

Women and Equalities Committee

Oral evidence: [Mental Health of Men and Boys](#), HC 213

Wednesday 23 October 2019

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Members present: Mrs Maria Miller (Chair); Tonia Antoniazzi; Angela Crawley; Philip Davies; Vicky Ford; Eddie Hughes; Jess Phillips.

Questions 1–69

Witnesses

I: Ms Nadine Dorries MP, Under-Secretary of State for Mental Health, Suicide Prevention and Patient Safety, Department of Health and Social Care, and Rt Hon. Nick Gibb MP, Minister of State (Minister for School Standards), Department for Education.

Written evidence from witnesses:

- [Department for Health and Social Care](#)

Examination of witnesses

Witnesses: Ms Nadine Dorries MP and Rt Hon. Nick Gibb MP.

Chair: I welcome our witnesses and those who are watching online or joining us in the Public Gallery. This is the final session of our inquiry into the mental health of men and boys. Today, we are very pleased to be hearing from the Minister responsible in the Department for Education, Nick Gibb, and the Minister responsible in the Department of Health and Social Care, Nadine Dorries. We want to hear more about the work the Government are doing in this area and to raise some of the questions and ideas that we have heard from witnesses during our inquiry. Thank you for joining us. Angela will start our questioning.

Q1 **Angela Crawley:** My first question is around stereotypes and the stigma affecting the mental health of men and boys. What is the Department for Education doing to encourage schools to tackle the harmful stereotypes associated with masculinity that prevent some men and boys from getting the mental health support that they need? Could you comment on what specifically the Department is doing to tackle that?

Nick Gibb: We think this is a serious issue and you are right to raise it. First, I welcome what the Committee is doing. The whole inquiry into the mental health of men and boys is an important subject. You are right that, of course, it all goes back down to schools initially. We have recently published our relationships, education and health guidance; RSHE is to be compulsory in schools from September 2020. We focus, among many other issues, on this issue. In paragraph 31, we say that schools “be alive to issues such as everyday sexism, misogyny, homophobia and gender stereotypes and take positive action to build a culture where these are not tolerated”. In the section for primary, we say that children should be taught what a stereotype is and “how stereotypes can be unfair, negative or destructive”. At secondary, we say how stereotypes, particularly stereotypes based on sex, gender, race, religion, sexual orientation or disability, can cause damage—for example, how they might normalise non-consensual behaviour or encourage prejudice. Those are now in the curriculum and will be compulsory from September 2020. We hope that will have an important impact.

Q2 **Angela Crawley:** It is great to hear that that will be incorporated into the curriculum from 2020 onwards. How have you been working with other Departments to limit the impact of negative masculine stereotypes portrayed in the media on boys and men?

Nick Gibb: There is also the online harms White Paper. In this relationship guidance, we also talk about children staying safe online. We worked with the Health Department in producing the mental health Green Paper for young people, “Transforming Children and Young People’s Mental Health Provision”, which is about addressing mental health issues in schools. If you can establish an ethos in schools whereby people of all genders are comfortable talking about mental health issues, it helps tackle the issue of



male mental health as well as gender stereotypes. It is not right to say, “Well, just man up.” We want to make it so that young people—girls and boys—can feel comfortable about talking about their mental health.

Going back to the RSHE guidance, we also have sections in it that talk about the importance of teaching about mental wellbeing. In primary schools, pupils should know that mental health wellbeing is a normal part of daily life in the same way as physical health, and we have similar requirements in the curriculum for secondary school pupils.

Q3 Jess Phillips: As somebody who has been deeply entwined with the guidance on PHSE—if a headteacher just decides that they don’t want to address these stereotypes, do they have to?

Nick Gibb: Yes, they do. It is set out in this statutory guidance—both primary and secondary. This element is statutory guidance, and it specifically says, under the section on respectful relationships—by the way, pupils cannot opt out of relationship education—what a stereotype is and “how stereotypes can be unfair, negative or destructive”. It says that pupils should know about that.

Jess Phillips: If a school, or a headteacher at a school, decided that they didn’t feel the need to look into the stereotypes, how would the Government know that, and what would they do about it?

Q4 Chair: Is there a role for Ofsted?

Nick Gibb: Yes, there is. Ofsted inspects the broad and balanced curriculum. They also inspect the social development of young people in schools. They look at all these issues as part of the objectives that they have to measure against. They absolutely look at the spiritual, cultural and social development of young people in schools, and they will therefore take this into account when they undertake those inspections.

Q5 Chair: Minister, Ofsted sometimes takes a very specific deep dive into particular issues. Would gender stereotyping and how it is being dealt with in schools be an issue that—maybe not now, but in the future—Ofsted could particularly look at?

Nick Gibb: Yes. It does not, any more, inspect particular subject matters in a general inspection, but it does, as you say, undertake special reports—special deep dives—into certain subjects, such as foreign languages or science. They could quite easily decide to do a deep dive into this issue as well, once it becomes compulsory from September 2020.

Q6 Chair: When you say, “They could decide,” could you ask—

Nick Gibb: It is for them to decide these issues. It is an independent, non-departmental public body, but we could also ask them to do such a deep dive.

Q7 Chair: By inference, this Committee’s views on that might be of interest to you.

Nick Gibb: All your views are of interest to us. Anything you come up



HOUSE OF COMMONS

with, we will take very seriously. Yes, your views on that particular curriculum area would also be of interest to us and to Ofsted.

Q8 Angela Crawley: Nadine, we have heard the Time to Change campaign was designed to reduce the stigma of mental health. Ultimately, it might not always get through to all men, so how else will the Department of Health and Social Care tackle the stigma associated with mental health?

Ms Dorries: Particularly for men and boys. I am sure you all noticed two weeks ago the launch of another campaign, Every Mind Matters. For that, we asked celebrities who have themselves suffered a mental health issue—Davina McCall, Nadiya Hussain and other well-known TV personalities, whom people would recognise—to talk about their own particular mental health issues. That campaign was voiced over by Prince William, Kate, Prince Harry and Meghan, again to talk about destigmatisation, and how mental health issues really affect everybody. One in four people will suffer a mental health problem in their lifetime. We have this particular problem as well with the fact that many males who commit suicide have never even contacted, and are not under any guidance from, the NHS or health services.

We launched that campaign and it went out straight into people's kitchens at supper time; it was given a huge amount of publicity—and that was just one strand of what we are trying to do. Celebrities—well-known celebrities whom you admire—are talking about their own mental health problems. That has to be one way of introducing destigmatisation.

Stigmatisation of mental health is an ongoing issue, and a long-standing one, and it was never going to be destigmatised overnight, but I think we are really beginning to get there. The more we talk about it, the more inquiries like this are held, the more adverts there are on the television, the more articles are written in newspapers, the more people talk about it and the more people whom others admire and look up to talk about it, then slowly and constantly that is chipping away at the stigmatisation.

I always say, if someone has a broken leg, they would have a plaster cast on and everyone would say to them, "How are you?", "How's it going?" and "When's your cast going to be removed?", but when someone has a mental health illness, no one really wants to talk about or engage with it—it is still over there. We need to get to a point where we regard mental health illness in exactly the same way as we regard physical illness, because it is exactly the same. We are not there yet as a society, but we need to get there, and the Department is certainly doing its best—I am doing my best—in terms of constantly talking about the parity between physical and mental ill health.

Q9 Angela Crawley: I absolutely agree. It is one of the primary health conditions that affects all socioeconomic groups. Having people talking about it is a really important factor—especially people in public life. But how is your Department monitoring the effectiveness of this work, especially with different groups of men and boys?



HOUSE OF COMMONS

Ms Dorries: Now, for example, with Time to Change, we know from research that has been done into how effective that campaign was that 5.4 million men and boys felt affected by it. They feel that it has had an effect. Time to Change was about "Ask twice!" If you ask someone whether they are okay and they say, "Yes, I'm okay," then you ask them a second time. If you ask them a second time, you get a different answer, and 5.4 million people say that they have both learnt from and been affected by that campaign. That is one way of monitoring.

Of course, monitoring stigmatisation of mental health is very difficult. People ask, "Why are you launching these campaigns? Why Every Mind Matters? It is there for a few weeks, all that money is spent on it, and does it make a difference?" Well, we can actually monitor—because it is an online campaign—how many people look at it, or how many people fill in responses saying whether it is effective and whether they have learnt from it. We can monitor that, particularly today, with the online responses that we can get from people. With organisations such as the Zero Suicide Alliance, which the Department of Health and Social Care is funding by up to £2 million, we can tell how many people have accessed it and how many people have completed the online training. We have those kinds of stats that inform what we want to do in the future in terms of policy and reaching out to people, and how effective what we have done in the past has been.

Q10 Eddie Hughes: Interesting stuff. Ireland and Australia have created national men's health strategies to help to combat issues such as high male suicide rates. What consideration have the Government given to a similar approach?

Ms Dorries: I actually met somebody from Australia the week before last. I think the package that they have out there is called mindspace. What we are doing is very similar. We have a different name for it and a different approach, because we are a different type of country and Government, but what we are doing is very similar.

Particularly with regard to men and boys, one of the most concerning facts for us at the moment is the increase in male suicides and how, despite everything we are throwing at reducing the number of male suicides, the figure has risen this year. It has to be taken in context; it is one rise. We have changed the way coroners report—whereas before, it could have been accidental death, it is now actually being recorded as suicide—so we do have that impact.

We are looking, however, at how we respond in terms of the increase in male suicide. We have invested £2.3 billion in mental health, as announced a few weeks ago. To put that in context, the overall spend in the UK on our annual prisons budget is £4 billion, so we are spending more than half of our total prisons budget on new investment in mental health. Via that process, what we are doing is increasing workforce, so most of that money will go on salaries, because we know that we cannot address mental health stigma, the growth in mental health, the particular mental health problems that men and boys suffer from or the reduction of

suicides in men and boys without an increase in the workforce and a completely new strategy for dealing with mental health.

We are going back to community health support teams and putting money and people into them, but also school mental health support teams, which Nick spoke a bit about. I went to see one of the school mental health support teams at work in Hounslow last week. I spoke to the children and saw how the school mental health support teams are working. It seems really important to me, actually, with men and young boys particularly—although mental health obviously affects everybody, but because of the suicides in men, that is the focus at the moment—how school mental health support teams are working with children. Teaching young people coping strategies at an early age seems to be an incredibly good way to prevent mental health problems developing and presenting later in life.

We are not doing the same as other countries are doing; we are doing it our way, but our way is to put in a huge amount of investment, look at how we deliver mental health services across the UK in community mental health support teams and in school mental health support teams, and look at the workforce that delivers that mental health support. We are not doing the same, but we are certainly doing as much, and we certainly hope that it will be effective, going forward. I am sorry that was such a long answer.

- Q11 **Tonia Antoniazzi:** There have been a number of high-profile factory closures involving largely male-dominated workforces. You talked about doing the work your own way, which is great, but is the Government putting in any targeted support to work with those specific factory closures? I see a large male workforce of a particular age that is at high risk of suicide.

Ms Dorries: That is a really interesting question, and I will tell you why. Those particular focused, vulnerable groups are something that we really need to look at. One of the most interesting stats from the male suicide figures of last year is the geographical locations. You would think—I assumed—that the highest number of suicides would be in the area with the highest population, the south-east of England. Actually, the highest number of suicides is in the east of England, North Yorkshire and Humber.

Although we have all these stats relating to why, we think, men are more likely to take their own life, if we look behind the figures, what I want to start looking at is the targeted groups. Are members of the trans community more likely to take their own life? We know these geographical reasons. What is it about the geography that makes the incidence of male suicide higher than in the south-east of England? We know there is a link with affluence, density of population and other things, but with regard to your particular factory closures, I will be honest: we at the Department have not said, "There are factory closures. Let's put something in."

However, what we are doing is reinforcing the local community health teams so that they are there to help, and we have set targets for the future so that people in crisis will be seen immediately in A&E. If



HOUSE OF COMMONS

somebody presents in A&E with a mental health crisis, they will be seen within an hour by a psychiatry liaison, so we are putting targets in place across the UK to make sure that people who are suffering from acute and chronic mental health issues get the treatment they deserve.

In terms of your factory closures, what is in place locally is what is there for them, but I hope that the owners of those factories will, as responsible employers, be overlaying that themselves by putting in their own mental health support. I hope they will take on board their corporate responsibility to do that.

- Q12 Eddie Hughes:** We heard evidence that men are unlikely to self-diagnose mental health problems. Those who do are less likely to report them and may be under-represented in data from the NHS adult psychiatric morbidity survey. Apart from that data, what factors do you take into account when making policy or funding decisions?

Ms Dorries: There is so much data that comes in; there are so many people working in this field, and so many organisations working hard to try to reduce the number of male suicides. I chaired a roundtable that meets once a quarter with academics, the bereaved, people with lived experience, and people who are working in these policy areas who are constantly diving into data. It really is the front focus of academics and policy teams, both within the Department and across Departments, to try to find out what we can do to reduce the number of suicides overall and the number of male suicides.

You are right: we know that men are more prone to risky behaviours such as gambling, drug abuse and alcohol. We know that is a problem with men, so we have people looking into that and delving into that information. But we also know there are some deeper issues. I learned yesterday that when men are under investigation for something at work, in their professional life, and they feel that everything they have worked for—their life's work—has suddenly been removed from them in terms of reputational damage, they become highly vulnerable and are more likely to take their own life than women in the same situation. That is one focus.

I met somebody from the trans community three weeks ago. Via meeting that person, I know of somebody in that community who has taken their own life and somebody who has attempted to take their own life. That is a particular vulnerable group. We know that men who lose their job—

- Q13 Eddie Hughes:** Is there a specific data source that we might be able to look at?

Ms Dorries: I do not know. I can get back to you on specific data sources, but I have asked to dive behind the data, rather than overarching data that gives us lots of—yes, we know more men take their own life. We know where they do it. I want to look behind that, to find the vulnerable groups behind that data, so that we can develop policy to target those particular vulnerable groups. That is what I am interested in working on in my portfolio. Only then can we begin to bring those numbers down. When



we know exactly who it is and why, we can target policy to reach those people.

Nick Gibb: We do know that diagnosable mental health conditions are more dominant in boys at a younger age. Between the ages of two and four, 4.2% of girls and 6.8% of boys have a diagnosable mental health condition. From the age of five to 10, boys are 12.2% more likely than girls to have a diagnosable mental health condition. Between 11 and 16, the numbers are broadly similar. As you go beyond 16, it moves the other way, and girls are more likely to have a mental health issue than boys are.

That shows the importance of the mental health strategy that we set out in the Green Paper in December 2017. It is a hugely important piece of work that was really driven personally by Jeremy Hunt when he was Secretary of State for Health, and supported by our Secretary of State in my Department. It is a joint piece of work. As Nadine has said, it is leading to these mental health teams being established across the country to support schools. We want every school to have a mental health lead—a senior member of staff—because the data show that we have these problems. If they can be addressed in schools, it can often prevent young people from developing more serious mental health conditions as they get older.

Peter Fonagy, who heads the Anna Freud Centre, makes it very clear that there are three types of issue. There is low-level anxiety, which, if it can be addressed early, will, hopefully, be prevented from becoming something more serious. If you have a mental health lead in each school who can set the ethos of mental health across the school, they can ensure that the issues are taught in the curriculum and that there are people to talk to if children have anxiety.

If it is something more serious, there are mental health support teams that we are establishing across the country in 25 trailblazer areas, as Nadine talked about. We want at least a quarter of the country covered by 2023. If it becomes more serious than that, we are piloting four-week waiting times for clinical mental health support for young people. If we can tackle these issues more in schools, we all hope that it will have an effect on reducing mental health problems in adulthood.

Ms Dorries: I went to see one of these trailblazer sites at a school a couple of weeks ago, and I was massively impressed not only by the people who were working in the school to deliver mental health support, but by the children. At the end of day, I had a roundtable session with children who were accessing these mental health services and who spoke quite openly about how much they have been helped. One young boy really impressed me. He described himself as a worrier, and he had presented with low-level anxiety that was developing. He has been taught that he should worry at a certain time of day. The mental health support team at the school have put an app on his phone, and between 6 pm and 6.15 pm each day is his worry time. That is when he worries. He has learned to channel his anxiety and cope with it. Those coping strategies deal with what, in a young person, could become out of control and lead to



deeper anxieties as he moves through school. By the time he becomes an adult, it could become something that is very difficult to deal with. This young boy is eight years old. Someone has intervened and talked to him to help him recognise what he was suffering from. They gave him a coping strategy to deal with it, and explained the dangers of his anxiety becoming a more deep-rooted anxiety. He is doing incredibly well in school.

A lot of these children come from what some people would describe as poor, chaotic families. In one school I learned of recently, there are 400 pupils, and a third of the pupils who access these services come from families where the parents are addicted to drugs or alcohol—really difficult families. These children are being picked up in school and taught strategies to cope with a lot of what they were bringing to school and having to deal with. Although we can explain on paper what these trailblazers are, when you get into them, you see them at work and how they deal with and identify children.

Let me give just one more example. Eating disorders, which also affect men, particularly concern me. This is one of the deadliest mental health diseases in young people. People normally present to a GP. In later life, when it is very difficult to treat, because it is deeply embedded physically, those people have gone a long way in the experience of their illness. It is the only illness where somebody fears getting better more than they do getting worse. These mental health support teams are trained to recognise eating disorders at a very early stage. If eating disorders are recognised very early on, we have a much greater chance of dealing with them. The mental health support teams should not be underestimated in the work that they are doing. It is going to transform mental health services in future and, I hope, contribute towards the reduction in male suicides.

Q14 Eddie Hughes: That brings us smoothly on to this question: given the rise in the number of people taking their own lives, especially men, is the Government on course to meet its target of reducing the suicide rate in England by 10% by 2021?

Ms Dorries: It is impossible for me to predict. The rise in male suicides this year was a bit of a blip. I am not going to sit here and predict. That is our target and what we are working towards. The Zero Suicide Alliance was a big step towards that, providing NHS workers with online tools for how to recognise suicide.

We have two incredible people working on this, whose names I should mention. They are the clinical leads at NHS England, Professor Tim Kendall and Claire Murdoch, who was a mental health nurse before she became clinical lead on this at NHS England. They are doing incredible work in developing and implementing policy to achieve this goal. We are doing everything we can; we are aiming to get there.

Every Mind Matters was not just about destigmatising mental health but about raising awareness of mental health and the consequences of poor mental health. We are doing all we can. We are investing £2.3 billion in



HOUSE OF COMMONS

mental health services, community health support teams and ensuring that people in a crisis are seen as soon as possible.

We are looking at developing a service in the 111 line, so that there is an alternative way to receive immediate help for a mental health crisis. We are looking at perinatal support. We are looking at so many areas in terms of delivering mental health, all with the overall objective of bringing down the number of suicides in the UK.

- Q15 **Eddie Hughes:** There is a lot going on, but some witnesses have told us that more needs to be done to integrate the strategies—the loneliness strategy and the suicide prevention strategy. Is enough being done, and what are the plans to do more?

Ms Dorries: The way to do that is to increase the workforce. Most of that £2.3 billion is going into salaries. There are universities doing new, accredited courses to train people. We realise we have this problem. We realise that mental health has become more of an issue.

Let me give you an example. When I trained as a nurse many years ago, nobody wanted to work in mental health. We had to do a 12-week placement either in maternity or mental health. My entire cohort chose maternity; no one wanted to work in mental health. Now, that has changed. We have had 2,000 applicants for 200 vacancies. I am sure the officials we let me know, but I think we had 4,000 applicants for the new mental health training places for people coming through.

We have the problem. We have put the money into training people and getting more mental health nurses through the strategy. We have made a commitment to increase our nursing workforce by 5,000. Once we have got the people through the training and into the workforce, developed the community mental health teams, got better services in community health and in school mental health support, and got shorter waiting times at CAMHS—I hope we are going to be there by 2023—then, as a generic process as part of that, we will see more synergy and more integration between the services that are available now.

- Q16 **Chair:** Before I bring Tonia in, can I get clarity on the numbers? It is £2 billion extra—

Ms Dorries: £2.3 billion.

Chair: For mental health, and you said most of that is going into salaries. What is the extra headcount in terms of healthcare professionals?

Ms Dorries: We are looking to increase by 5,000. I am sure the officials will slip me a note if I have got that wrong, or if it is more, but I think we are looking to increase by 5,000 trained mental health nurses and support.

- Q17 **Chair:** Does that include the schools, or are the schools extra?

Ms Dorries: I will have to come back to you on that.



HOUSE OF COMMONS

Nick Gibb: In terms of mental health support teams—again, officials will pass me a note if I have got the figure wrong—we are training 2,000 education mental health practitioners to provide the mental health support teams. That will reach between 20% and 25% of schools by 2023. Then when we roll it out nationally, that will be up to 8,000 education mental health practitioners. They will all be overseen, of course, by clinical mental health professionals.

Q18 **Chair:** So it is 5,000 through the NHS, plus—

Nick Gibb: These are NHS people as well. I am talking about—

Chair: Is it 5,000 plus 2,000, or just 5,000?

Nick Gibb: That is what we will try to find out. We will try to get that.

Ms Dorries: It is probably a good idea if we get you a note on the figures.

Chair: That would be really helpful.

Nick Gibb: I think you have a note there.

Ms Dorries: Do I? Oh—I am completely wrong. It is 21,000 new posts by 2021. That is our ambition.

Q19 **Tonia Antoniazzi:** That leads on to my question, because I was wondering how you were going to attract such a great number of people into the profession, when you have taken away the nursing bursary.

Ms Dorries: One thing that we are pleasantly surprised by is the number of people who are applying for posts. As I said, we had 200 posts advertised recently and we had 2,000 applicants. People are actually actively interested in working in this area now, whereas they were not before. That is why I tried to draw the comparison. We have actually turned the corner. I think we have already—I am sure my officials will pass me a note if I am wrong—made 3,000 new posts that have been filled. We have actually turned a corner, and 3,000 new people have come into the area just in the last year.

Q20 **Tonia Antoniazzi:** Is any of that workforce European?

Ms Dorries: I would not know the actual make-up, but 3,000 people are now working. We have turned the corner on people not wanting to work in mental health and now wanting to work in mental health.

Q21 **Jess Phillips:** Those are people who were already qualified, presumably. Tonia was asking about the bursary for training. Jobs being advertised and people going into them is one thing—unless I am completely wrong and you are talking about thousands of people applying for 200 places in a nursing placement. They are two separate things.

Ms Dorries: Yes. Well, we do not provide nursing bursaries. I have another note; there has been an increase of 3,258 people working in mental health since 2017. That is all mental health staff. It does not say whether they are mental health nurses—we do not have the breakdown—



HOUSE OF COMMONS

but they are all people who are working to deliver mental health, so they would be people in the school mental health support teams. The people I met at the trailblazer site in the school last week had recently qualified in mental health qualifications at university. That is what we have. It is not particularly nursing. There is a role for nursing, but actually, nurses tend to want to work in hospitals and actually, no mental health service was ever better delivered in a hospital than in the community. What we are looking for is people—

Q22 Chair: May I ask for a piece of information? To become a mental health nurse or practitioner—

Ms Dorries: It is not necessarily nursing. There are people working in mental health who are—sorry.

Chair: To become a mental health practitioner, do you have to have a previous qualification to then take this as an additional qualification? Sorry, we are not the Health and Social Care Committee, so we are slightly at sea on this. We should probably move on then, because we have dwelt on this for a long time, but it is important to understand how achievable the 21,000 by 2021 is. Are they going to be people who have already pre-qualified and then will be moving into a new area, or will they be fresh, new practitioners?

Ms Dorries: It is a mixture of both. Working in mental health and psychiatry has been quite difficult for many people for a long time. That is because there are a certain number of recognised qualifications—to work in a clinical setting as a psychiatrist or a psychologist, I think you need a minimum of seven years' training. We are therefore introducing accredited mental health courses at universities. The first 200 people qualified this autumn, and I think another 240 have just started on a university-accredited mental health qualification. That is not a nursing qualification, which is something quite different.

Q23 Chair: We are running a bit short of time, so I suggest that it would be useful to have a short note on the numbers involved and the pathways for those people to achieve the numbers. That would be helpful for the Committee—

Ms Dorries: And the type of qualification, because mental health isn't all about nursing—a lot of people just don't need that. For those working in school mental health support teams, we don't need nurses; we need people who are trained in recognising psychiatric and mental health conditions, and in being able to intervene. We need a different type of qualification for working in those settings.

Chair: But I think you are hearing from the Committee that we really understand the importance of having professionals involved, and we want to understand the Government strategy for achieving your objective.

Q24 Eddie Hughes: The suicide prevention plan expects councils to contribute to a reduction in suicide rates in England but, from what we have heard from councils, they do not have the budget to deliver what they would



HOUSE OF COMMONS

like to do. What discussions have you had with regard to funding councils to provide the service that they need given their responsibilities in respect of the plan? Will you commit to ensure that local authorities have sufficient funding to help implement that strategy over the next five years?

Ms Dorries: I think the figure is £100 million for local authorities. All local authorities have a suicide prevention plan in place—

Q25 **Eddie Hughes:** But do they have enough money to implement it? That is the question.

Ms Dorries: They do. I will give you the example of my own local authority, which is Central Bedfordshire. Central Beds is working with Bedfordshire and Milton Keynes on an overall strategy that works between Luton and Dunstable University Hospital, Bedford Hospital and the local authorities in between, developing a suicide awareness and prevention plan. There is no excuse for any local authority not to have a suicide prevention plan in place. I believe—I was told this yesterday—that all now have a plan and action in place.

Q26 **Eddie Hughes:** And they will have sufficient funding to continue to support that plan for the next five years.

Ms Dorries: I will have to come back to you on the next five years, but I know that most councils have published their plans online, and those that haven't will publish online shortly.

Q27 **Jess Phillips:** Just to pick you up on the £100 million that you said was going to local authorities—

Ms Dorries: Sorry, that was too much. We have invested £25 million—

Jess Phillips: Twenty-five million pounds for 353 local authorities in the UK—

Ms Dorries: Twenty-five million pounds to support prevention efforts locally over three years. We are going further through the NHS long-term plan by committing to suicide prevention funding for every area of the country by 2023-24.

Q28 **Jess Phillips:** But we don't know what that funding is. There are 300-odd local authorities, but £25 million between them for early help in suicide prevention at local authority level. I am not a nurse, but I used to work in a mental health early help project that was local authority funded. How much do you expect each local authority to get?

Ms Dorries: We expect the local authorities to publish their own suicide prevention plan—

Q29 **Jess Phillips:** I am talking about the funding specifically. What funding do you expect to give them, to help them? We can all have a plan—I have some cracking plans, but no cash to deliver them.

Ms Dorries: We have the £2.3 billion—



HOUSE OF COMMONS

Jess Phillips: That is for healthcare and education—

Ms Dorries: That will be delivering the mental health services. They will be commissioned by, as you know, the clinical commissioning groups—

Q30 **Jess Phillips:** The £25 million is within that £2.3 billion?

Ms Dorries: Twenty-five million, yes.

Jess Phillips: Is within that £2.3 billion.

Chair: I get very confused by the numbers. It is probably easier to get a note.

Ms Dorries: The £25 million is just for local authorities to publish their suicide prevention plans.

Q31 **Jess Phillips:** Not for the delivery of services, just for them to publish—okay. Back to children, what are the next steps for implementing the “Transforming children and young people’s mental health provision” Green Paper?

Nick Gibb: You have heard about the 25 trailblazer areas. There are two reasons why the plan is to reach between 20% and 25% of schools. First of all, we need to train 8,000 professionals to reach the whole country, and training 2,000 will be challenging. We also want to learn from those trailblazers about how to do this better. There is a pilot element to it: what Nadine has seen is exemplary, but we can learn from what is happening in mental health support teams and in the trailblazer areas, and we will take that experience and apply it when we roll it out nationally.

Q32 **Jess Phillips:** When you are training these people in these trailblazer areas, are they current school staff, for example, or are they additional staff going into schools?

Nick Gibb: We want to have a mental health senior lead in every school. That will be somebody—

Jess Phillips: Currently on the staff.

Nick Gibb: Currently on the staff, currently in the school. Already, about 49% of schools have such a lead in their schools. That is more prevalent among secondaries than primaries, although we think it is important to be in primaries as well. The DFE will be providing funding to train those mental health leads, and then the staff in the mental health support teams will be NHS staff. The money to fund the employment and training of those people will come from a separate pot of £300 million.

Q33 **Jess Phillips:** Presumably, there won’t be one in every school; there will be hubs of schools.

Nick Gibb: They will support a number of schools in an area.

Q34 **Jess Phillips:** How will we measure whether this policy improves the mental health of young people, and specifically of boys?



HOUSE OF COMMONS

Nick Gibb: That will be something that all of us will be doing. Ofsted will be looking at schools, at the metrics about the prevalence of suicide rates and so on, but also the referrals for serious mental health issues. The philosophy and the hope behind this approach—driven, again, by Peter Fonagy—is that if you can deal with the low-level anxiety early in schools, if somebody has somebody to talk to, and if you change the ethos of a school so that mental health is something that people are relaxed about talking about, it will lead to fewer referrals to more serious mental health provision, although we want to—

Jess Phillips: Eventually.

Nick Gibb: Yes, eventually, although we want to reduce the waiting time, so we are piloting reduced waiting times in 12 trailblazer areas, to four weeks. You could argue that if we see fewer referrals for serious mental health issues over a long period, that would be a demonstrable—

Q35 **Jess Phillips:** Is there a framework set out for how we will measure, just taking the trailblazers—

Nick Gibb: We will send you a note about that.

Jess Phillips: Some sort of framework of peaks and troughs in certain communities, for example, or different sorts of school environments and setups. You will send a note?

Nick Gibb: We will send you a note on how we are going to monitor that.

Q36 **Jess Phillips:** The Green Paper relies on work with young people in schools. How will you make sure that schools will be resourced and ready to do this?

Nick Gibb: As I said, we are providing funding—£95 million—for the training of those mental health leads.

Q37 **Jess Phillips:** And that fully funds it?

Nick Gibb: That is to fund the training.

Jess Phillips: It is fully costed.

Nick Gibb: The staff are already employed. We want this person to be somebody who is known to the pupils in the school; we do not want it to be a visiting person coming in. As you know, we have announced very significant funding increases for schools: £14 billion over the next three years.

Q38 **Jess Phillips:** So none of this training will have to come from the budgets of the schools. For example, lots and lots of schools have stated that they have to take some of the funding out of their general school budgets to help fund, for example, some of their SEN provision, but this will be fully costed, fully funded training in every school in the country.

Nick Gibb: Yes, the training of the mental health leads is a separate fund.



HOUSE OF COMMONS

Q39 Jess Phillips: Good. How will the strategy aim to help boys with mental health problems who have been expelled, or who have little interaction with the education system?

Nick Gibb: The mental health support teams are also there to support alternative provision settings as well; it is not just schools. We also have a very serious approach to tackling behaviour in schools. We are rolling out behaviour hubs so we can spread best practice.

What helps all pupils, but particularly boys, is if you have a very disciplined, calm environment that ensures pupils know what the behaviour rules are and that they are enforced consistently. That is important, because our statutory guidance says to headteachers who are considering excluding a pupil that, if there is persistent disruptive behaviour by a pupil, it is important to assess whether there are any underlying needs that have caused that disruptive behaviour, whether those are special needs or family problems, but if you have a school that is systemically ill disciplined, it is very difficult to identify pupils who might have those particular problems. The better disciplined a school, the better the behaviour policy of a school and the more consistent the application of that policy in a school, the clearer it is that there must be, or there is likely to be, some underlying problem causing children who, despite all that, still show persistent disruptive behaviour to behave disruptively.

Q40 Jess Phillips: You are the Minister for Schools; however, your Department is responsible for children and young people more generally, including for children's social care, so do the strategy and what has been laid out in the Green Paper account for those who are without the school system? I do not even just mean those in PRUs; every single one of us will have children in our constituencies—I have to say they are largely boys—who are completely without the school system, for one reason or another. Do you have a strategy for how we are going to make sure that these children, who arguably are the most vulnerable, have assistance with their mental health?

Nick Gibb: Yes. First of all, we want to make sure, for any child who is excluded, that the alternative provision they go to is of increasing quality. That is the prime focus of our policy on exclusions: to make sure that alternative provision is at a higher standard. I could take you to alternative provision settings that are exemplary and very high quality, but we need to make sure that that is spread across the country, and we are doing a huge amount of work to improve that quality. However, as I said, all the mental health support that is available to schools is available to those settings as well, and we will expect all those settings to also have mental health leads.

Q41 Jess Phillips: Okay. You are the Schools Minister, so I shan't push you on that too much. Some witnesses have suggested that young men between 18 and 25 may need extra support as they move into adulthood. What is being done to support the mental health of men aged 18 to 25 specifically?



HOUSE OF COMMONS

Ms Dorries: Well, anybody aged between 18 and 25 needs more support as they move into adulthood. We know that suicide and serious mental health issues in particular are triggered as people move from primary school to senior school, from senior school to university and from university into work life. We know that those are the times when people are at their most vulnerable and need the most help. We are aware of that, and that is why we are putting in place community health support teams so those age groups in those transitional periods can be assisted to a greater degree.

As you will all be aware, at the moment there is a cut-off at 18 for CAMHS. We are looking to abolish that so that the mental health support services people receive when they are younger are not just stopped at 18 but continue. The predicted time for stopping those services is now 25, but I am arguing that that is just another cliff for people to fall off. The time mental health support should stop is when people no longer need it. As we know, with CAMHS at the moment, the cut-off for children and young people's mental health support is 18. We are stopping that and making that support continue, and we are trying to work towards establishing what is the best time to stop that support.

Jess Phillips: That is incredibly welcome. The idea of the cliff edge is horrendous for people in that situation.

Q42 **Chair:** When are you going to make that decision?

Ms Dorries: It has been made. The decision to stop the cliff edge at 18 has already been made. Again, it is part of this £2.3 billion. We need the money to put the people in place to keep supporting people across. That is part of the service going forward: by '23, I think, there will be no more cliff edge. Somebody will pass me a note if it is even sooner.

Q43 **Jess Phillips:** The year 2023, not the age 23?

Ms Dorries: Yes, 2023—sorry. People will continue going forward from CAMHS until 25—I think that is what is predicted—but I have argued that, actually, that is just another cliff edge, and that it should stop when they no longer need the services.

Q44 **Tonia Antoniazzi:** The Department of Health and Social Care's evidence acknowledges that men can be reluctant to engage with health and other support services. What are you doing to encourage more men to engage with these services? Does the Government have, for example, a list of identified engagement actions to engage with men?

Ms Dorries: There are lots. This sector is huge, and it is not just the Government. We as a Government do not best deliver all mental health services. In fact, there are some amazing charitable organisations, which we do fund—the Department provides the money—to provide the services, because they do it so well at a local level. We find engagement is most effective, most useful and best delivered via local organisations funded by the Government, such as Men's Sheds and Time to Change. There are lots.



If you go into any community, you will find organisations funded by DHSC providing local community services. Those one-to-one local community engagements are all over the UK and they do engage with men. There is another one: a whole organisation that works with men—men will talk in a barber's where they will not talk anywhere else. We are working with that. So we are working on these points of engagement and conversation, but it is not best delivered by the Department of Health and Social Care; it is best delivered at a local level.

- Q45 **Tonia Antoniazzi:** It would be quite useful, though, to have a best practice document shared not just throughout England but the United Kingdom. That would be practical and useful, with your role as a Government to put in the money and hook all the services together. Does that exist?

Ms Dorries: No, it doesn't. I do agree, because the services are so varied and tailored so locally. I agree with you in terms of best practice and standards, but I do not agree with homogenising all the services across the UK when actually local areas have very particular needs and particular charities who work with those people.

Tonia Antoniazzi: I totally agree, but we can learn best from across the country. That is what I was trying to get to.

Ms Dorries: Of course. I agree.

Nick Gibb: Can I come in on this question as well? You are talking about the attitudes of men in terms of seeking medical assistance and check-ups and so on. Really, those attitudes are best set in at school. There is an element of that in the health education part of RSHE, which as I said is compulsory from September 2020. For example, pupils should know how to talk about their emotions accurately and sensitively, using appropriate vocabulary. They should be taught about common types of mental ill health and also the associations between physical activity and the promotion of mental wellbeing. It then goes on to things like health and prevention: pupils should know about the benefits of regular self-examination and screening.

It is trying to inculcate in boys—and girls as well—the importance of these health prevention measures. We would expect that starting to think about health at an early age would translate into being more open to seeking help as adults and to seek screening and preventive check-ups.

Ms Dorries: It goes back to Angela's first question about stigma. A lot of men think it is a shameful thing to admit they have got a mental health problem.

- Q46 **Tonia Antoniazzi:** On stigma, some witnesses have expressed the need for male-friendly mental health services. Have the Government given any consideration to creating them?

Ms Dorries: I want our mental health services to be male and female-friendly. I would not even like to accept that our mental health services

were less friendly to men than to women. I would hope that they are equally welcoming and friendly to both men and women.

- Q47 **Chair:** The evidence that we have been given suggests that they are not, so would your objective be to change that so that they are welcoming to both?

Ms Dorries: I would need to see more evidence about that. The evidence I have heard is about women wearing a hijab—this is in a maternity setting, not a mental health setting—who may not be given the same information as someone who comes in booted and suited and accompanied by a barrister husband. That is where I have seen or heard the most evidence about a disparity in the delivery of health services. I would want to see more about a disparity in the delivery of mental health services based on gender. I have not had that evidence yet, but I would like to see it. If that does exist, we have to address it. I think it is the other side of the coin, about men not wanting to do that. That is not because it is unfriendly, but because of issues that they experience that mean they do not want to come forward and engage with mental health services.

- Q48 **Angela Crawley:** I think that you are right in some respects; this is perhaps not about whether existing health services are suitable, but about how people engage with them. There is a question about whether this really needs to be a marketing exercise in encouraging men to engage with those services. Health and education are devolved in Scotland, but one point that has been raised with me is the waiting lists for CAMHS. If someone is referred to that process, they need to wait a very long time. We know that people from BAME or LGBT backgrounds are 11 times more likely to have to engage with mental health services, but what about looked-after children, who often fall through the cracks? If they are within a referral process and are moved to another foster family, where is the follow-up to ensure that they get the mental health support they need?

Ms Dorries: That is down to CCGs and local health services, and that particular problem cannot be managed from a high-up level in Whitehall; it must be managed by local authorities. I would hope that looked-after children would be within one authority and move between foster homes within that authority, and therefore the mental health services would follow them. That would be the ideal situation. Where the situation is not ideal, I would expect the local authority to track that child and ensure that those mental health services are put in place.

It is an absolute objective to reduce CAMHS waiting times, and not just by a small percentage, but massively. Again, I go back to the £2.3 billion, the development of the community and mental health support teams, and the work we are doing in hospitals for people who present at A&E. We are looking at much wider areas—we do not want anyone going into a police cell. The desired objective is for nobody with a mental health condition to go into a police cell. Nobody will be transported to hospital in a police car. We are putting in place many measures to support mental health services for men. We want early referrals for CAMHS—with one week when in



HOUSE OF COMMONS

crisis, and four weeks for follow-up. It could be two weeks—I am waiting for a note.

I hear the horror stories from across the country about waiting times for CAMHS. That cannot continue. Young people with a mental health condition cannot be left waiting months for an appointment. That is why we are putting in £2.3 billion. We know that this is unacceptable and must be addressed, and hopefully that money will completely reverse the situation.

Nick Gibb: We have just published the review of children in need, which includes looked-after children. We want greater visibility for those children in schools, and to ensure that training for the senior mental health lead includes understanding the impact that adverse events will have had on those children's mental health needs. That review is an important piece of work that hopefully will address some of the concerns you have raised. On waiting times, 12 of the trailblazer pilots will pilot a four-week waiting time for a referral to CAMHS.

Ms Dorries: We are currently trialling 12 pilot areas with a four-week wait in clinical setting in CAMHS, and we want to take that forward.

Chair: Excellent—consistency.

Q49 **Tonia Antoniazzi:** How will the Government improve mental health services for men and boys from ethnic minority backgrounds, and those from the GBT+ community, as part of their commitment to improve and expand mental health services?

Ms Dorries: That is down to CAMHS and the new community mental health support teams. On the LGBT community, I am the Minister responsible not only for mental health issues but for suicide prevention, and a particular area of concern for me is reducing the number of male suicides as we have seen a recent increase in that. It is difficult to get information on that issue because I do not believe anyone's sexuality is mentioned on a coroner's report when someone takes their own life. I want to drill behind all the data that we have. We know from organisations such as Stonewall and others that it is a problem within LGBT communities, but I would like more data. You cannot shape policy unless you actually have the evidence and the data.

Q50 **Chair:** You might want to look at the report that we published yesterday, because it contains quite a lot of that data. Maybe that would be helpful to the Department.

Ms Dorries: We will. It is about extracting that data, because we need the raw data to develop those policies. As I said earlier, we are focusing our services on vulnerable groups and on where the level of suicides is high, to try to bring it down. We can do all this overarching policy. We can put in mental health support teams. We can put in school mental health support teams and community mental health teams. We can put all the policies and money in place, but until we actually know who those vulnerable groups are among men and boys, it is difficult to target the services.



HOUSE OF COMMONS

- Q51 **Tonia Antoniazzi:** I am talking about a different group. A recent guide produced by working clinicians, and supported by NHS England, highlighted that people from ethnic minorities are less likely to access mental health services. What action are the Government taking to ensure that this is no longer the case?

Ms Dorries: That is exactly what I have already highlighted in my answers to your previous questions. No one can say that we are not out there putting out campaigns, such as Every Mind Matters and Time to Change. It is one campaign after another—they are going out on television, going on apps, going into publications, and being written about in newspapers. In every way we can, we are trying to engage with people and inform them how mental health services are changing, and who they should contact if they feel vulnerable. We are signposting how to access help if you feel vulnerable, and that is reaching all communities.

- Q52 **Tonia Antoniazzi:** Are the Government able to measure the level of engagement or the success of these campaigns?

Ms Dorries: As I said in a previous answer—I think it may have been to Jess—there are organisations such as the Zero Suicide Alliance, which has received £2 million of Department of Health and Social Care funding. We know who is accessing their websites and where people completing the suicide awareness training have come from—which groups of people they are. We can extract the data from those campaigns.

- Q53 **Tonia Antoniazzi:** What improvements will be made following the recommendations made in the independent review of the Mental Health Act?

Ms Dorries: That was a huge piece of work carried out by Sir Simon Wessely, in which he made 154 recommendations, some of which we have already adopted and put in place. I think we have adopted all 154 in principle. Some incredibly good work was done there—issues around restraint; upgrading the mental health estate; how we relate to people; and giving patients and mental health sufferers a voice, which is one of the most important aspects of the entire review.

When someone has had an acute phase of psychosis, or had whatever treatment for which they were sectioned and for which they ended up as an inpatient in mental services, they should be able to say, “If I ever come back to hospital”—many of them do, because it is repetitive—“please do not restrain me in this way. I do not want to be treated with these particular drugs.” Patients should actually have a voice—when they are again in that situation, their voice should be heard, because it cannot be heard at that point in time.

Before 1959, I think, if you had an acute psychotic breakdown or other mental health illness, the person who could make decisions for you was either your father or your employer. We then moved to the closest relative. One of the most important things we have done is give patients the ability to name the person, whether family or not, who they want to be responsible for decisions about their mental health treatment moving



HOUSE OF COMMONS

forward. Those recommendations in the review will transform how mental health services are delivered in future.

- Q54 **Tonia Antoniazzi:** This is the last question from me. Black men are more likely than any other group to be detained under the Mental Health Act. How will you work with men and boys in black communities to get them the health support they need?

Ms Dorries: They absolutely are, and it is a huge problem. The mental health review by Sir Simon Wessely addresses some of this. Again, it comes down to a local level, to where services are provided, providing information for those services to identify those vulnerable groups in those communities.

You are absolutely right but we have problems. I have noticed problems across my portfolio, as I just mentioned for the woman going into maternity services wearing a hijab. We have problems with such disparities across my portfolio. Reaching these communities and these people is very difficult, because they come from a culture or background where mental health is seen as shameful, not to be talked about and something that men do not suffer and should not experience.

It goes back to the need to break down stigma. That has to be across the board with all communities, but they have particular issues in those communities about mental health. We have just got to keep going, trying to break down the stigma and reach into those communities.

- Q55 **Philip Davies:** Following on from Tonia's questions, you acknowledge that there is a lack of data about mental health in BAME communities, so how did the Government identify the needs of those people when developing the current policy?

Ms Dorries: There is data. As the Chair just said, you have data and evidence in your report. What I would like to see is even more focused and targeted data. I am talking about the smaller groups. With the number of male suicides, we know the data and what comes from particular groups. I want to go even deeper.

I want to know about the situation in the LGBT community. Do we know what the prevalence of suicide is among the trans community? I want figures, not just, "We know it is more prevalent." I would like to know the numbers and what we could do to bring them down. We don't know what will work until we have the actual figures. I can get you a note on the evidence to develop that policy—no policy is developed without there being absolute data and evidence.

- Q56 **Philip Davies:** How were the needs of BAME men taken into account in the Government's policy?

Ms Dorries: I will have to get you a note on that. I can't tell you how they were taken into account because I have only been in the job since September and was not there when the policy was developed.

- Q57 **Philip Davies:** Also following on from what Tonia said, Mind has asked



HOUSE OF COMMONS

the Government to set up a men's mental health taskforce to complement the work of the women's mental health taskforce. Are the Government going to do that?

Ms Dorries: Mind is very much going to do that.

Q58 **Philip Davies:** Are you? It wants you to do this. This is not about what Mind is doing; it is about what it is asking you to do.

Ms Dorries: We work very closely with Mind in developing our policy. It is a really close relationship. I would imagine that, if Mind have asked us to do that, that is a piece of work that will be underway—I know there is a note somewhere on that. Because we very much respect the work that Mind do in this area. They are one of the longest established charities working in the area of mental health.

We work with other organisations, Mental Health England and people like Professor Tim Kendall and Claire Murdoch at NHS England. Policy on mental health is not just developed on what officials say or one particular group or charity says. It is a huge piece of work that takes in evidence from academics, people with lived experience, charities working in the sector and organisations such as Mind.

Q59 **Philip Davies:** So the Government will do that.

Ms Dorries: Yes, if the evidence is there. We are not going to take evidence from organisations such as Mind and have £2.3 billion to spend—if they have a good case for setting up a men's mental health taskforce, I would imagine that is what we are doing.

Q60 **Chair:** Minister, do you think it was a mistake not to have more detail in the strategy about these various different groups, such as BME communities and younger people, and that that should have been inherent in the strategy from the start?

Nick Gibb: We are doing equality impacts on most policies.

Ms Dorries: No, I am not going to say it was a mistake, because all I see is good work happening at the moment. I will look into your question, because I think this issue of the BAME groups, males, and even further down—the sub-groups within those—needs more work to be done. The mental health crisis—and it is a crisis that we are suffering from in the UK, because there has been a huge increase in the number of people presenting with mental health problems and we have seen an increase in the number of male suicides last year—is, I do not want to say a work in progress, but it kind of is. We do not have all the answers on the day the problem presents. We need to do the work and work through it to find out the right answers to those problems, particularly with male suicides.

Q61 **Philip Davies:** Nick, Mind has said that the latest NHS Digital data on children and young people's mental health found that one in 10 boys with a mental health problem had been excluded from school. Is that a figure that you recognise? If so, what do you make of it?



HOUSE OF COMMONS

Nick Gibb: We know that boys are more likely to be excluded than girls, and we know that there is a link between children with mental health problems and exclusion. This is one of the reasons why the Government as a whole, from No. 10 downwards, regard addressing mental health concerns as a Government priority. That is what led to the development of our mental health Green Paper.

Q62 **Philip Davies:** I know. It is one thing to say that boys are more likely to have a mental health problem, but it is quite a shocking statistic that one in 10 boys with a mental health problem have been excluded from school. Do you not think that is rather alarming and needs some urgent attention?

Nick Gibb: What needs urgent attention is making sure that we are addressing mental health concerns and issues in school, and that is what has driven the whole of the Green Paper policy. The earlier you can identify, address, support and help those children, the less likely it is to lead to an exclusion and the less likely it is to manifest itself in later life for those people. That is what is driving it.

Mental health in young people in schools is absolutely a key policy driver, and it is a very serious policy. The reason it is taking a considerable period of time to roll out the mental health support teams, to between 20% and 25% of schools supported by 2023, is because it is not just re-badging existing provision; it is setting up and establishing new provision and training new people to provide a significantly higher level of mental health expertise to schools, because we see the rising concern about mental health as an important issue that needs to be addressed.

That does not mean to say that schools should not exclude pupils, because we also need to make sure that schools are calm, ordered and happy places for young people. We do not want to see bullying in our schools, because that in itself leads to mental health concerns, so we need to give headteachers the discretion—and we will support headteachers in this—to exclude, either for fixed periods or permanently, those children who are engaged in persistently disruptive behaviour. As I said earlier, however, they also have statutory guidance indicating that they should make sure that the cause of that persistently disruptive behaviour is not mental health issues or other home life issues.

Ms Dorries: In school, when mental health issues present in children, they present very differently in young boys. If young boys are suffering from a mental health condition or issues at home that would contribute to a mental health condition, they tend to be more physical and more disruptive in their presentation. Actually, girls would tend to go more inwards and withdraw, while boys would tend to engage in the behaviour that might lead to that.

Q63 **Philip Davies:** I appreciate that, and I would also support schools in having the right to exclude pupils who are causing a problem, but do you not think the extent of that—one in 10 boys with a mental health problem have been excluded from school—suggests that perhaps there are too



HOUSE OF COMMONS

many exclusions and not enough work going on to stop the exclusions? It is the easy way out—"Let's just exclude them"—rather than actually dealing with the underlying issues. That is the point that I am getting at.

Nick Gibb: To put that in context, 5% of school enrolments lead to fixed-period exclusions, so you are talking about double the rate for children who have mental health issues. There is statutory guidance, as I have said, for headteachers to make sure that they are assessing any underlying needs that have led to that disruptive behaviour, and headteachers take that very seriously. However, headteachers are humans and are fallible, and there will be young people with mental health issues who are excluded notwithstanding that requirement on headteachers to look at those underlying issues. I think a consequence of our focus on mental health, both through the RHSE curriculum changes and the Green Paper, will be that the system as a whole takes mental health issues in our schools more seriously in the years ahead than they perhaps have in the past.

Q64 Philip Davies: We are told that some boys can take an average of up to 25 years to report abuse that they have suffered. How are your Departments working together to encourage more boys and men to seek help if they have experienced abuse?

Nick Gibb: This is not an area that I am particularly expert in. We will send you a note about child sexual abuse, so that you have the chapter and verse of our policy.

Ms Dorries: I would say that, actually, boys are far more protected from abuse than girls; that is a fact. Girls are more exposed to it, and in terms of domestic abuse, more are victims of it than boys. I am not sure—again, I will get you a note on any data we have; I know we have stats on it—how many boys suffer from mental health issues as a result of abuse, but it is not anything like the number of girls who do. I am not sure of the reasons why boys are more protected from abuse than girls, but they are.

Q65 Philip Davies: Of course, the other issue is boys witnessing abuse in the home, which obviously applies to girls as well. Is anything being done to help not only those who suffer abuse directly but those who experience it and witness it?

Ms Dorries: It doesn't matter why—I should not say it doesn't matter; that is probably a poor choice of words. For whatever reason someone develops mental health issues—whether due to abuse, depression, bullying, online harms; whatever the reason—the point is that the mental health services should be both easily and quickly accessible and there to serve everybody. For me, the relevance of what you are talking about applies more in trying to reduce the number of suicides and self-harms.

In terms of mental health services, it is important that the standard is excellent for everybody, regardless of why they are experiencing a mental health condition. We talk about making sure that there is something in place for people who have been abused. We could list 100 reasons that trigger mental health conditions in men and young boys, but we cannot



HOUSE OF COMMONS

put in place 100 policies and 100 strategies for dealing with all the causes of mental health conditions. The important thing is to make sure that the mental health services are there to treat anybody who comes to them with a mental health condition, whatever the reason for it.

Nick Gibb: The review of children in need that I mentioned will also have an impact on this area, because the outcome of that review is that we want schools to be more visible about those children who are working with social workers or who have experienced domestic or other abuse at home. What will come out of that review is a greater visibility and focus on ensuring that schools are aware of where those children have suffered and take that into account when dealing with behavioural issues, such as not completing homework or attendance issues.

Q66 **Philip Davies:** There is a clear link between mental health and substance misuse. What services are available to support men and boys who want help for substance abuse?

Ms Dorries: The same services that are there for men and boys who want to access help because of alcohol or gambling abuse, or whatever risky activity they have taken part in. We know that men and boys are more prone to risky drug taking, gambling or alcohol abuse. We know that. We are developing, through child and adolescent mental health services—CAMHs—and with local community mental health support teams, more easily accessible and readily available services to deal with that. However, as with the answer to my previous question, that is just one of the many reasons why men and young boys suffer from mental health issues.

Q67 **Philip Davies:** Are enough services available for people who are suffering from substance abuse? Is there sufficient capacity in the system?

Ms Dorries: As I said earlier, many services that are available locally are charity, volunteer and local-led, and are helped through DHSC funding to provide those services in those areas. You would find more charities and organisations that we help support in vulnerable areas, where that is more of a problem than in other areas. I do not believe there is one overall service for men and young boys who are suffering from substance abuse, any more than there is for men and young boys who are suffering from any other kind of risky activity.

Nick Gibb: Of course, prevention is better than cure, and the health education curriculum has, even at primary, things that pupils should know: the facts about legal and illegal harmful substances and associated risks, including smoking, alcohol use and drug taking. At secondary, it is even more detailed about the law, the effects of addiction and alcohol dependency and so on, so hopefully the next generation will come out of our schools fully aware of the risks and harms arising from this kind of behaviour.

Q68 **Chair:** And it is a jolly good thing that relationship and sex education is now mandatory for all school-aged children.

Nick Gibb: Your role in it was pivotal, Chair.



HOUSE OF COMMONS

Q69 Vicky Ford: May I ask another question, because it is quite topical? The Office for Veterans' Affairs has obviously just been established; it is new, and one concern that comes up quite a lot is PTSD among former servicemen—and servicewomen as well. How is your Department interfacing with the Office for Veterans' Affairs to look at PTSD and other mental health issues?

Ms Dorries: To start with, I am going to make the point that we must not stigmatise and victimise veterans as people unable to cope and suffering with their mental health, because they loathe that. The majority loathe it. Yes, there is an issue that some people coming back from activity overseas or active service struggle to integrate into civilian life, but the vast majority do not. That is an important point to make.

Vicky Ford: Absolutely true.

Ms Dorries: In fact, Johnny Mercer and I were talking only yesterday about how we integrate the mental health services that are available with his side, dealing with the Office of Veterans' Affairs. We are going to be doing something jointly soon.

Yes, veterans' mental health is important. The £2.3 billion for the development of community help is going to be there for everybody who needs mental health services. Although I have said several times that we want to drill behind where the data comes from to help us reduce the number of suicides, it is important that at the same time, we ensure there are overarching mental health services for everybody.

I have just been passed a note, as you will have seen. Those who have served in the armed forces have spent their careers defending our country, as I have said. In December last year, as part of the long-term plan, NHS England announced an extra £10 million to expand current capacity and develop a veterans' mental health high-impact service for those who need emergency and urgent care and treatment. That is what Johnny and I are going to be talking about: how we best represent veterans.

We know that there is another side to the veterans' story. Yes, they do struggle—we have homelessness and various problems—but there is a whole other side, the veterans who are saying, "Please don't represent us as victims." We need to be very careful of the language we use in talking about that. That other side of the story, and how we need to be a bit more careful going forward, is one of the issues that has arisen with this whole focus on veterans at the moment.

Vicky Ford: Very helpful. Thank you.

Chair: Ministers, thank you so much for your time. We know how busy you are, and that you have packed diaries, but you have afforded us an incredibly useful hour and a half. Thank you very much. That closes today's witness session.