, wash your hands and not get too close to people. There are things that you can do that will reduce your risk". That is dealing with the normal level of anxiety.

We should be proud of our children. In Mina's OxWell study of the 19,000, children were more worried about their friends and families than they were about being lonely and missing school. That is the normal end of things. Thinking about the age groups, it is hard to be more worried about one group or another, because there are stresses for them all, but they are different. The school situation for younger children, including pre-schoolers, is essential. Children learn by play. It is how they pick up social skills, learn what behaviour is and is not acceptable and learn to

control their emotions. Those are key skills that you learn in interaction with other people. Keeping the schools open for younger children is key, also because they will be less able to access online social activities and schooling. A 15 or 16 year-old can sit in front of a screen and take part in a conversation in the way a three or four year-old cannot.

Constructive use of social media may be an explanatory factor for studies showing that, in certain groups of teenagers, emotional difficulties are slightly reduced, because you can be in touch with your peers and mitigate the loneliness and isolation. But we still see many reports of more loneliness and sleep reduction, which will impact on mental health, and probably is doing so. We have to bear in mind that there is something desperately wrong with how we are structured at the moment, which is impacting on our teenagers, but particularly young women, a quarter of whom have a clinically impairing mental health condition.

Q212 **Baroness Blackwood of North Oxford:** I was particularly struck by the point made by Professor Ford and others about not all being in the same boat. A particular challenge of policy response is with pregnant women, who are both immunocompromised and at a higher risk of mental ill health. I have connected questions. First, is there any evidence of increased antenatal and perinatal mental ill health in this group during Covid? Secondly, have we got the balance right, in terms of access to mental health services, based on the physical and mental health risks faced by pregnant women during Covid? Thirdly, what more could be done to increasing formal support to them, in the context of social distancing, during what is a very important time? We know that mental ill health can have a serious effect, not only on the mother but on the neurodevelopment of the child.

Professor Tamsin Ford: The very quick answer is that I have not seen any studies looking particularly at the mental health around the perinatal period. It is a gap. Maybe they are falling down the gap between the adult work and the child work, although there are some very good perinatal researchers and we should probably get them on the case. I defer to Professor Johnson about the mental health support available for this group.

Professor Sonia Johnson: My colleague Louise Howard has written a paper, which is about to be published as a preprint, looking at experiences of perinatal care from a staff perspective. It suggests lots of problems with people being isolated from the usual support and challenges in assessing people who may be developing perinatal difficulties after birth in the context of current infection control. I am sure this area needs more attention. I would be happy to send through that paper, which goes into some detail on the deficit in care, if that would be useful.

Baroness Blackwood of North Oxford: That would be really helpful. Thank you very much.

Q213 **Lord Mair:** Can I follow up on the question that Lord Winston addressed to Professor Ford? In the context of mental health and the role of schools,

which you have talked quite a lot about, Professor Ford, what do you think schools should do? Should they change the balance between academic education and personal development in light of Covid, or carry on doing pretty much the same thing they normally do?

Professor Tamsin Ford: That is an excellent question. I and many others had concerns about the direction that schools were going in prior to the onset of Covid. There is a huge amount that schools can do. They need to have a whole-school well-being policy. Bullying is one of our most tractable public health risk factors that we can do something about. There are loads of evidence-based programmes; we are just really lousy at doing them. That would be a quick win, and it casts a shadow over adult mental health as well as child mental health.

We should be teaching kids how to look after their mental health. We teach them about physical health, and eating and diet. We should be teaching people how to spot what stresses them and to keep themselves calm and healthy. Actually, there is a lot of overlap in that.

On the management of behaviour, I was part of a team that did a systematic review for the Education Endowment Foundation, which has been published. It has six simple guidelines. We could be a lot better at managing behaviour more constructively, in a way that would help children optimise their development and reduce quite a lot of stress for both teachers and children.

Our schools were not healthy places for pupils or teachers before Covid hit. I really worry that a focus on just the academic catch-up, which will be needed, would be disastrous. For those who are struggling, and there will be a big overlap between struggling with education and struggling with mental health, it will be a wasted effort if all the focus is on that when they first go back.

Lord Mair: Can you get this message across to schools? What guidance is being given to schools at the moment?

Professor Tamsin Ford: It is very confused. We have the problem, as we have done since the SEAL programme in the late 1990s and the early 2000s, that the best schools listen and do it, but reaching the schools that are less interested is very difficult. The Education Endowment Foundation is constantly bringing out practitioner guides, which are brief, because teachers are very busy people, but are backed up with sound science. There is a training that optimises classroom management skills. We do not formally teach our teachers and teaching assistants how to manage classrooms. That would go a long way to improving the mental health of younger children. There is evidence for it. We need to find a slot for it in teacher training or in the newly qualified teacher years. There are some quite quick tweaks we could do.

Lord Mair: In the earlier session, we heard about the importance of messaging. Baroness Rock asked about that and some interesting comments were made about communications and messaging. What needs to be done to target children in particular?

Professor Tamsin Ford: That is a really interesting question. I am ashamed to say that the average literacy level in this country is age 11. If we get it right for adults, we will get it right for the majority of children. There needs to be a balance between managing your risk and getting on with life, making sure that you eat, sleep and do things you enjoy. Time and time again, with the presentations, we are hearing about how there is no fun. Sometimes you have to diarise fun and, particularly if you are struggling with your mental health, that can be really hard. Simple, clear messages are good: "Behave as if you have coronavirus and you do not want to give it to anyone, but do not let that stop you living your life. Carry on with your exercise and hobbies as far as you can, keep in contact with people and try to keep up with your school work".

Q214 **Lord Hollick:** Can I come to the impact on mental health services and the professionals delivering the service? What has been the effect of this and what is the state of morale in mental health services? How effective have remote services for mental health been over the last six months? To what extent is it possible to increase the capacity of mental health services? We have heard in both sessions today that demand has risen considerably, but can supply be increased and the methods of working improved so that more people can have their problems addressed professionally?

Professor Sonia Johnson: Starting with remote working, it is clear from previous evidence and research studies before the pandemic that it can work well in people who are up for it. Effective care can be delivered by that means. During the pandemic, it has worked well for some people. It probably has improved the efficiency of care for some people. It has reduced the environmental impact. One thing that people are reporting is great is using it to communicate between staff. For instance, the traditional problems of staff in different teams not talking to each other, or lack of communication between inpatient and community services, is often overcome by using Microsoft Teams, or other tools, for joint meetings.

Some trusts seem to be doing really well, using lots of video calls and putting innovations in place, such as connecting patients on the wards so they can talk to each other or to relatives. Those are ways to overcome digital barriers. A lot more can be done to make it work as well across the board as it does in a few settings and places. Having said that, the clear message is that there are people and situations for which it is unlikely ever to work well. There are groups of people, such as homeless mentally ill people or people who live alone and have cognitive impairment, who are likely never to engage with it all that well.

Another task is to be appropriately selective in its use and use it to improve capacity where we can, but be clear about circumstances in which it does not work. There is a lot of work to be done. Some people seem to have just dropped out of care when it has been delivered digitally. There is a big task in working out what works for whom. It

probably can be used to increase capacity, if that is done appropriately, selectively and in an intelligent manner.

Professor Tamsin Ford: All the same things apply to children and young people. The additional risk is safeguarding. If you are having a conversation with a young person and you can just see a box, you do not know who is sitting outside that box, and they may be being coercive. It is not insurmountable, but we need to co-produce guidelines for good practice and be aware of who this works for. It could increase capacity because of reduced travel time, and some families welcome it because of the reduced disruption to them. We also need to be getting smart and skilling up other people, for example school nurses, health visitors and school counsellors, who do not necessarily have the formal training.

There are reasonably quick trainings we could think about for them to enhance their skills. You do a bit of skill shifting and uplifting to make the workforce bigger, because there will be many more children who need help, and we were underfunded and underresourced before this happened. The coming recession will equally cause a further deterioration in children and young people's mental health, and I suspect throughout the rest of the population. I would have thought safeguarding would also be an issue around the elderly.

Lord Hollick: Caroline Abrahams, could you comment on the situation of mental health in the elderly, from your perspective?

Caroline Abrahams: Mental health problems in older people are significantly underrecognised and underdiagnosed. Older people find it very difficult to get access to things such as talking therapies, despite very good evidence that they are more effective with older people than with most others.

To my remarks at the start about mental health of older people through the pandemic, we are largely finding people who do not recognise they have a mental health problem, have not sought help for it and are just struggling in many ways, as my colleagues have explained for other groups in the population. The difference is that older people, particularly those living on their own, are especially vulnerable. This is more likely to be older people who are not digitally included. Once you get to the age of 75, the majority of people are not online.

Even when they have tried to access GP and other health services, we have heard from older people that, if they are not online, not used to using a smartphone and so forth, they have found it very difficult. They do not particularly like talking about personal problems, especially issues to do with mental health, over the phone to somebody. They fall at the first barrier; they cannot express their views to somebody who might be in a position to help. They are very much living with these issues on their own, as far as we can see.

Q215 **Baroness Hilton of Eggardon:** We heard from earlier witnesses about underfunding and pressures on professional mental health teams. Professor Rooney said that one needed to have general community support for people who are suffering, not from grave mental illnesses but

from the level of depression and anxiety that we see in the community as a whole. We heard from Professor Ford about what can be done by schools to help alleviate the problems for children. I wondered what should be done by the community for young adults, who I gather are particularly affected, and for old people.

Professor Sonia Johnson: Talking to people with mental health conditions, it is striking that they often did not feel included in the neighbourhood mutual support that was very obvious early in the pandemic. Those were often friendly assemblies of neighbours, but people with relatively severe conditions that might make people more wary of them, unfortunately, seemed not to be engaged by those wider community initiatives.

Having said that, the difficulties that mental health services were trying to cope with during the pandemic were often quite basic things, such as getting food to people and access to money. Mental health services have always spent a lot of time addressing quite basic social problems, and even more now. That is a focus for wider community initiatives, provided they are careful to engage with those who do not easily engage. The same applies to the social connections that are very valuable for mental health. There is a need to consider people who are not easily included.

Peer support has been reported to be of great value to people. There are new online peer support initiatives for people with mental health conditions, which it is important to develop and support.

Caroline Abrahams: Some older people have benefited from spontaneous start-up community initiatives: people putting letters through the door, offering to help, and that sort of thing. It has been quite patchy, though; it depends on your area. As people started having to return to work, that tailed off, which suggests, as you would expect me to say, that the role of the voluntary sector is really important in this. Over the last few months, local Age UK branches and Age UK nationally have spent an awful lot of time and money trying to support people with their loneliness, as well as with the practical issues that my colleague referred to just now, such as shopping and collecting medication.

Part of Age UK is the Silver Line, which some of you may have heard of, which Esther Rantzen founded. It is a friendship telephone line, open 24 hours a day, which offers ongoing friendship services, as does Age UK, via the phone. Demand for those services has greatly outstripped supply during the pandemic and continues to be very substantial. That shows that there is a real appetite among older people, particularly those stuck at home who feel it is not safe to go out, to at least get some support over the phone.

Q216 **Lord Browne of Ladyton:** I have a generic question about research, which is substantially informed by yesterday's joint statement by the Academy of Medical Sciences and MQ mental health research. As they put it, they have taken it upon themselves to further galvanise the mental health research community, from relevant disciplines across the UK, to build a platform for research. They are now recommending that all

research into the direct and indirect effects of the virus involving human participants must consider the mental health effects of Covid-19.

I do not expect any of our witnesses to disagree with that, but how can it be achieved? What recommendations could we make that might achieve that? For example, we have heard about this post-hospitalisation Covid-19 research, PHOSP-Covid. How can we achieve the objective, which appears to be the holy grail, of proper integration of care for effective interventions in people influenced or affected by Covid-19?

Professor Tamsin Ford: That is an excellent question. When you want to be broad, or the focus of the study is not primarily mental health, there are lots of validated, brief research measures that could give you a handle on mental health. For children and young people, the one most commonly used is the strengths and difficulties questionnaire. It has two sides of A4 paper. The first side has 25 questions covering the range of things: peer relationships, prosocial behaviour, behaviour problems, attention, concentration and emotion. It works best with younger children. The back page gives you detail about function: "Are you struggling?" "How is that impacting your life?" That second question is important.

If that were included in any study involving children related to Covid, it would be tremendously powerful. The study could be about serum rhubarb or all kinds of clever biomedical science that I do not understand, but there would be scientific researchers interested in analysing it. Professor Johnson and Caroline will be much more au fait with the important questions to ask for adults. We cannot separate mind, body and brain. They are all interlinked, so we should try to make sure that mental health is integrated into studies of physical health. The more our sciences progress, the more we realise that there seems to be an inflammatory component to depression, for example.

Professor Sonia Johnson: As you say, I am very unlikely to disagree. I believe a fair number of the relevant physical health studies already incorporate measures of things such as depression. It would produce a lot of very valuable data across the board if they all did. Another thing that would be really helpful at this point is good access to government-collected datasets. The data on service use that is not currently accessible would be quite informative to us. We could do with a new cohort of people who are living with severe mental health conditions. Currently, in this country, we lack longitudinal evidence from robust studies on that.

Caroline Abrahams: There are tools for scoring well-being in adults and older people. Thinking about what my colleagues just said, there is a really important dataset for older people called ELSA, which is a longitudinal study on ageing. Incorporating those would be helpful. More generally, making sure that an academic geriatrician is part of the thinking does not half make a difference, because they are experts in older people's brains, well-being and physical health. I think we all agree that that is really important here.

Professor Tamsin Ford: I would reiterate what Professor Johnson has said. There are data that have been collected. We have national surveys in both adult and child mental health. They are sometimes very tricky to access and are therefore underutilised, but they would offer really useful policy advice. Likewise, we have amazing administrative data. If we could link research studies and datasets, we would be able to look at people of whatever age who have done badly in their mental health in relation to Covid, and look back at what predisposed that, so we can pick them up better, and follow them forward in their hospital attendance and service use. For young people, linkage to the national pupil database would also be key.

Q217 **Lord Borwick:** I was impressed by Professor Ford's phrase that we are in the same storm but not necessarily in the same boat. At the beginning, in March, the Government's communication seemed to be all about telling people that there was a storm going on, for fear that they ignored the whole thing. Now, the problem seems to be different levels of acceptance of the rules between teenagers and older people. I am generalising, but these rules seem to be getting ignored by teenagers and terrifying older people. Is there a way of getting the communication more exact on the particular age groups that we need to address?

Professor Tamsin Ford: That is a really good question. We need to set examples for young people. Everybody has lockdown fatigue, and everybody is bracing themselves for the prospect of local, regional or—let us hope not—national lockdown again come the winter. Young people are much more socially active than older people. For the older people, I would say, "Unless you're particularly vulnerable, these are the ways you can look after yourself", as I was saying for dealing with anxious children. Help people with what they can control but emphasise that unnecessary journeys and social contact are not a good idea. If you are in a crowded space for a long time without wearing a mask and without social distancing, you are putting yourself and others at risk.

I am not sure the message should be nuanced across the age groups. It is about helping people to understand the perception of risk. Older people are more vulnerable, so I can see why they would be more anxious. When you are 19, you are immortal.

Caroline Abrahams: I agree. There was quite a lot of resistance earlier in the pandemic among active older people, when the guidance was based on age, in that everybody over 70 was regarded as vulnerable. Although age is an enormous risk factor for becoming seriously ill with Covid, it is not the only one. The extent to which you have other comorbidities is crucial. With that, the risk was that we just annoyed a lot of older people who were perfectly able to make their own decisions. Our advice to government throughout has been to treat older people as grown-ups. Age UK will be launching a campaign within the next couple of weeks, which is geared at giving advice to older people on how you can survive this winter with your sanity intact, as well as your health. There are some simple things that everybody can do, but as a society we

all need to rally round and support our older population. I very much hope that will happen.

Q218 **Baroness Young of Old Scone:** Are there ways to get across the severity of the situation for the second wave without frightening the living daylights out of everybody and making them overanxious? Is there a balance on that? Yesterday's press conference from the Chief Medical Officer and the Chief Scientific Officer was another example of trying to make us all scared again.

The Chair: No, it was science.

Professor Tamsin Ford: We need a certain amount of anxiety for people to understand that it is a serious situation. The simple message is this: avoid prolonged contact that is socially close without a mask in a confined space. Better still, put it the other way round. You can wear a mask, avoid social contact or getting too close to people, wash your hands, treat your phone like an infectious petri dish and carry on as best you can. This is probably wise advice at the moment. Young people may be less likely to die from it, but some young people are dying and some are having very nasty longer-term effects. The young need to be cautious as well.

The Chair: We heard that last week. I am sorry; we have run out of time. Thank you very much, all three of you, for your presentations and answering all our questions. It was most informative.