Witness Name: Dr Elaine Lockhart
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Dated: 24 April 2024

UK COVID-19 INQUIRY

WITNESS STATEMENT OF DR ELAINE LOCKHART

I, Dr Elaine Lockhart, will say as follows:

1. I am the Chair of the Royal College of Psychiatrists ("the RCPsych"/"the College") Faculty of Child and Adolescent Psychiatry ("CAP"). I have held this post since June 2021.

2. I also work as a Consultant Child and Adolescent Psychiatrist in NHS Greater Glasgow and Clyde.

3. I offer this statement in response to the Rule 9 request the RCPsych received from the UK Covid-19 Module 3 Inquiry team on 10 January 2023 and on behalf of the CAP Faculty.

4. I welcome the opportunity to make this statement and submit relevant documentation pertaining to Module 3 of the UK Covid-19 Inquiry.

Introduction

5. This section outlines the role, function and aims of the RCPsych CAP Faculty, the scope of this submission, and key areas it covers.

6. The RCPsych's CAP Faculty promotes the mental wellbeing and treatment of mental health conditions in children and young people, working with their families and carers. We contribute to, and draw from, an established knowledge base to inform the prevention, early intervention and treatment of mental health conditions in children and young people. Our objectives are to promote the training of medical students, doctors in training, and substantively employed psychiatrists; act as a forum for the exchange of experience and research; promote the developmental perspective, and the importance of family functioning in mental health within wider RCPsych functions; influence public policies in appropriate directions; promote mental health awareness through working with the media and offering information directly to the public; and organise regular national conferences and local meetings to promote professional development, clinical education and peer networking opportunities for those working in mental health and other children's services.

7. The RCPsych is the professional medical body responsible for supporting psychiatrists. It works to secure the best outcomes for people with mental illness, intellectual disabilities and developmental disorders by promoting excellent mental health services, supporting the prevention of mental illness, training outstanding psychiatrists, promoting quality and research, setting standards and being the voice of our members and the profession. Representing over 21,000 members and with approximately 1,600 mental health services signed up to our quality networks (a range of professional networks that connect our members and support their work in areas such as Child and Adolescent Mental Health Inpatient Services), we work in all four nations of the UK, as well as supporting members internationally. The RCPsych is a charity, with approximately 280 employees and more than 150 patient and carer representatives, registered in England and Wales (228636) and in Scotland (SC038369).

8. This statement endeavours to reflect the RCPsych CAP Faculty's understanding of the scale of the problem facing Child and Adolescent Mental Health Services ("CAMHS"). It covers a range of areas relevant to the impact of the pandemic on CAMHS. In doing so, it sets out the impacts of the pandemic on capacity and demand; children and young people in community and inpatient mental health, learning disability and autism settings, as well as in the population; and psychiatrists and the broader mental health workforce. It points to and summarises existing research where relevant, including

analysis undertaken by the College during the pandemic. It also provides information from child and adolescent psychiatrists, drawn from the five RCPsych Covid-19 member surveys conducted over the course of the pandemic.

9. The pandemic and the associated impacts of infection prevention and control ("IPC") measures have led to an increase in mental ill-health among children and young people across the UK. This affected the most vulnerable children and young people disproportionately. To be prepared for another pandemic or similar event, significant investment is needed to ensure that CAMHS are sufficiently robust to cope with any further increase in stress on the mental healthcare system. Better resourcing and training needs to be provided to CAMHS, as it does to the range of services that contribute to the early prevention, detection, and treatment of mental health conditions in our young people.

10. The points made in this statement are drawn from members' anecdotal experience and analysis of publicly available datasets, and in addition to those in the written statement of the President of the Royal College of Psychiatrists, Dr Lade Smith CBE, which also, in part, covers aspects of the impact of the pandemic on children and young people. Where necessary in our attempt to paint a complete picture, there is overlap between both statements.

11. As the scope of this submission includes England, Wales, Scotland and Northern Ireland, we have endeavoured to present relevant data from across the UK where possible. This statement does not provide analysis of all data that is currently available from each nation of the UK for each point covered, but rather illustrative figures and analysis where appropriate. To varying degrees, each part of the UK is dealing, broadly, with many of the same issues when it comes to mental health need in children and young people and how this is impacting on CAMHS. Where comparable mental health data is not currently available, or there is an absence of nation-specific data on any one point, we have used illustrative statistics from those nations where it is available. Accurate data collection is a priority of the RCPsych, and we are of the view that systems for collection and interpretation of relevant mental health data need to be improved across the UK, but particularly in the devolved nations as a matter of equity.

Impact on Children and Young People

Prevalence

12. Rates of probable mental disorder in children and young people increased over the relevant period. For those between the ages of seven and 16 years, rates increased from 16.7% in 2020 to 18.0% in 2022; for young people aged 17 to 19 years, rates were 17.7% in 2020 and 25.7% in 2022 (Exhibit EL/01 - INQ000442207).

13. The most recent data indicates concerning rates of prevalence persisting. In 2023, one in five children and young people between the ages of eight and 25 had a probable mental disorder, including 20.3% of those aged eight to 16 years; 23.3% of 17- to 19-year-olds; and 21.7% for 20- to 25-year-olds (Exhibit EL/02 - INQ000442208).

Schools, educational settings and vital support services

14. The mental health and wellbeing of children and young people has been adversely affected by a range of factors associated with the pandemic and population-level approaches to managing it, including lockdowns; financial stress affecting families; and bereavement and loss.

15. In particular, the closure of schools and other educational settings has had a profound and detrimental impact on many children. Schools are an important source of support, offering children and young people the opportunity to engage with friends and trusted adults. Families, too, often receive support from teachers. For some children, school is where they get their main meal of the day and where safeguarding concerns can be raised or monitored. Our members reported that some school staff worked throughout the pandemic to provide food and support to some vulnerable families. This was seen as vital to their wellbeing and there could be learning from how this was managed.

16. Vulnerable children were affected by school closures and the withdrawal of vital support services the most. Children with severe neurodevelopmental conditions, for example, have not fully recovered from the prolonged loss of routine, structure, and predictability, and some support services have not returned. While loss of contact with trusted adults and the sustained inability to access activities outside the home affected all children and young people, those who were more vulnerable developed clinical conditions, such

as anxiety and mood-based disorders; eating disorders and disordered eating; and self-harm and suicidality.

17. Specifically, the physical and mental health and wellbeing of young people with special educational needs and disabilities ("SEND") were disproportionately impacted by the pandemic and the associated measures put in place, including lockdowns. On the closure of vital support services and facilities for children with intellectual disabilities during the relevant period, our members have recounted that many parents and young people at the time felt that keeping such facilities open should have been prioritised. The closure of such facilities only compounds the disadvantage faced by children with intellectual disabilities. For parents, school closures removed one of the few respite opportunities they had to recharge and attend to their own needs, as well as those of other family members. With children and young people's intellectual disability education services not being provided in special schools, families were really struggling to care for their children safely at home. A high proportion of parents reported poor mental health to our members, as well as high stress and anxiety levels, with many parents of children with SEND feeling they had reached a breaking point during the first period of school closures in the spring and summer of 2020. When special schools did begin to open, initially for one day a week for only a handful of children, this led to an increase in crisis calls and prescribing for children with an intellectual disability and mental health needs.

18. It should be noted that lockdown measures did have some positive impacts with respect to education for some children. Those who found attending school stressful felt more at ease being at home and away from the pressure to adhere to strict measures. Additionally, those who found social situations with peers difficult were relieved at the prospect of learning from home, with older young people reporting that having more time to concentrate on their studies was a positive thing, particularly as extra-curricular activities were cancelled or postponed. Some young patients, particularly those with an intellectual disability and autistic children and young people for whom school can be stressful, found that lockdown made life easier.

19. However, while certain levels of anxiety are to be expected when a young person has not been in school for six months, we heard of a significant increase in the stress levels

of children when school returned far in excess of normal levels of anxiety, with many not having made it back to school since the lockdowns were eased. Following the pandemic, persistent school absence has increased significantly; in Spring 2023, 1,476,165 pupils – or 20.5% – were persistently absent compared to 922,566 pupils being persistently absent prior to the pandemic, representing a 60% increase (Exhibit EL/03 - INQ000442209).

20. Welcome progress has been made in establishing Mental Health Support Teams ("MHSTs") in schools, with 398 operational teams covering 35% of pupils as at spring 2023. 500 teams are expected to be operational by April 2024 and 50% of pupils in England are expected to be covered by March 2025. It is important, however, that operational teams cover every primary and secondary school, with sufficient resourcing and training to provide additional support to children and young people with complex mental health needs.

21. Similarly, the extra £5 million announced in October 2023 to improve access to ten existing Early Support Hubs across England for children and young people aged between 11-25 years, and the recent announcement of an additional £3 million to expand the support to a further 14 hubs across the country, is a positive step and will improve timely access to mental health support. However, a longer term, sustainable funding commitment is needed.

22. MHSTs and Early Support Hubs are not a substitute for investment in specialist services; as such, it is important that they are well connected with these services and are able to refer children and young people on to well-staffed CAMHS when necessary.

23. Local authorities, faced with reduced funding, are less able to support children and young people in recent years than they were previously, further limiting access to mental healthcare.

Infants and young children (Exhibit EL/04 - INQ000442210)[1]

24. Regarding the impacts of the pandemic on the mental health of babies and young children, there was a significant impact on the mental health of mothers and on the development of young children partly mediated by parental practices (Exhibit EL/05 - INQ000442211); birth and being raised during the pandemic were associated with a significant risk of communication impairment among infants (Exhibit EL/06 - INQ000442212); and during the pandemic, parents who had experienced child adversity were more likely to cope poorly with childcare duties and engage in child neglect, verbal abuse, and reduced feeding frequency (Exhibit EL/07 - INQ000442213).

25. The impacts of early life exposure to childhood adversity on mental health have been compounded by the pandemic (Exhibit EL/08 - INQ000442214), which has contributed to unemployment, poverty, and stress among many families who were already disadvantaged, thereby further increasing socioeconomic inequalities. The consequences of the pandemic have also increased the exposure of the very young to adverse childhood experiences, with a potential impact on long term mental health. Following the pandemic, many families have been struggling with isolation, stress, and mental health problems which has been compounded by the cost-of-living crisis (Exhibit EL/09 - INQ000442215) (Exhibit EL/10 - INQ000347129). There is evidence that the pandemic has significant ongoing impacts on many babies' and children's wellbeing and development – including those born post pandemic – and on the ability of services to meet their needs. More under 5s are falling behind expected outcomes, and many services are reaching a crisis point where they are unable to identify or meet families' needs (Exhibit EL/11 - INQ000442217).

26. Relatedly, there was also an increase in domestic violence during the relevant period, which raises various safeguarding concerns. Between October 2021 and March 2022, 1.7 million women and 699,000 men reportedly experienced domestic violence in England and Wales (Exhibit EL/12 - INQ000280193).

27. Domestic violence, which can start in pregnancy and escalate in frequency and severity during pregnancy and the first year after birth, is a significant factor for poor perinatal

[1] Much of the information from this section is drawn from the RCPsych's 2023 report, *Infant and early childhood mental health: the case for action* (Exhibit EL/04 - INQ000442210).

and maternal mental health (Exhibit EL/13 - INQ000442219) (Exhibit EL/14 - INQ000442220). Long-term alterations in childhood growth and development are associated with domestic abuse during pregnancy (Exhibit EL/15 - INQ000442221). In addition to the impact on the infant of poor maternal mental health during pregnancy and early childhood, exposure to domestic violence is an additional risk factor for childhood mental health conditions. In 90% of domestic abuse incidents, children were in the same or the next room (Exhibit EL/16 - INQ000442222).

28. Anecdotally, the pandemic also compounded the prevalence of mental health conditions on young children under the age of five. However, data available on the prevalence of mental health conditions for under 5s is limited. In England, 5.5% of 2- to 4-year-olds experienced a mental health condition in 2017 (Exhibit EL/17 - INQ000442223), although this is the only time mental health condition prevalence in under 5s has been measured in a UK national survey – there were none conducted during the pandemic, nor have there been any since. There is currently no national data collection on the prevalence of mental health conditions in under 2s. In England, although national psychiatric morbidity surveys found that only a minority of children and young people aged 5 years and over with a mental health condition received any treatment, no information on treatment coverage was available for 2- to 4-year-olds with mental health conditions.

29. However, we do know that between 10–25% of young children experience significant difficulties in the relationships with their main carer(s), greatly increasing the risk of a range of poor social, emotional and educational outcomes, including increased risk of mental health conditions. Socioeconomic deprivation and the Covid-19 pandemic are strongly associated with other risk factors such as child adversity and poor parent-infant relationships, and are therefore particularly important to address. Data collected during the pandemic indicated that a disproportionate degree of stress and adversity was experienced by households from the lowest incomes, and young people from minoritised ethnic groups (Exhibit EL/18 - INQ000268039). During the pandemic, parents who had experienced child adversity were more likely to cope poorly with childcare duties and engage in child neglect, verbal abuse, and reduced feeding frequency (Exhibit EL/07 - INQ000442213).

30. Only a minority of under 5s with a mental health condition receive treatment across the UK and there is insufficient provision of interventions to promote resilience and wellbeing and prevent mental health conditions. The pandemic and the preceding years of austerity in the UK have further widened the implementation gap due to the withdrawal of many community services. Consequently, many young children do not come into contact with public services, and their needs and vulnerabilities are not known. Meanwhile, services that exist are struggling to respond to the needs of those children and families who are known to them (Exhibit EL/19 - INQ000442225).

Impact on Child and Adolescent Mental Health Services

31. Following an initial decrease in the demand for CAMHS in the early months of the first lockdown, and over the second lockdown (although less significantly), we have heard from our members that children and young people who then presented to services were more unwell than had ever been seen before, and in a greater volume. It is not simply that presentations and contacts with services increased, but rather, the nature and severity of mental ill-health among those presenting had worsened markedly.

32. Although clinical mental health services continued during the pandemic, children and young people were supported with a combination of face to face, video and phone reviews. While some good practice emerged as a result, the impact of the Covid-19 pandemic on the mental health of our children and young people is still be felt across the UK.

Referrals and contacts with services

33. During both periods of lockdown, referrals to, and contacts with, both community and inpatient CAMHS decreased, although this decrease was more significant in the first lockdown than the second. Between lockdowns and subsequently, demand for CAMHS has increased rapidly, overtaking previous levels; Figures 1 to 4 illustrate these trends.

34. In April 2020, the total number of Emergency Department presentations for all needs in England was 917,000, representing a 56.6% decrease on the same month of the previous year (Exhibit EL/20 - INQ000442226). At the time, these were the lowest number of attendances reported since the NHS Digital database collection began. The

reduction in attendances was also significant between March 2020 and March 2019, but smaller than that between April 2020 and April 2019.

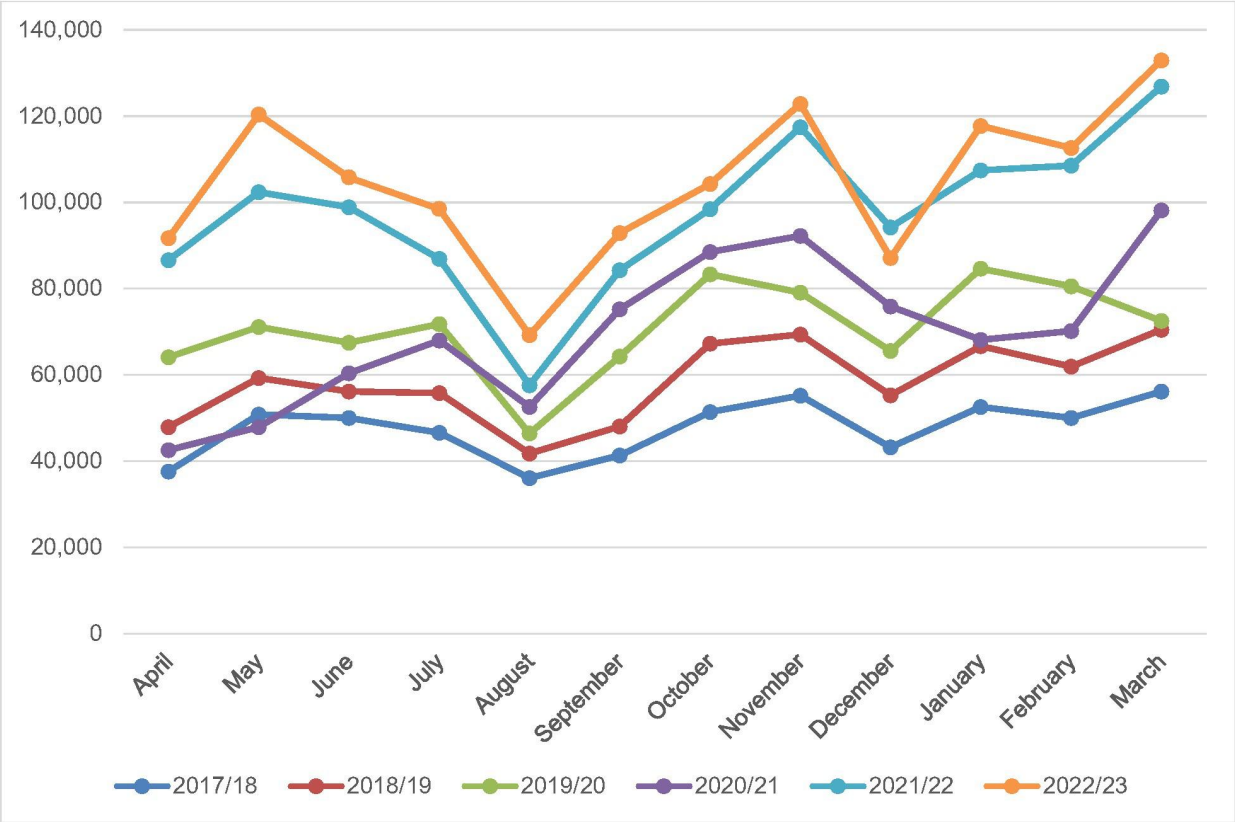
35. It is often people in schools and the community who identify young people who may be struggling. As such, the decrease and subsequent increase in demand may be in part due to school closures and restrictions around social activities, as these would have made it difficult to identify those who were in need of care; the development of, and exacerbation of existing, mental health conditions were less likely to be picked up on. This may have contributed to the initial fall in referrals, and the subsequent rise immediately following the first and second lockdowns.

36. The significant rise in the demand for treatment – for referrals, contacts with services and waiting times – has placed extraordinary pressure on already stretched CAMHS.

37. On 11 May 2020, NHSE launched a campaign to communicate to the public that the NHS was 'open' and that mental health services would be available. This campaign, titled *Help us help you*, covered mental health services as part of its messaging.

38. In England, a particularly striking growth in referrals has been seen in CAMHS, with 1.2 million new referrals for under 18s to NHS funded secondary mental health, learning disability and autism services from 1 April 2021 to 31 March 2022, compared to 0.88 million in 2020–21 (40.6% increase) and 0.66 million in 2019–20 (87.0% increase). Before this substantial rise, the number of referrals starting for under 18s decreased at the very beginning of the Covid-19 pandemic, from 80,555 in February 2020 to 72,532 in March 2020 (a decrease of 10.0%). This was followed by a drop of 41.4% to 42,540 referrals in April 2020; please refer to Figure 1. (Exhibit EL/21 - INQ000442227) (Exhibit EL/22 - INQ000442228) (Exhibit EL/23 - INQ000442229) (Exhibit EL/24 - INQ000442230)

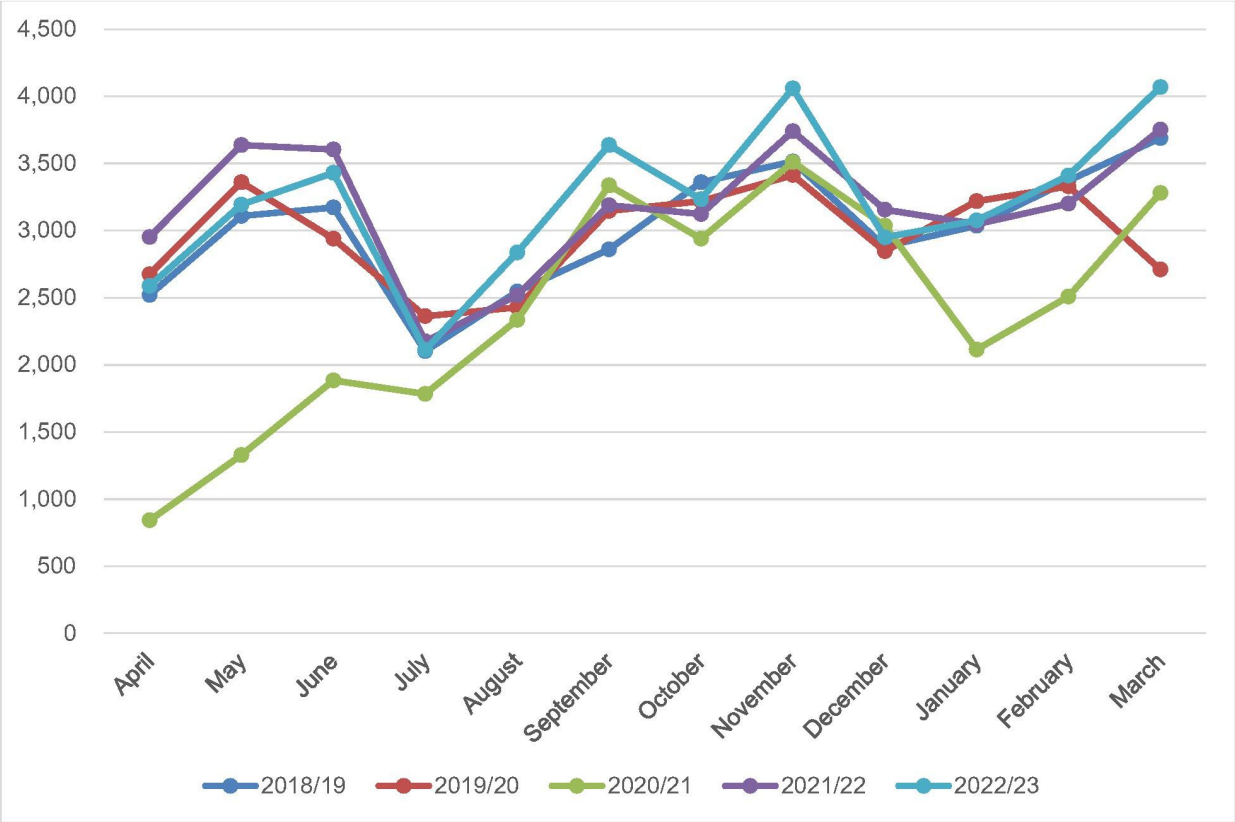
Figure 1: Referrals to NHS secondary mental health, learning disability and autism services for 0–18-year-olds starting in the reporting period, England, April 2018 to March 2023



39. 470,499 children and young people in England (aged 0 to 18 years) were in contact with mental health services at the end of March 2022 compared with 339,850 in March 2019, the year before the pandemic, and 384,581 in March 2020, at the start of the pandemic. This equates to increases of 38.4% over three years and 22.3% over two years. This trend continued into 2023, with 502,485 children and young people in contact with mental health services at the end of March 2023. The proportion of children and young people among the total number of people in contact with mental health services has increased from 26.5% in March 2019 to 32.7% in March 2022. (Exhibit EL/25 - INQ000442231) (Exhibit EL/26 - INQ000442232) (Exhibit EL/27 - INQ000442233) (Exhibit EL/28 - INQ000442234)

40. As seen in England, the number of referrals received to CAMHS in Scotland dropped at the start of the Covid-19 pandemic, from 3,330 in February 2020 to 2,711 in March 2020 (a decrease of 18.6%). This was followed by a fall of 69.0% to 841 referrals in April 2020; please refer to Figure 2. (Exhibit EL/29 - INQ000442235)

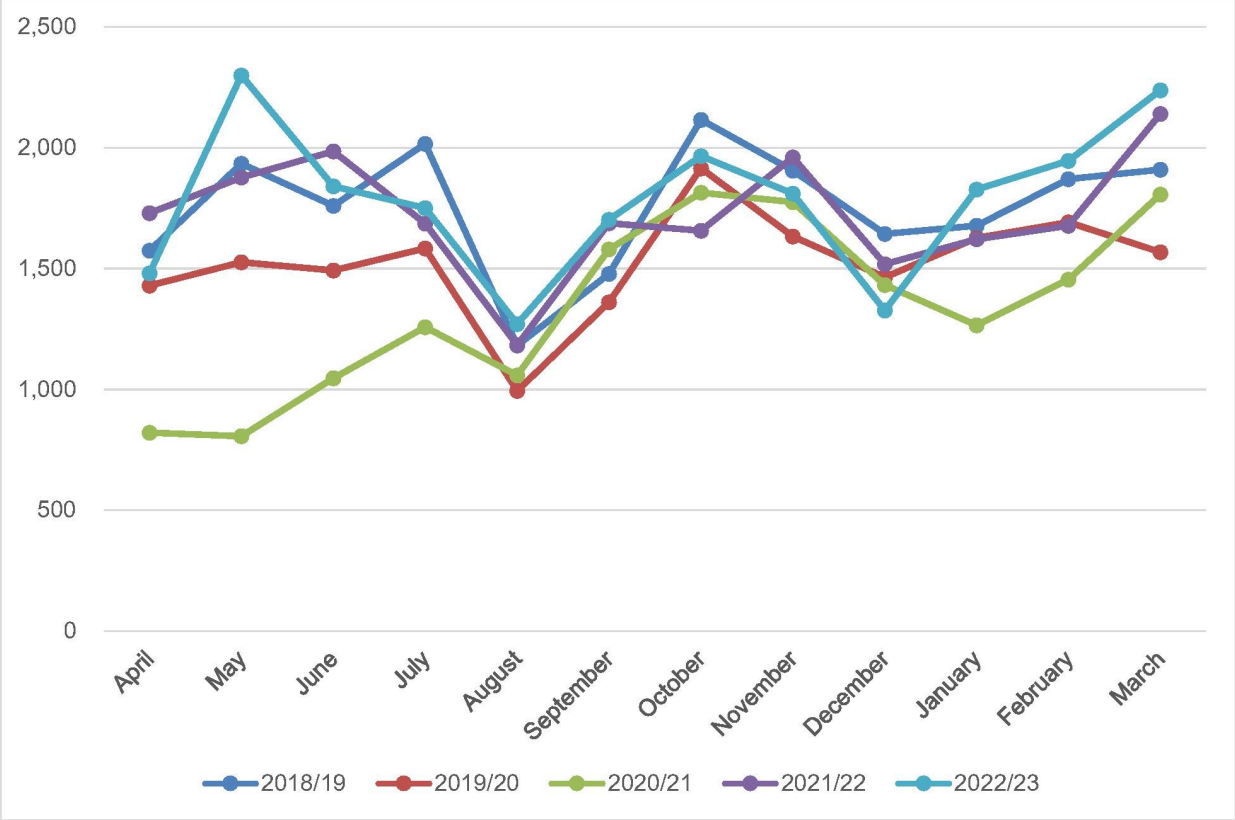
Figure 2: Referrals received to CAMHS, Scotland, April 2018 to March 2023



41. Prior to the Covid-19 pandemic, 3,884 children and young people commenced treatment at CAMHS services in Scotland in the quarter ending December 2019. The number increased by 6.6% in January–March 2020 (4,139), slightly increased by 0.6% in the year to January–March 2021 (4,162) and grew by 19.0% in the year to January–March 2022 (4,954). In the most recent figures for the quarter ending September 2023, 4,686 children and young people started treatment in Scotland (20.6% higher than the figure for the end of December 2019). (Exhibit EL/30 - INQ000442236)

42. At the beginning of the Covid-19 pandemic in March 2020, there were 1,568 referrals to child & adolescent psychiatry services in Wales; the number of referrals has continued to rise annually in the past three years, with 1,806 in March 2021 (an increase of 15.2%), 2,140 in March 2022 (a further increase of 18.5%) and 2,238 in March 2023 (a further increase of 4.6%). 29.2% of all referrals to mental health services in March 2022 were for child & adolescent psychiatry services. As with the other nations in the UK, the number of referrals to child & adolescent psychiatry services initially dropped from 1,568 in March 2020 to 821 in April 2020 (a decrease of 47.6%), followed by a further decrease to 806 in May 2020 (please refer to Figure 3). (Exhibit EL/31 - INQ000442237)

Figure 3: Referrals to child & adolescent psychiatry services, Wales, April 2018 to March 2023



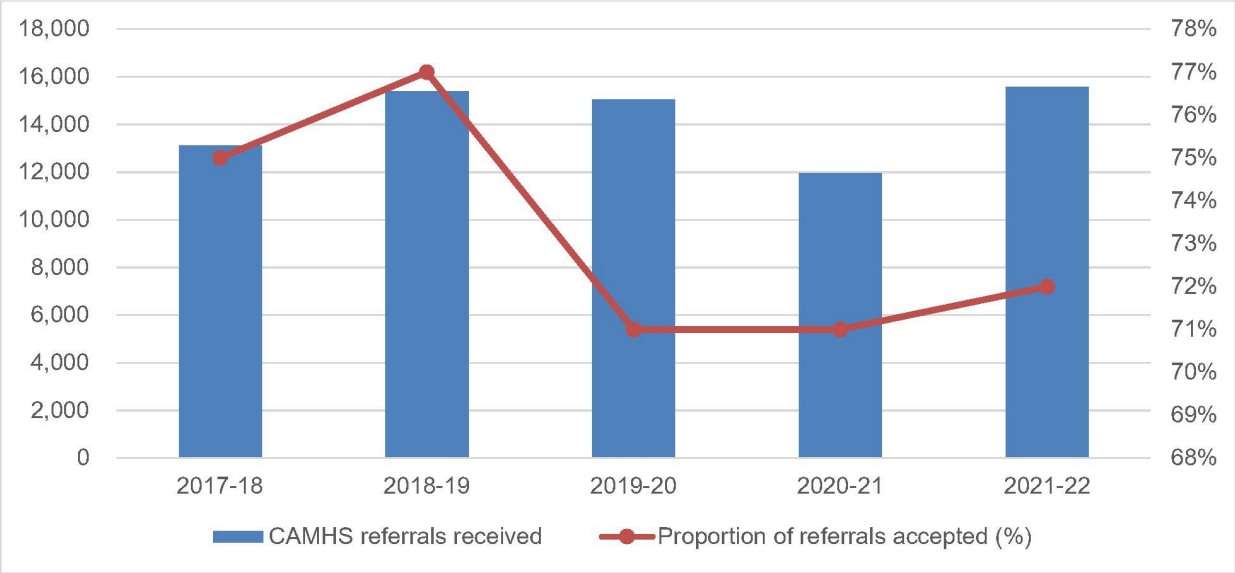
43. The number of referrals to CAMHS in Northern Ireland decreased substantially from 15,057 in 2019–20 to 11,961 in 2020–21 (a drop of 20.6%); the Northern Ireland

Commissioner for Children & Young People ("NICCY") attributed this reduction to the 'pandemic effect'. The number of CAMHS referrals reached pre-pandemic levels in 2021–22, with 15,580 referrals in the twelve months leading to 31 March 2022, an increase of 30.3% from the prior year and 523 more referrals than 2019–20. The proportion of global referrals[2] accepted to CAMHS in Northern Ireland slightly decreased from 75.1% in 2018–19 to 71.4% in 2019–20 and 2020–21. The NICCY reported that CAMHS is not appropriate for approximately three in ten young people who are referred to the services, and thus, other forms of support are needed. (Exhibit EL/91 - INQ000472316)

44. In Northern Ireland, CAMHS referrals are classified as routine, urgent and emergency. Routine referrals, those which are assessed as requiring an appointment within 9 weeks, continue to make up the largest proportion of referrals to CAMHS. However, 86.4% of referrals were routine in 2021–22, dropping below 90.0% for the first time since 2018–19, with emergency and urgent referrals accounting for a greater proportion of CAMHS referrals. During the pandemic, the proportion of emergency CAMHS referrals doubled from 2.6% in 2018-19 to 5.2% in 2021–22, and the percentage of urgent referrals slightly increased from 7.0% to 8.4%. (Exhibit EL/91 - INQ000472316)

[2] Global referrals include all referrals received into CAMHS for Step 2, Step 3 CAMHS, Eating Disorder Service, Crisis Response Home Treatment ("CRHT"), and Drug and Alcohol Mental Health Services ("DAMHS").

Figure 4: Referrals to CAMHS, Northern Ireland, 2017–18 to 2021–22



Waiting times

45. The average length of waiting times and the proportion of young people who have been referred and are still waiting for treatment have, expectedly, been impacted by increasing levels of demand. Two surveys conducted by the European Society for Child and Adolescent Psychiatry showed that while specialist CAMHS were not meeting clinical demand before Covid-19, waiting lists have only increased due to the rise in referrals (Exhibit EL/32 - INQ000442238) (Exhibit EL/33 - INQ000442239).

46. With more and more young people in contact with mental health, learning disability and autism services, there has been variable progress made in lowering the proportion of young people referred who are waiting for services and in meeting associated waiting time standards. Although these are positive signs, this trend is not consistent across the UK. It is our view that more needs to be done to ensure that children and young people, no matter where they live in the UK, have access to timely, high-quality mental health treatment. In some areas in particular, it is clear that there simply are not sufficient resources to meet the increased level of demand that we are seeing.

47. Early intervention is particularly important for children and young people. Approximately half of mental illnesses in adults start before the age of 14 and three quarters before

the age of 24 (Exhibit EL/34 - INQ000442240). Many mental health conditions are avoidable and can be cured if treated early; if behaviours indicating a possible mental health condition are identified and treated early, they can be prevented from persisting into adulthood. The longer a young person waits for treatment, however, the more likely they are to experience a deterioration in their mental health or encounter a crisis situation.

48. In April 2020, 54.4% of Local Primary Mental Health Support Services ("LPMHSS") assessments for children and young people aged under 18 years were undertaken within 28 days of referral in Wales. 17.7% of patients waited over 56 days from referral for a LPMHSS assessment; while this figure decreased by 3.5 percentage points in March 2021 (14.2%), it increased by 4.8 percentage points in the two years leading to March 2022 (22.5%). In the most recent findings for September 2023, the proportion of children waiting more than 56 days for referral dropped to 5.9%.

49. 68.1% of patients aged 18 and younger in Wales started a therapeutic intervention within 28 days following a LPMHSS assessment in April 2020, while 15.4% waited over 56 days for a therapeutic intervention. The proportion of patients waiting over 56 days decreased by 2.4 percentage points in March 2021, but then more than doubled to 30.9% in March 2022. 41.0% of children waited for more than 56 days in September 2023 (Exhibit EL/35 - INQ000442241).

50. The proportion of children waiting for a first specialist CAMHS appointment in Wales for over four weeks in March 2020 was 30.9%, 4.3 percentage points lower than 35.2% in December 2019, before the Covid-19 pandemic. This figure continued to decrease in March 2021 to 24.2%, but then doubled to 50.2% in March 2022, indicating that over half of patients were waiting more than a month for a first specialist CAMHS appointment (Exhibit EL/36 - INQ000442242).[3]

51. The Scottish Government standard states that 90.0% of children and young people should start treatment within 18 weeks of referral to CAMHS. In January to March 2020,

[3] It should be noted that the proportion of children waiting for specialist CAMHS appointments does fluctuate each quarter; the most recent findings for September 2023 reported that 16.9% of children waited more than four weeks for an appointment.

66.6% of children and young people commenced treatment within 18 weeks in Scotland, only 0.2 percentage points greater than the proportion for the previous quarter (66.4%) and 23.4 percentage points lower than the target. While the percentage of patients seen within 0-18 weeks does fluctuate each quarter, the proportion increases incrementally each year; for the quarter ending March 2021, 72.4% of children and young people were seen within 18 weeks of referral, followed by 73.2% at the end of March 2022 and 74.2% at the end of March 2023. As of September 2023, the Government target has not yet been met, with 75.6% (14.4 percentage points lower than the target).

52. 11,458 children and young people in Scotland were waiting to start treatment at the quarter ending March 2020, an increase of 19.8% compared to 10,820 in the previous quarter (October–December 2019). Nonetheless, this figure has fallen each year since, with 11,006 children waiting to start treatment at the end of March 2021 (a decrease of 3.9%), 10,406 waiting at the end of March 2022 (a further decrease of 5.5%) and 7,701 waiting at the end of March 2023 (a final drop of 26.0%). In the most recent data for September 2023, there were 5,344 children and young people waiting to start treatment, a drop of 53.4% from March 2020 (Exhibit EL/37 - INQ000442243).

53. In Northern Ireland, the total number of children and adolescents referred to mental health services who were waiting for their initial assessment by CAMHS dropped by 30.0% at the end of March 2021 (1,281), however, grew to 2,106 at the end of March 2022 (an increase of 64.4%) and then to 2,388 at the end of March 2023 (a further increase of 13.3%) (Exhibit EL/38 - INQ000442243).

54. As of 31 March 2020, there were 1,829 children and adolescents waiting for a CAMHS assessment in Northern Ireland, 707 (38.7%) of whom were waiting for more than nine weeks. There were 19 more children waiting for a CAMHS assessment at the end of March 2020, compared with 1,810 children waiting at the end of December 2019. In the most recent statistics, there were 2,017 children waiting for an initial assessment on 30 September 2023.

55. A similar trend was reported for the proportion of children waiting for over nine weeks for an initial assessment by CAMHS in Northern Ireland; the percentage fell from 38.7%

at the end of March 2020 to 29.7% at the end of March 2021 (a difference of 9.0 percentage points), but subsequently increased to 44.2% on 31 March 2022 (an increase of percentage points) and 45.5% on 31 March 2023 (a further increase of 1.3 percentage points). For the quarter ending September 2023, 58.9% of children waiting for an initial assessment by CAMHS had been waiting for more than nine weeks (Exhibit EL/39 - INQ000442245).

56. For children and young people with eating disorders in England, performance against the 95% waiting time standards peaked in the first quarter of 2020–21 for urgent cases (87.8% started treatment within 1 week) and in the second quarter of 2020–21 for routine cases (89.6% started treatment within 4 weeks). The Covid-19 pandemic period saw demand for children and young people eating disorder services increase substantially, with a concurrent decline in performance against both waiting time targets. There were 2,632 completed urgent pathways across 2021–22 compared to 1,373 in 2019–20 (91.7% increase), and 9,825 completed routine pathways in 2021–22 compared to 6,661 in 2019–20 (47.5% increase). Performance against the urgent and routine targets fell as low as 59.0% in Q3 2021–22 and 64.1% in Q4 2021–22, respectively. In the most recent complete data for Q1 2022–23, it was also reported that 102 out of 229 (44.5%) of children still waiting for urgent treatment had been waiting for more than 12 weeks. This can be compared to the report that only two of 18 of those still waiting for urgent treatment had been waiting for more than 12 weeks in the quarter immediately preceding the pandemic (Jan-March 2020) (Exhibit EL/40 - INQ000442246) (Exhibit EL/41 - INQ000442247). Routine and urgent eating disorder cases for children and young people are increasing, with young people often presenting later and more unwell than our members have seen before.

Mental health funding

57. Mental health services have historically been underfunded; addressing this lack of funding is an important next step towards achieving parity with physical health. The provision of funding is critical if access to and quality of mental health services is to be improved, capacity issues for these services addressed, and sufficient coverage for preventative early interventions achieved. Across the UK, there has been a general, welcome ambition to increase funding for mental health at a national level.

58. A fifth (20.6%) of the UK population is made up of 0- to 17-year-olds (Exhibit EL/42 - INQ000442248) and almost a third (32.7%) of all people in contact with mental health services across England in March 2022 were children and young people (Exhibit EL/27 - INQ000442233); it is important to assess the extent to which mental health spend is increasing as a proportion of NHS spending, and indeed whether children and young people mental health spend is increasing as a proportion of mental health spend.

59. The 2022/23 spend on ICB mental health services in England, including spend on intellectual disabilities, autism, and dementia, was £13.6 billion, a real terms increase of 8.4% on the 2019/20 spend (£12.6 billion, 2022/23 prices) and 6.5% greater than the spend in 2020/21 (£12.8 billion, 2022/23 prices). However, the current mental health spend amounts to just 14.0% of the overall ICB spend. In 2022/23, £1.1 billion was spent on children and young people's mental health ICB services, including intellectual disabilities and eating disorders, comprising 8.0% of the total spend for ICB mental health services. The spend for children and young people's eating disorder services was £83.5 million, amounting to only 0.6% of the total ICB mental health spend. The spend on children and young people's mental health ICB services per child (0 to 17 years) in 2022/23 was £88.81. This equates to a small increase of 1.7% in the past year (£87.30 per head in 2021/22) and an increase of 13.6% from prior to the pandemic in 2019/20 (£78.16 per head) (Exhibit EL/43 - INQ000442249) (Exhibit EL/44 - INQ000442250) (Exhibit EL/42 - INQ000442248).

Figure 5: Spend on children and young people's mental health ICB services, including intellectual disabilities and eating disorders (2022/23 prices), England, 2016/17 to 2022/23

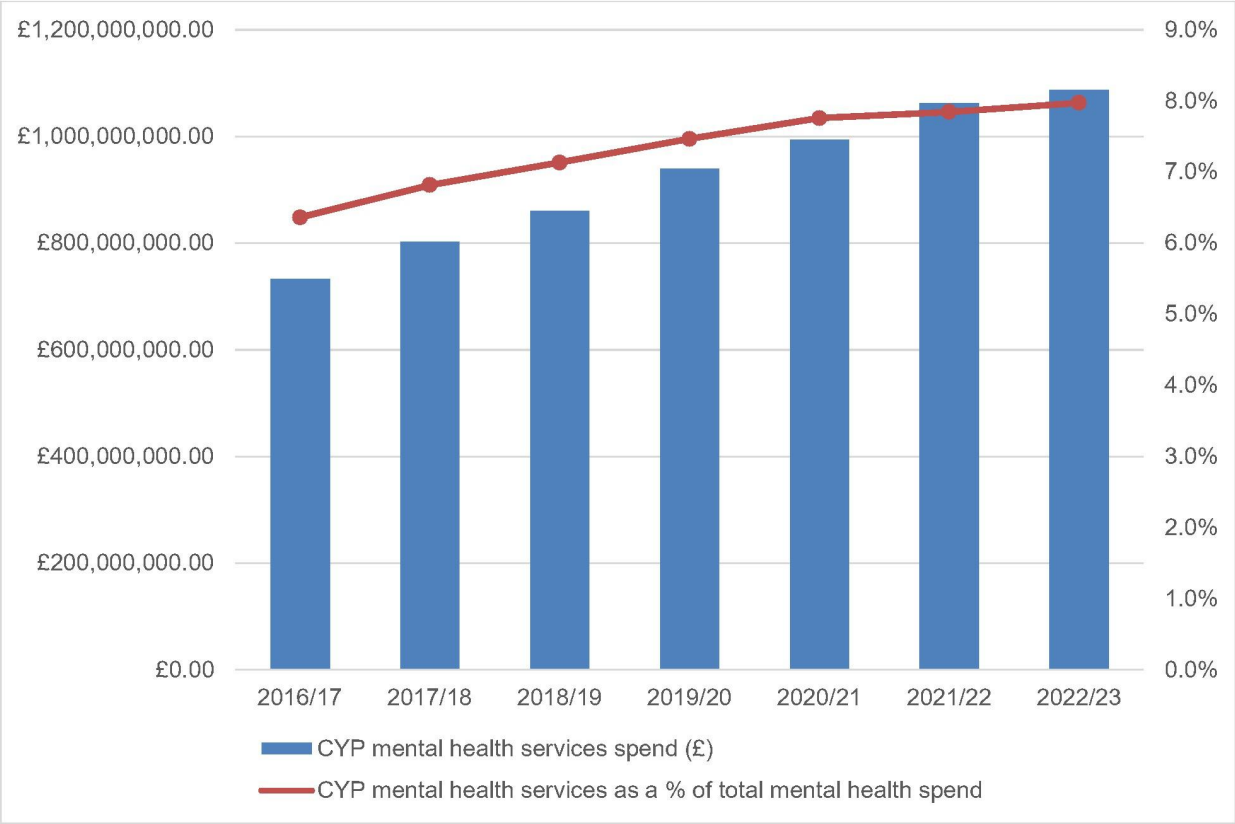
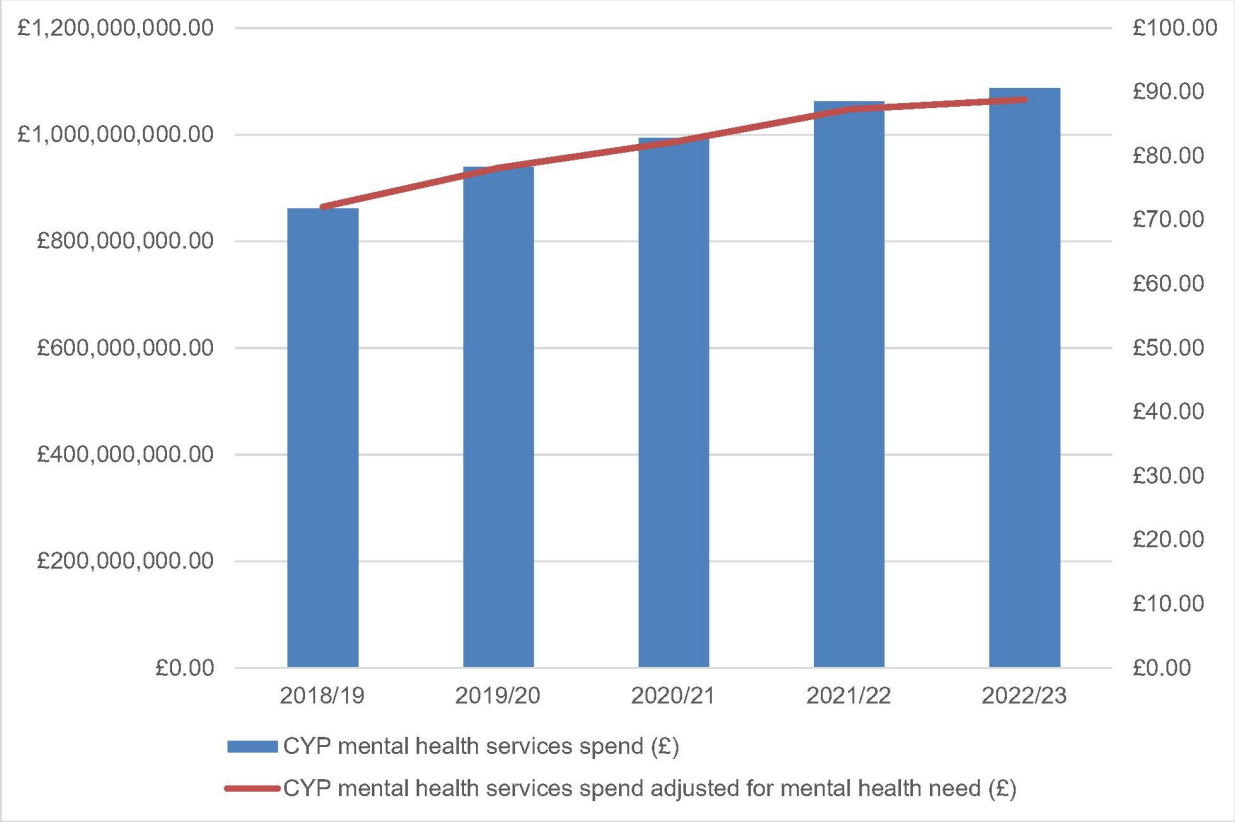


Figure 6: Spend on children and young people's mental health ICB services per child (0 to 17 years) in 2022/23 prices, England, 2018/19 to 2022/23



60. There is a lack of data on mental health funding in Northern Ireland. As such, it is difficult to assess the extent to which this funding is being delivered. A 2023 Northern Ireland Audit Office report noted that, as a result of the complicated nature of delivery and recording systems, overall funding and spend cannot be readily identified. The report estimated that mental health spend in 2019/20 was £340 million, equating to 5.7% of the overall health and care budget in Northern Ireland (Exhibit EL/45 - INQ000442251).

61. In Scotland, while total net mental health spend has increased year-on-year from £877.0 million in 2011/12 to £1.3 billion in 2022/23, there has only been a real terms increase in 2022/23 prices of £182.5 million (Exhibit EL/46 - INQ000442252). In the last year, there has been a 4.4% (£60.4 million) cut in real terms from £1.4 billion in 2021/22. In the 2021 Scottish Parliament election manifesto, the Scottish National

Party (SNP) committed to spending 10.0% of the frontline NHS budget on mental health services and 1.0% on CAMHS (Exhibit EL/47 - INQ000442253). However, in real terms, mental health spend as a proportion of total NHS spending has decreased from 9.2% in 2012/13 to 8.5% in 2022/23. No health board achieved the 10.0% target in 2022/23, and only NHS Lothian invested at least 1.0% of its funding into CAMHS. £114.8 million was spent on CAMHS in 2022/23, amounting to 8.8% of the mental health expenditure and 0.7% of the total NHS expenditure. In contrast, 57.6% of the mental health expenditure went towards adult psychiatry (£752.6 million, almost seven times greater than the funding for CAMHS) and 22.6% was spent on older adult psychiatry services (£294.8 million, almost three times the funding for CAMHS) (Exhibit EL/46 - INQ000442252).

Figure 7: NHS spend on CAMHS (2022/23 prices), Scotland, 2011/12 to 2022/23

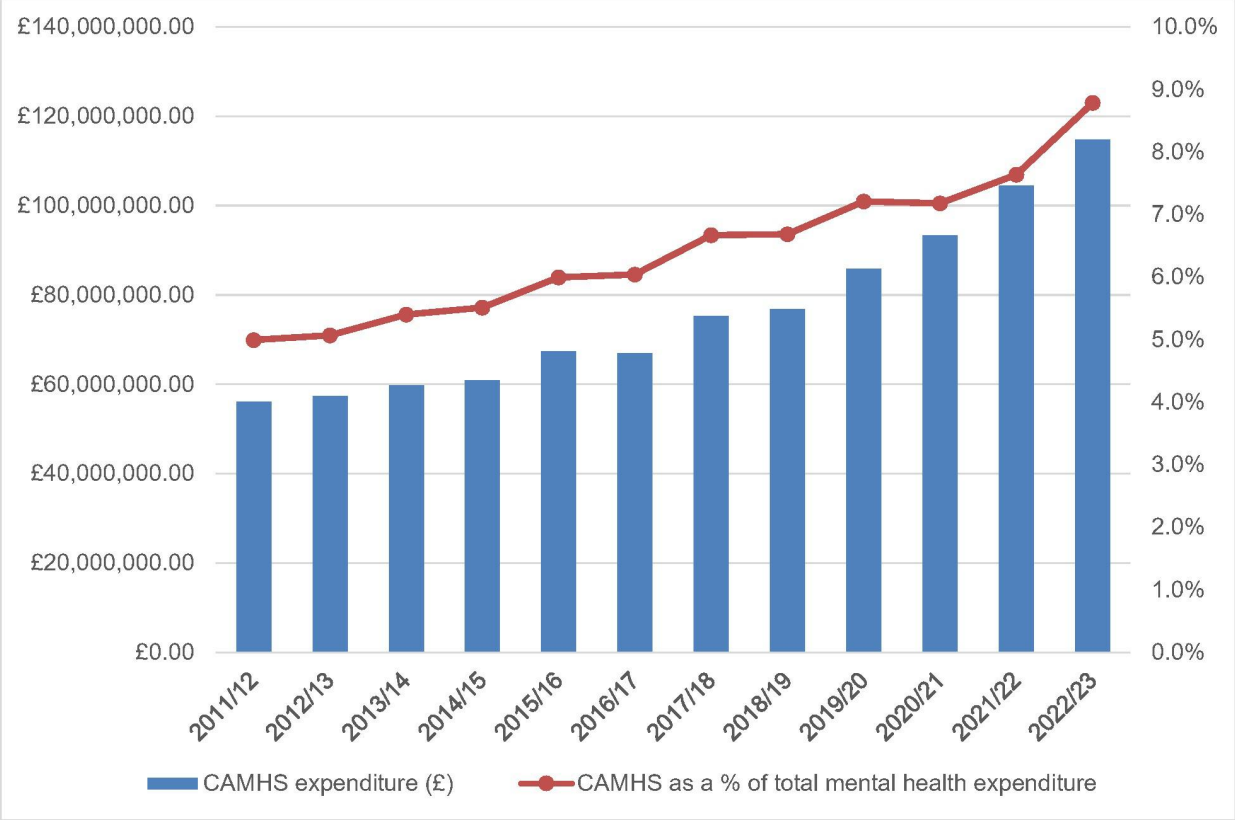
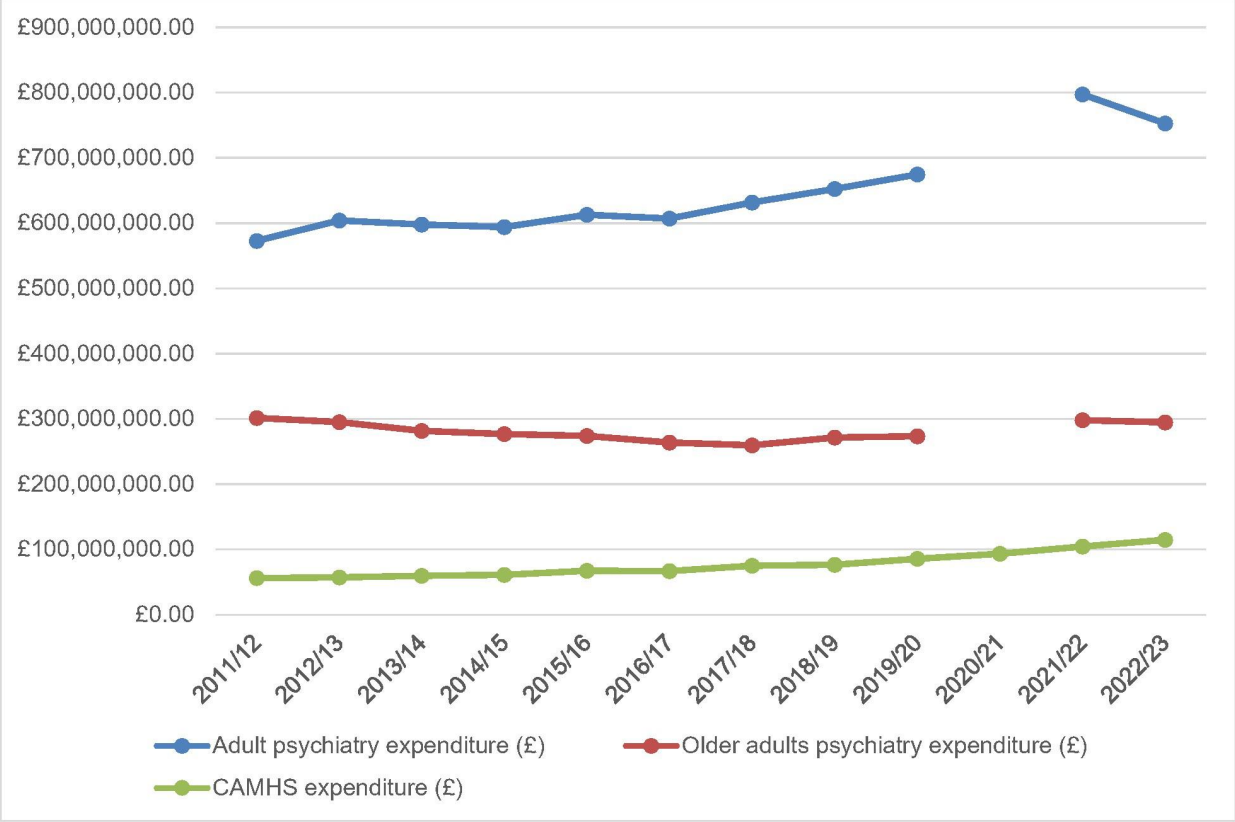


Figure 8: NHS expenditure for adult psychiatry, older adult psychiatry and CAMHS (2022/23 prices), Scotland, 2011/12 to 2022/23



62. In Wales, despite some annual fluctuation, there has been a real terms increase (2021/22 prices) in mental health spending between 2006/07 (£735.5 million) and 2021/22 (£961.6 million) (Exhibit EL/48 - INQ000442254). However, mental health funding accounted for 10.9% of total NHS spending (in cash terms) in 2021/22, which was down from 11.2% in 2020/21 and 11.1% in 2019/20. £90.9 million went to CAMHS in 2021/22, 1.0% of total NHS spend and 9.5% of mental health spend. 47.5% of the mental health spend went towards general mental illness services (£456.4 million, five times the spend for CAMHS) and 27.9% went to elderly mental illness services (£268.3 million, triple the spend for CAMHS) (Exhibit EL/49 - INQ000442255).

Figure 9: NHS spend on CAMHS (cash terms), Wales, 2011/12 to 2021/22

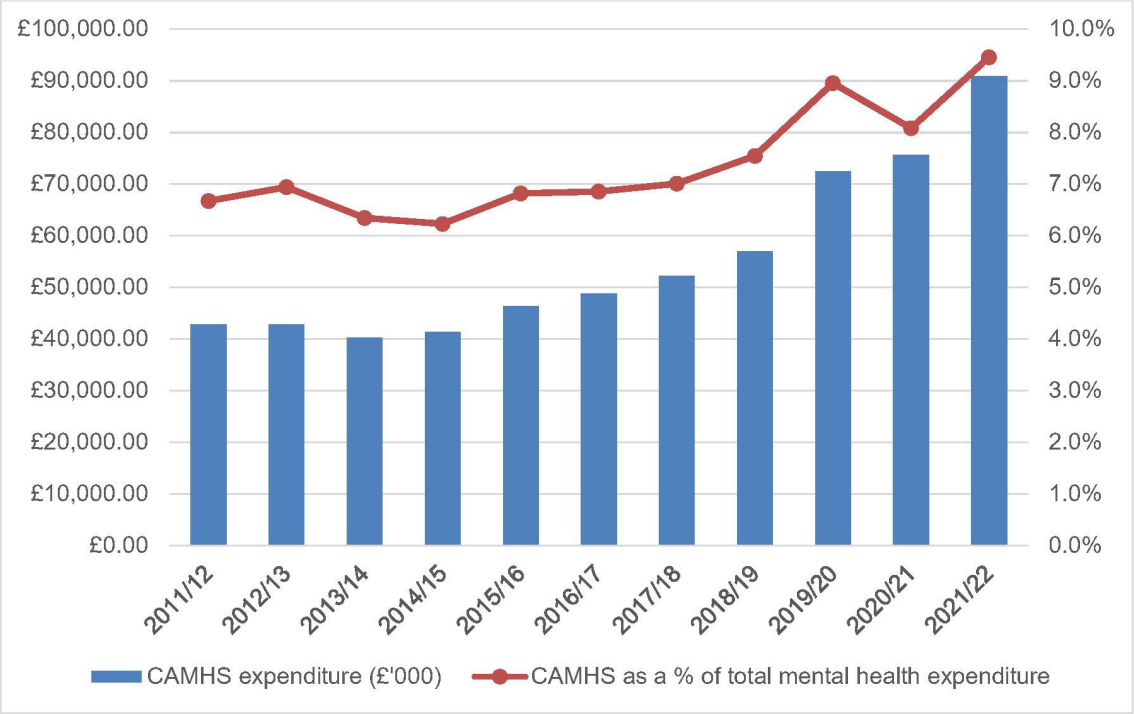
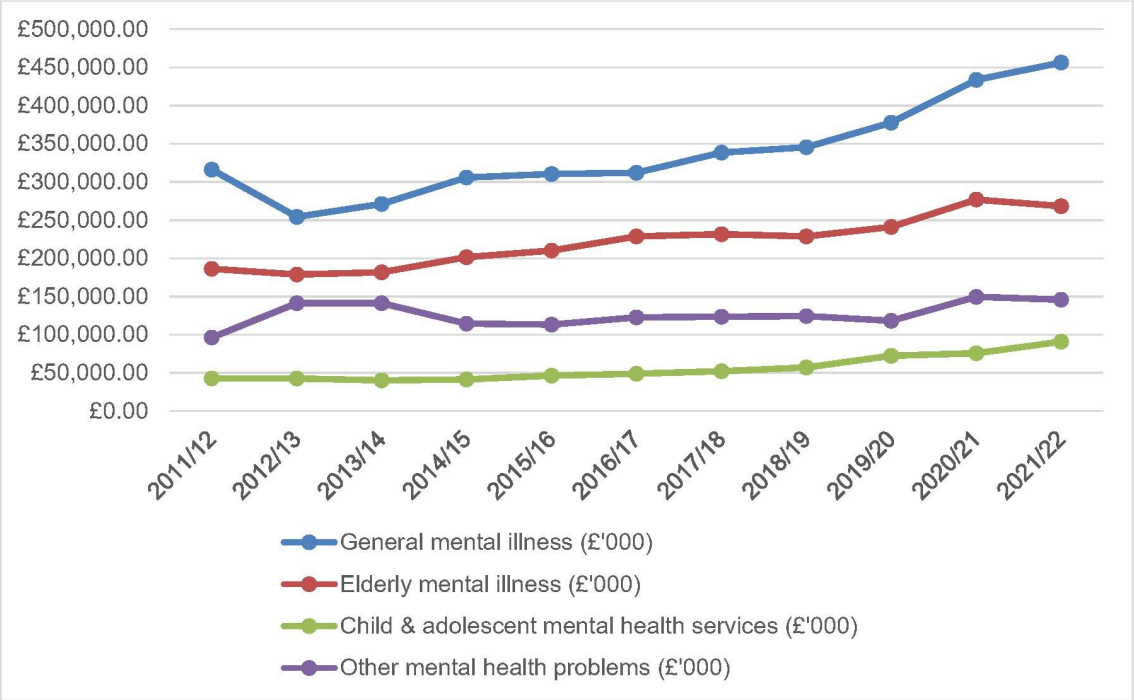


Figure 10: NHS expenditure for general mental illness, elderly mental illness, CAMHS and other mental health problems (cash terms), Wales, 2011/12 to 2021/22



Community Provision

63. Red Amber Green ("RAG") triage coding was implemented during the first lockdown for the purpose of deciding which patients services should focus on at a time where there was a significant reduction in face-to-face contact. Patients who were risk-assessed using the RAG scale as having a 'red' rating were considered vulnerable and at high risk, requiring frequent face-to-face contact. For those with 'amber' ratings, regular monitoring and review via telephone was recommended, with an option to step up to face-to-face contact if required. For those with 'green' ratings, telephone or digital contact was recommended. The RAG system meant that those children and young people who needed to be seen most urgently were, while others were placed on waiting lists and did not receive in-person treatment. This led to a drop in the total number of face-to-face contacts for community CAMHS. Fewer patients with mental illness were seen face to face by a psychiatrist or the wider mental health team, which would have led to poorer mental health outcomes for some. As part of this, patient loads were reviewed regularly to ensure patients were being prioritised appropriately according to need. Young people who were able to access services were cared for and provided treatment by staff as well as capacity constraints allowed in the circumstances.

64. Face-to-face appointments would have been appropriate and clinically beneficial in some circumstances in which they were not received. At the early stages of the pandemic, the impact of offering assessments or appointments digitally compared with offering them face to face, in person but wearing masks, was not sufficiently understood, with each option being seen as having its advantages and limitations.

65. For example, the increase in video and telephone appointments with children and young people led to increased appointment attendance. For some, remote appointments can improve accessibility to treatment where physical geographical location is a constraint, particularly as young people often do not have their own means of physically attending appointments. In terms of accessibility, then, digital appointments and therapies can provide some children and young people with the potential for better engagement.

66. However, for children living in digital poverty, with no access to internet, without sufficient roaming data available to them, or who did not have digital literacy or access

to a telephone, the offer of remote appointments effectively removed their ability to engage with mental health services and receive treatment.

67. It is also important to note that preferences for the type of remote appointment for each young person varied, with some children preferring video appointments while others preferred those held over the phone. If a child is able to access remote treatment but not the means to attend the appointment type they prefer, this may impact how effective such appointments are for them. Additionally, we have heard from members that, when given the option, many children and young people preferred to be seen face-to-face than remotely. Health outcomes for young people who could not come to hospital and whose access to digital technologies was limited would potentially have been the poorest among this group.

68. There were also some safeguarding concerns associated with remote appointments, including those related to containment and having a meaningful one-to-one session with a child or young person. There would, for example, be family members in the house and, at times, in the same room or even in the background of the appointment itself. We have heard from members that those patients with a history of complex trauma or abuse found it particularly difficult to engage in online sessions. Some young people also struggled with self-consciousness associated with seeing themselves on the screen.

69. It may also have been difficult for some immediately following an online appointment; when the screen goes blank, a young patient may find it troubling to deal with difficult emotions on their own within their home. This may have been detrimental to the mental health of a young person who was feeling isolated, particularly if they were living in an unsafe situation or if their needs exceeded the support that was being remotely provided to them at that time.

70. The physical proximity of in-person meetings may be conducive to creating an environment in which some patients are more likely to explore their experiences and feelings; for others, meeting over a screen may have offered them a feeling of safety, allowing them to be open and disclose to the clinician treating them. Ultimately, a child

and adolescent psychiatrist's ability to assess, treat and manage psychological risk was compromised by an absence of face-to-face contact.

71. There is a sufficient body of evidence showing that face-to-face therapeutic relationships for patients with mental health difficulties leads to improved outcomes. However, more research is required to understand the efficacy of the therapeutic relationship for patients in both digital and telephone formats, with a particular focus on children and young people's experiences of therapy, impact on concordance with medication, and ongoing reviews.

Inpatient admissions, bed occupancy rates, and length of stay

72. We have been told by members that there was both an implicit and explicit increase in thresholds for inpatient care in an anticipation of, and during, lockdown. This meant that acuity and risk were higher; some young people who may previously have been admitted to inpatient care prior to the pandemic may not have met the threshold for admission during this time due to capacity constraints. This marked change in practice on CAMHS inpatient wards was primarily due to a reduction in capacity, both in terms of a decrease in the number of beds available in some parts of the UK, as well as a workforce shortage for CAMHS (with a limited workforce being the ultimate arbiter of bed numbers).

73. We have heard reports from members in some areas of mental health beds from both CAMHS and adult provision being requisitioned by physical health services in anticipation of beds being required for Covid-19 patients. Some members have also expressed that mental health provision for children and young people was not given the level of priority that was required.

74. In England, the numbers of bed days and admissions in CAMHS wards for patients aged 0 to 17 years appeared to drop over the course of the Covid-19 pandemic. From 1 April to 30 June 2020, there were 876 admissions of children and young people under 18 in CAMHS tier 4 wards, a reduction of 15.9% from 1,042 in the same reporting period in 2019–20 and a decrease of 13.4% from 1,012 in the prior quarter (1 January to 31 March 2020). The number of admissions continued to decrease each quarter, with Q3 2021–22 having the lowest number of admissions on record (548 admissions). In the

most recent data for Q4 2022–23, the number of admissions has slightly increased to 651, although 35.7% below the number of admissions three years ago, prior to the pandemic in Q1 2019–20.

75. In contrast, the number of bed days and admissions in adult wards for children aged 0 to 17 years in England dropped at the start of the Covid-19 pandemic and have fluctuated from Q2 2020–21 onwards.[4] 72 children and young people were admitted in adult in-patient wards from 1 July to 30 September 2020, amounting to 1,517 bed days, 45.9% fewer than the 133 children admitted in Q2 2019–20 but 35.2% more bed days (1,122 in Q2 2019–20). The most recent complete figures for Q1 2022–23 were 50 children admitted and 727 bed days in adult in-patient wards, both figures lower than the respective pre-pandemic values. (Exhibit EL/50 - INQ000442256) (Exhibit EL/51 - INQ000442257)

76. In terms of inappropriate out of area placements ("OAPs")[5] in England, there was no data published on the scale of inappropriate OAPs for children and young people until August 2023, for the reporting period of May 2023. We have heard anecdotally from members, however, that travel restrictions at the start of the pandemic largely precluded the use of out of area provision. Unlike the practice of inappropriate OAPs for adult patients in acute care, a target date has not yet been set for the elimination of OAPs in CAMHS. In the most recent NHS England data release, there were 8,309 inappropriate bed days for children and young people aged 0 to 17 years from 1

[4] There is not a national policy for the minimum age for children to be admitted to an adult ward. However, there is the 'age appropriate environment duty' which was written into the MHA in April 2010 (S131A) which "places hospital managers under a duty to ensure that patients aged under 18 admitted to hospital for mental disorder are accommodated in an environment that is suitable for their age (subject to their needs). In determining whether the environment is suitable, the managers must consult a person whom they consider to be suitable because of their experience in child and adolescent mental health services cases." In practice, admitting a young person to an adult ward who is under the age of 16 is a serious untoward incident that requires reporting to the CQC. 16- and 17-year-olds can, however, still be admitted. All trusts have developed clear admission of minor policies to ensure that the Act is met.

[5] An inappropriate out of area placement for acute CAMHS inpatient care can be defined as when a child or young person with assessed acute mental health needs, who requires mental health acute inpatient care, is admitted to a unit that does not form part of their usual local network of services. That is, a CAMHS inpatient unit that does not usually admit young people living in the catchment of the young person's local community mental health service, and where the person cannot be visited regularly by their care coordinator to ensure continuity of care and effective discharge planning. This is especially challenging for the under 18s who will have less access to their family, peers and educational settings.

September 2023 to 30 November 2023, a slight increase of 0.7% from the previous rolling quarter of August 2023 - October 2023 (8,250). (Exhibit EL/52 - INQ000442258) (Exhibit EL/53 - INQ000442259)

77. In Scotland, the most recent version of Mental Health and Learning Disability Inpatient Bed Census conducted by the Scottish Government found that occupancy rates across children's units and young peoples' units combined were 87%, same as the rate for 2019, but lower than the rates in 2018 (98%) and 2016 (96%). There were 46 mental health, addiction or learning disability inpatients aged under 18 at the 2022 Census, compared with 52 in 2019, 57 in 2018, 36 in 2017, 55 in 2016 and 50 in 2014. The average (median) number of days since admission at the time of the Census was 34 days. This is 17 days shorter than the 2019 Census. Around 1 in 3 (30%) children and young people had been in hospital for less than 2 weeks at the 2022 Census. (Exhibit EL/54 - INQ000442260)

78. For child & adolescent psychiatry inpatient stays in Northern Ireland, there were 136 admissions under the mental health programme of care in 2020–21, a rise of 14.3% since 2019–20 (119 admissions), just before the Covid-19 pandemic. The number of admissions has consistently decreased each year since, with 85 in 2021–22 (a drop of 37.5%) and 72 in 2022–23 (a further decrease of 15.3%).

79. The bed occupancy rate for child & adolescent psychiatry in Northern Ireland has increased consistently across the course of the Covid-19 pandemic, from 61.9% in 2019–20 to 81.1% in 2021–22 (a difference of 19.2 percentage points). In the most recently findings for 2022–23, the bed occupancy rate has risen slightly to 83.2%. (Exhibit EL/55 - INQ000442261)

80. We know that prolonged admissions are associated with poorer patient outcomes; clinicians in CAMHS continue to work hard to reduce the average length of stay, working with community-based services to prevent admission and facilitate timely discharge.

Mental Health and Capacity Legislation

81. The subjective experience of detention for young patients during the pandemic was varied. Wards were more acute and, by virtue of IPC measures, more restrictive. The care received was more impersonal, with mask wearing and online meetings. Family contact was limited, and peer contact was often constrained in line with IPC guidance and concerns.

82. In particular, we have heard from members that challenges arose from mechanisms for enforcing IPC measures for patients who lacked the capacity or competence to consent to them, or refused to do so. There was lack of clarity, especially at beginning of pandemic, of legal context for enforcing such restrictions. Interventions traditionally used to mitigate subjective experiences of admission, including access to Section 17 leave, home leave, and visits from friends and family, were not available or significantly limited.

83. Detentions under the mental health acts in the UK are challenging, and assessments for detention should ideally not be done remotely (Exhibit EL/56 - INQ000442262). Admitting a child under the mental health acts involves removing them from their family and support network. As such, it is only used when a child is unable to engage fully in the assessment and/or treatment of a mental illness due to the severe nature of the illness, and where there are risks posed to themselves or others if left unassessed or untreated. When considering whether to use a mental health act, a child or young person's age and developmental stage must be addressed; as part of this, a child or young person's capacity to consent or to refuse treatment, and the impact the mental illness has on this, must be addressed. The least restrictive option must be used with clear evidence of reciprocity; that is, being detained against one's will must be balanced by it being the only means of accessing assessment and/or treatment for a mental illness which must be available where they are admitted. Historically, clinicians have relied more on parental consent for children, but it has been recognised that this places an undue burden on the parent-child relationship. The mental health acts bring with them external scrutiny and protection of the child's rights. Given the constraints in assessing patients face-to-face, it is reasonable to suggest that the Covid-19 pandemic and subsequent lockdowns had an impact on the number of detentions across the UK.

84. For context, on 4 February 2021, Claire Murdoch CBE, National Mental Health Director at NHSEI, sent a letter to mental health system leaders outlining a court's ruling on remote MHA assessments – a practice that had been introduced during the pandemic. The letter outlined that Devon Partnership NHS Trust sought a declaration from the Court as to whether remote assessments could be used to lawfully detain someone under the Mental Health Act 1983 ("MHA"). The letter stated that the Court's ruling was restricted to its interpretation of the phrases "personally seen" in section 11(5) and "personally examined" in section 12(1), and concluded that the physical attendance of the person in question (the Approved Mental Health Professional and doctor) was required when assessing a person for detention under the MHA. Based on this ruling, it was advised that a Court would find a detention following a remote assessment carried out under section 11(5) and section 12(1) to be unlawful. NHSEI therefore advised that there were to be no further remote assessments for detention or constraint under section 11(5) and section 12(1). With regards to section 2, section 3, section 4 or section 7, anyone who was, at the time, currently detained in hospital under section 2, 3, 4 (or who was subject to section 7) as a result of such a remote assessment, should be reassessed without using remote technology as soon as possible; and NHSEI guidance on conducting remote assessments during the pandemic period was redacted.

85. In England, the annual number of children and young people detained under the Mental Health Act 1983 has decreased since the start of the pandemic. From 1 April 2019 to 31 March 2020, there were 1,172 new detentions among children aged 17 and under (2.3% of the total number of detentions). This figure decreased by 3.2% in 2020–21 (1,134 detentions, 2.1% of the total) and dropped by 17.8% in 2021–22 (963 detentions, 1.8% of the total). The number of detentions in 2019/20 was 17.6% greater than the most recent figure for 2022–23 (997 detentions, 1.9% of the total). After accounting for population size, there were 9.7 detentions per 100,000 children aged under 17 years in 2019–20; this figure decreased by 3.1% to 9.4 per 100,000 in 2020–21, and then dropped by a further 14.9% to 8.0 per 100,000 in 2021–22. The most recent data for 2022–23 shows a slight increase of 6.3% over the past year to 8.5 detentions per 100,000 children aged under 17 years, although the detention rate remains lower than pre-pandemic levels. Detention rates for young people aged 17 and under were consistently lower than rates for all adult age groups. (Exhibit EL/57 - INQ000442263)

(Exhibit EL/58 - INQ000442264) (Exhibit EL/59 - INQ000442265) (Exhibit EL/60 - INQ000442266)

86. In Wales, the Welsh Government collates statistics showing the number of detentions for children under Section 135 and 136 of the Mental Health Act 1983. The total number of detentions for children under the age of 18 at the end of March 2020 was 17.4% fewer (19 detentions in total) than the number recorded at the end of December 2019 (23 detentions in total), three months prior to the start of the Covid-19 pandemic. However, this figure rose by 31.6% in the twelve months leading up to March 2021 (25 detentions in total) and then increased by a further 20.0% in the months leading up to March 2022 (30 detentions in total). While the number of detentions for children under the age of 18 appeared to increase year-on-year over the course of the pandemic, the figures do fluctuate each quarter. At the end of June 2023, the highest number of detentions was recorded (55 detentions in total) and the number of detentions in the following quarter reached pre-pandemic levels. There were 21 detentions in September 2023, which equates to a 61.8% drop from the previous quarter. (Exhibit EL/61 - INQ000442267)

87. In Scotland, the data collected by the Mental Welfare Commission for Scotland shows an increasing number of T4 certificates (a T4 certificate provides notification of the provision of urgent treatment for a patient who is subject to detention under mental health legislation) under the Mental Health (Care and Treatment) Scotland Act 2003 for children and young people under the age of 18 from 2019–20 to 2020–21.[6] From 1 April 2019 to 31 March 2020, there were 55 T4 certificates for children (13.5% of all T4s in Scotland); this figure increased by 69.1% to 93 T4s in the following reporting year, equating to 20.6% of all T4s issued in Scotland, the highest proportion on record. There was a slight fall in 2021–22 (a decrease of 12.9% to 81 T4s), followed by another reduction in 2022–23 (a decrease of 13.6% to 70 T4s) (Exhibit EL/62 - INQ000442268).

[6] The Mental Health (Care and Treatment) Scotland Act 2003 clearly lays out the requirement for the medical examination of any patient, including patients below the age of 18 years, when they are detained and given compulsory treatment. During the pandemic, only in exceptional cases would it have been appropriate for such assessments to have been undertaken remotely, and all criteria for detention and compulsory treatment would have been required to be met regardless of the mechanism for assessment.

88. As reported in the Northern Ireland Statistics and Research Agency (NISRA) annual hospital statistics, the number of mental illness and learning disability compulsory admissions under the Mental Health (NI) Order 1986 for children and young people under 18 years in Northern Ireland have increased over the course of the Covid-19 pandemic. From 1 April 2019 to 31 March 2020, 23 children aged under 18 years were detained at point of mental illness admission; a year later, this figure more than doubled to 52 compulsory admissions (4.9% of all mental illness compulsory admissions). In 2021–22, the number of children detained decreased to 41 (a reduction of 21.2%) and in 2022–23, the number of detentions reached pre-pandemic levels (27 detentions, a further reduction of 34.1%). Similar trends were reported for learning disability compulsory admissions under the Mental Health (NI) Order 1986 from 1 April 2019 to 31 March 2023. The number of children admitted in 2020–21 tripled from one to three (75.0% of all learning disability compulsory admissions) and then more than doubled to seven in 2021–22. A reduction of 14.3% was reported in the most recent findings for 2022–23 (six admissions, 40.0% of all learning disability compulsory admissions), greater than pre-pandemic levels. (Exhibit EL/63 - INQ000442269) (Exhibit EL/64 - INQ000442270) (Exhibit EL/65 - INQ000442271) (Exhibit EL/66 - INQ000442272)

89. Reductions in the use of mental health acts does not reflect a reduction in the proportion of children and young people in hospital being there compulsorily.[7] This may reflect a lack of availability of beds to detain a child or young person to. The experience of many of our members since the start of the pandemic has been a significant reduction in the number of children and young people presenting to hospital on a voluntary basis, with many reporting that informal admission[8] is now an unusual occurrence.

90. We have heard from members that there has been an increase in the proportion of children and young people detained in hospital as a total portion of the inpatient population. This may plausibly be a function of the increase in threshold for admissions,

[7] Note, figures for England, for example, are subject to caveats from NHS England with regard to them potentially being incomplete.
[8] Informal admission refers to voluntary admission as opposed to compulsory detention under the provisions of relevant mental health legislation.

and because informal admission was less feasible or appealing as an option in the context of restrictions being secondary to infection control.[9]

91. It is important to note that when a young person is admitted to inpatient care, mental health legislation provides a level of protection that is not otherwise afforded under informal, voluntary admission. As such, clinically, detaining a young person under a mental health act is preferrable to having voluntary consent or consent from a parent or caregiver. Mental health legislation brings a degree of rigour and scrutiny to the admission of a young person. For a patient with an eating disorder, for example, a child or young person may urgently require certain interventions, such as a nasogastric tube, that mental health legislation allows the provision of in a timelier way. Mental health legislation also makes the process of admission for a child or young person a transparent one.

Infection prevention and control

92. We have heard from some members that personal protective equipment ("PPE") and IPC guidance was largely focused on general hospitals. There were specific issues and challenges in psychiatric settings that persisted, including managing young patients who had tested positive for Covid-19 who coughed at or spit on staff or used PPE for self-injurious behaviour. There were also issues encountered for patients who either lacked capacity to consent to, did not consent to, or refused to comply with, IPC measures, including those relating to the implementation of isolation; appropriateness of restrictive practices to manage infection control risk; and the availability and appropriateness of access to Section 17 notices, which allows a detained person out of inpatient care temporarily on a leave of absence.

[9] There was a reluctance to admit any child or young person unless absolutely necessary, not just because of the risk to them of contracting Covid-19, but also because of the additional restrictions placed on them due to the pandemic, including, for example, being placed in isolation for at least 48 hours until there was a negative Covid-19 test and the inability for them to have visits and time off the ward as would usually be the case. Some children and young people, for example, tested positive for Covid-19 and were then nursed entirely separately from their peers; staff wore additional PPE when treating them and they were unable to access the usual therapeutic and recreational activities – all while being acutely unwell, psychiatrically, at the same time.

93. Members have told us that room size was a major issue and constraint with treating patients. This was, however, partially compensated for by information technology ("IT") interventions but the rollout of this took time.

94. We also heard of the difficulties in maintaining consistency with approaches to Section 17 leave,[10] both escorted and unescorted, in response to national guidance and when some restrictions were lifted. There was also a struggle for consistency in relation to visiting arrangements.

95. Managing, following and implementing the broad range of guidance that was being disseminated from different bodies at different levels, was, at times, difficult for CAMHS staff to navigate. With the issuing of central government guidance, public health guidance, regional guidance, and local guidance, there were difficulties in following all simultaneously, particularly due to the pace at which the evidence base was changing. There could be, for example, overlapping jurisdictions and issuers of advice, or a lack of clarity with respect to whether any one piece of guidance should be adhered to or overridden owing to a specific clinical or management reason. Valuable time was often spent interpreting and implementing guidance at a time where real urgency was required, with guidance and rules often not adapted for working with children.

Discharge and patient reviews

96. We have heard from members that some staff had to move location. One member recounted a situation in which two CAMHS wards from different sites were combined into one, with many staff members finding this unsettling at an already difficult time for staff who needed to move. The requirement to make this work at such short notice

[10] Section 17 is a provision in the Mental Health Act 1983 (England and Wales) which allows a detained person out of hospital temporarily on leave of absence. Decisions regarding Section 17 leave are ultimately a matter for the Responsible Clinician ("RC"), but, in addition, the Mental Health Tribunal may recommend leave; the Ministry of Justice must approve it in restricted cases; and the RC will only grant leave having taken into consideration the advice of the other professionals involved in the case. Leave of absence is a way for the RC to test the patient and assess risk. It may begin with escorted ground leave for a short duration, build up to unescorted community leave, and culminate with overnight leave to proposed discharge accommodation. The imposition of conditions, the requirement to remain in custody, and the revocation of leave and recall of the patient must all be justified on the ground that the RC considers it to be necessary in the interests of the patient or for the protection of other persons.

meant discharging a cohort of patients rapidly and earlier than would have happened under different circumstances.

97. With respect to processes of Care Programme Approach or Care and Treatment Reviews, these continued as they had before the pandemic. There was, however, a need to adopt teleconferencing facilities almost immediately.

98. There were significant changes to discharge processes. Previously, discharge was usually a function of exploring safe Section 17 Leave (under the MHA in England and Wales) and reengagement with community services. This was no longer possible, as a patient going on home leave now meant an extended period of quarantine on return. As such, patients essentially had to be considered well enough to be definitively discharged to be granted leave, which, in part, may account for the increase in the average length of stay as previously outlined. Day patient services, which provided transitional 'step down' care also ceased to be available because of IPC measures.

99. The absence of T3 provision (second opinion appointed doctor for when patients are incapable of consenting to treatment), with staff working from home, also made the process of discharge more challenging. Patients were required be 'better' at point of discharge, rather than fit for discharge into a pre-lockdown world when we could be assured of more robust community provision.

100. In Scotland, the Mental Welfare Commission continued to appoint Designated Medical Practitioners ("DMPs"). DMPs provide second opinions for patients being treated under Part 16 of the Mental Health (Care and Treatment) (Scotland) Act 2003. For children and young people, this would be for medication given after two months, artificial nutrition or electroconvulsive therapy ("ECT"). Technology was permitted to assist in the remote assessment of young patients who were isolating due to infection or to ensure the DMP complied with travel restrictions. We have heard from our members that DMP assessments were carried out within recommended timeframes for treatment, such as seven to 10 days for nasogastric tube feeding or ECT and 14 days for medication. As DMP opinions must be given within these timeframes, it is unlikely that the use of remote assessments impacted on lengths of stay or discharge processes. Our members have advised that discharge processes were, however,

impacted by an inability to send patients home on a pass to test their ability to be at home; inability of occupational therapy staff to take patients out to shops, cafes and on public transport to see how they would function in such environments; periods of isolation in rooms for up to ten days; and delays in finding suitable social care placements. Discharge processes were particularly impacted in cases where patients were from distant localities and when there was not an intensive community CAMHS resource available.

101. Often for young patients on wards, a significant number of therapeutic and treatment activities take place in the community. In these settings, a young person who has lost the skills of daily living might be supported in the community to regain those skills. For example, a young person with an eating disorder could be supported by a dietician to select their own groceries at a supermarket. These therapeutic community encounters ceased during the early stages of the pandemic. As such, patients were less prepared to leave the ward, and this led to a delay in their discharge. Again, it became more of a binary decision whereby clinicians had to be absolutely sure that a young patient was well enough to leave inpatient care or they would not be discharged.

102. More young people were discharged from care and fewer seen face to face during the relevant period. In order to deliver quality care in a resourced-constrained scenario, these decisions were made on the basis of the best available information at the time. However, looking back, the impact of undelivered care across CAMHS in particular is likely to have contributed negatively to patient outcomes.

Patient experience

103. Group-based work is an important part of inpatient care, but the provision of this kind of work was significantly hampered during the pandemic, particularly during the acute phases. Young patients often found it difficult to engage with staff who were wearing masks, and there was far less in-person contact with their peers. Each patient had to be treated individually, as opposed to a therapeutic approach with a group, which made some patients feel more isolated and restricted; when a person is mentally unwell and left without such interactions for long periods, they may be forced to think more about how unwell they are. This is quite a burden that many young people had to endure over the course of the pandemic.

104. Some patients were impacted by IPC measures, including mask wearing, more than others, including autistic children and young people and those with hearing impairment and/or who lip read. The lack of transparent face masks also significantly impacted communication for people with intellectual disabilities and patients with hearing impairment and/or who lip read. Communication through available PPE was often both quiet and muffled due to the constraints of the items used, seriously impacting the ability of CAMHS staff to connect with patients and make them aware of changes to their care.

105. We know that lockdown conditions and the reduction in face-to-face appointments meant that some young patients felt they had less access to distractions from their illness. Patients transferring from CAMHS to Adult Mental Health Services also experienced difficulties, particularly where adults were not permitted to have face-to-face appointments.

106. While there is not necessarily a concept of long-stay wards for children and young people, some may have prolonged admissions, such as on medium secure units, for example.

General paediatric wards

107. There are anecdotal reports of increase in use of general paediatric beds for patients who were primarily there for mental health need, and especially for those with eating disorders.

108. Research by the Royal College of Paediatrics and Child Health ("RCPCH"), conducted prior to the pandemic in September 2019, found that children presenting with a mental health crisis in England are often admitted to general acute paediatric services. The findings show that approximately 6% of general paediatric inpatient beds, during the weekday, were occupied by children and young people admitted due to a mental health issue. As stated by the RCPCH, general paediatric wards are not appropriate locations for children in acute mental distress and thus reflects a lack of community resources (Exhibit EL/67 - INQ000442273). This is because staff working in general paediatric wards have not received the specialised training necessary to

manage acute mental distress, and the environment of these wards is not configured safely for these young patients. The management of children and young people with mental health disorders is now reported to be one of the main challenges for acute children's services (Exhibit EL/68 - INQ000442274). Over the course of the pandemic, there have been anecdotal reports of increasing numbers of children with mental health problems being admitted to acute paediatric care (Exhibit EL/69 - INQ000442275).

Adult psychiatric wards

109. Young people may be placed on adult wards in cases where a bed on a specialist service may not be available and where a short inpatient stay may be preferrable to them being admitted far from home for treatment.

110. The Mental Health (Care and Treatment) (Scotland) Act 2003 places a legal obligation on health boards to provide appropriate services and accommodation for young people admitted to hospital for treatment of their mental ill health.

111. According to Public Health Scotland, the majority of instances where a young person needs inpatient care is provided within the regional or national specialist child and adolescent inpatient units. During 2019–20, there were 103 admissions – involving 88 children and young people under the age of 18 – to non-specialist hospital wards, primarily adult wards, in Scotland. The number of these admissions dropped by 16.5% during 2020–21 (86 admissions), but slightly increased by 4.7% in 2021–22 (90 admissions). For all three reporting periods, young people aged 17 years made up the greatest proportion of admissions of children and young people under 18 years to non-specialist environments, with 49% in 2020–21 and 2021–22, a slight decrease of four percentage points from 53% in 2019–20. The percentage of children aged 15 years and under slightly decreased from 24% in 2019–20 to 20% in 2020–21 and proceeded to reach pre-pandemic levels with 25% in 2021–22. In the most recent data for 2022–23, the proportion of 17-year-olds grew to 62%, while the proportion of children aged 15 years and younger halved to 12% (Exhibit EL/70 - INQ000442276).

112. During the year-long period ending 30 September 2022, 31.9% of overall psychiatric admissions of children and young people under the age of 18, for care and treatment of their mental health, were to NHS non-specialist wards (Exhibit EL/71 -

INQ000442277). From 1 April 2020 to 31 March 2021, 38% children remained on those wards (mostly adult wards) for over a week and 8% remained for over five weeks, representing decreases of three percentage points and five percentage points, respectively, from prior to the pandemic in 2019–20. Nonetheless, the proportion of cases lasting for over a week is now increasing, with 47% in 2021–22 and 49% in 2022–23. From 2019–20 to 2021–22, there have been year-on-year increases in the mean length of stay, from 21 days in 2019–20 to 26 days in 2021–22 (Exhibit EL/70 - INQ000442276).

113. The CQC reports data on the number of patients under the age of 18 in England who have been placed in adult wards for more than 48 hours. The majority of these extended admissions are due to a lack of age-appropriate alternatives. While these figures may be underreported, they do show indications of an increase in the number of children and young people on adult psychiatric wards during the relevant period (Exhibit EL/72 - INQ000442278) (Exhibit EL/73 - INQ000398545) (Exhibit EL/74 - INQ000442280).

- 2014/15: 233
- 2015/16: 241
- 2016/17: 260
- 2017/18: 200
- 2018/19: 152
- 2019/20: (not reported in 2019/20 but anecdotal reports of increase)
- 2020/21: 197
- 2021/22: 260

Independent and private hospitals

114. We have liaised with members of the RCPsych CAP Faculty, and accounts of the private sector offering capacity over the course of the pandemic for children and young people have not been forthcoming. Anecdotally, members found there to be a reduction in independent and private provision for children and young people over the relevant period which, we have heard, has not returned.

Impact on Psychiatrists and Mental Health Workforce

115. In the mental healthcare sector, being able to recruit enough skilled staff to meet the needs of patients was already an urgent and substantial challenge before the pandemic. The retention and recruitment of staff has been widely recognised as the most significant risk to the delivery of mental health commitments in the NHS Long Term Plan, including those set out for children and young people, as well as to achieving parity of esteem.

116. Significant clinical demand on services began during the first year of the pandemic and there has been no break for an exhausted workforce.

Staff from minoritised ethnic backgrounds

117. On 13 May 2020, the RCPsych published guidance on risk mitigation for minoritised ethnic staff, which was widely commended and used by other organisations. The report set out the impact of Covid-19 on minoritised ethnic staff in mental healthcare settings and identified key areas for risk mitigation, including PPE, testing, remote working, redeployment and changes to staff rotas. The development of this report was in response to the high and disproportionate numbers of deaths of staff from minoritised ethnic backgrounds. The report presented evidence of the significant disparity in deaths from Covid-19 among healthcare staff, including doctors, trainees and students, nurses, allied health professionals, social workers and support staff from minoritised ethnic backgrounds compared to White staff; at the time of the report – 13 May 2020 – evidence suggested that approximately two thirds of healthcare staff who had died were from minoritised ethnic backgrounds, despite making up around 20% of the overall workforce. Furthermore, the report stated that a significant portion of the mental health workforce were from minoritised ethnic backgrounds (39% of RCPsych members). As of September 2023, 44% of UK RCPsych members are from minoritised ethnic backgrounds, with over a quarter (28%) from Asian or Asian British backgrounds, 8% from Black or Black British backgrounds, 5% from Other ethnic backgrounds, and 3% from Mixed ethnic backgrounds. The report also stated that a risk assessment should be carried out for all staff from minoritised ethnic backgrounds as a priority so that a personalised mitigation plan could be put in place for each member of staff.

118. Over half (51%) of the Child & Adolescent Faculty UK members are from minoritised ethnic backgrounds (Exhibit EL/75 - INQ000442281).

Personal protective equipment

119. Anecdotally, we have heard from staff that PPE availability was limited at the beginning of the pandemic. For example, when the first confirmed Covid-19 cases were appearing on CAMHS wards, one member reported there being centralised locations handing out single boxes containing PPE. However, as time went on, availability markedly improved.

Staffing

120. The reduction in bed numbers, referrals and contacts during the early stages of the pandemic and particularly the first lockdown – with fewer, often more unwell patients staying for longer periods of time – enabled CAMHS inpatient services to cope despite workforce and staffing pressures. However, the incremental increase in demand, with no appreciable reduction in acuity, that has been observed since has placed significant pressure on an already constrained CAMHS workforce. We have heard from members that, due to workforce issues, pre-pandemic levels of CAMHS bed availability have not returned, with workforce issues as the primary cause. Setting aside the uncertainty and existential angst that was present for CAMHS staff during pandemic, which is only possible with hindsight, working in CAMHS is, in many respects, more challenging now than during the relevant period.

121. The impact of Covid-19 itself on the CAMHS workforce was significant, with psychiatrists and other staff becoming unwell and having to take time away from work. There were also colleagues who died, and the toll this takes on colleagues and all those who knew them cannot be overstated.

122. We have heard from members that staff were also lost to carrying out interventions outside of the remit of their regular role, such as those aimed at deflecting attendance away from Emergency Departments ("EDs").

123. Staffing shortages were also an unintended consequence of staff shielding and isolating, although it should be noted that psychiatrists and other healthcare

professionals working in CAMHS who were shielding did support their colleagues in a variety of ways. Positive relationships and feelings of connectedness contribute to good health and wellbeing – with lockdown restrictions limiting social contact, both were inevitably affected by the pandemic, particularly for staff who were shielding.

124. Just as staffing was impacted by sickness, it was also impacted by family members of staff who were unwell well or poorly; shielding is likely to disproportionately affect women who are more likely to carry the burden of domestic and caring responsibilities, and who are also more at risk from factors like domestic violence which was also significantly increased following Covid-19.

125. CAMHS are predominantly staffed by woman. In fact, women make up 85% of the NHS CAMHS workforce (Exhibit EL/76 - INQ000442282). Women often carry the main share of caring responsibilities in their own lives and, as such, staff working in CAMHS during the pandemic were far more likely to be affected by the requirement to homeschool children, take care of family members who became unwell, and looking after elderly and frail relatives, all in addition to attempting to continue their clinical work. Many members working in CAMHS opted to reduce their workload, with many others choosing to leave the service altogether during, or in the aftermath of, the pandemic, compounding workforce constraints and placing further pressures on the service.

126. On 25 March 2020, RCPsych staff began modelling what a 20%, 40%, 60% and 80% staff absence rate would mean for community mental health, liaison mental health, and CYPMHS in England. Modelling was based on the state of play as of December 2019, which was the most recent data point for both the workforce and mental health services data set from NHSD. We used data from the MHSDS showing the number of people in contact with services as a proxy for patients in these staff absence ratios. Workforce data was broken down by specialties, where patient data was available, and by grade to allow, for example, for the reduction of foundation year one doctors, as we were aware that they were being transferred to the acute sector. Given the challenges around trust footprints, models were based on HEE regions. For child and adolescent psychiatry, modelling was based on the number of people in contact with CAMHS (235,706) as opposed to the number of 0- to 18-year-olds in contact with mental health services as a whole (368,398). There were 234.1 people in contact with CAMHS for

each psychiatrist working in such services. We found that there would be 292.6 patients per psychiatrist if 20% of staff were absent, 390.2 at 40%, 585.2 at 60% and 1,170.5 at 80%.

127. In England, the number of full-time equivalent child & adolescent psychiatrists at all grades stood at 994.8 at the end of March 2020, a decrease of 1.1% from the end of December 2019 (1,005.9). Between 31 March 2020 and 31 March 2021, the number of FTE child & adolescent psychiatrists at all grades working for NHS organisations increased by 6.7% to 1,061.1; this increasing trend was also seen for the same reporting period in later years, with 1,075.2 in March 2022 and 1,131.9 in March 2023. In relation to FTE child & adolescent psychiatry consultants, there was a decrease of 8.0 consultants (1.3%) from December 2019 (622.1 FTE) to March 2020 (614.1 FTE). In the year to March 2022, the number of child & adolescent psychiatrists remained very similar, with 632.1 FTE in March 2021 and 631.3 in March 2022; this was followed by a slight increase of 7.6 FTE child & adolescent psychiatry consultants in post in March 2023 (638.9 FTE), equivalent to an increase of 1.2%. (Exhibit EL/77 - INQ000442283)

128. In Wales, At the end of March 2021, there were 51.0 FTE child & adolescent psychiatrists at all grades, a slight reduction of 0.4% from 51.2 FTE at the end of December 2019 and a decrease of 2.3% from 52.2 FTE in the year prior. Following March 2021, the number of child & adolescent psychiatrists (all grades) in post increased year-on-year, with 53.8 FTE at the end of March 2022 (an increase of 5.5%) and 56.1 FTE in March 2023 (a further increase of 4.8%). For child & adolescent psychiatry consultants, the number of consultants has appeared to decrease each year, with the exception of March 2022; from 31 March 2020 to 31 March 2023, the number of child & adolescent consultant psychiatrists have decreased by 14.1% (4.8 FTE), from 34.0 FTE to 29.2 FTE. (Exhibit EL/78 - INQ000442284)

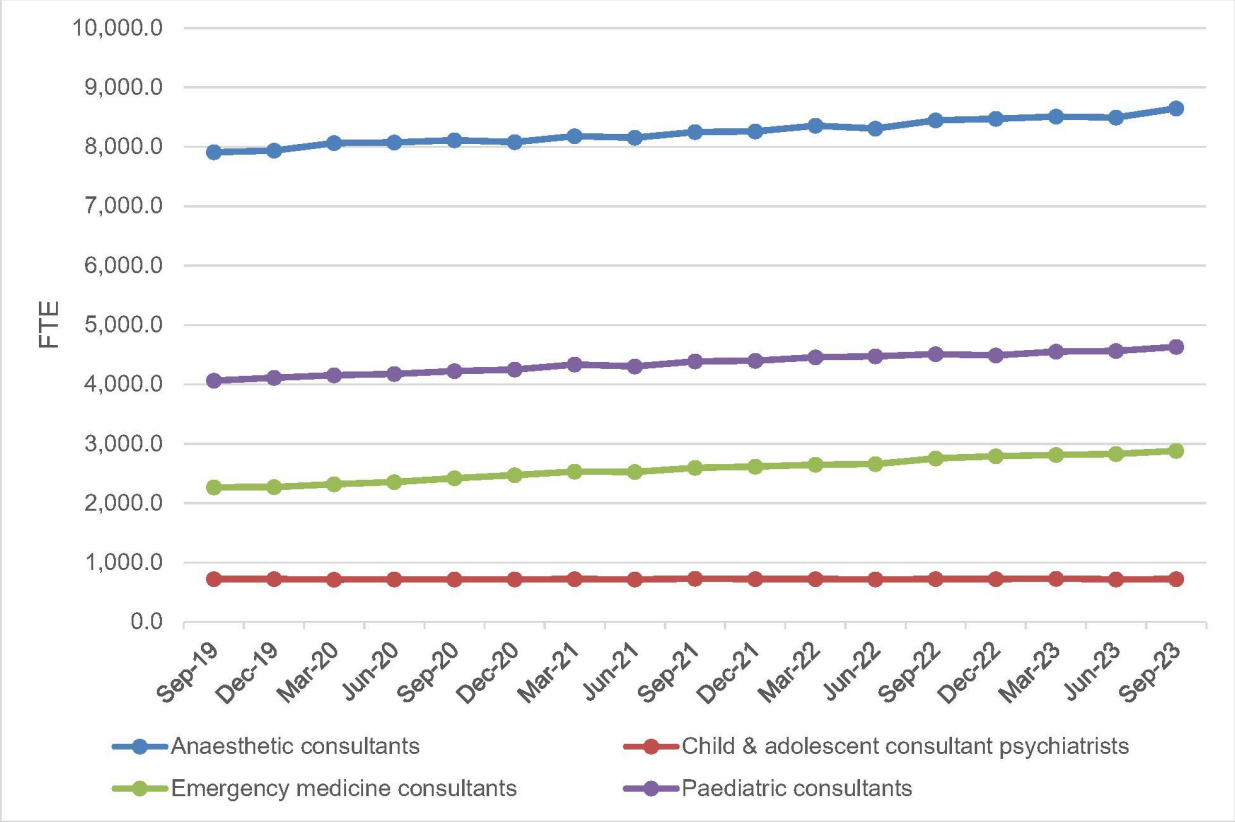
129. In Scotland, the number of whole-time equivalent (WTE) clinical staff working in CAMHS inpatient services was 5.0% higher at the end of March 2021 (176.9 WTE) in comparison with a year earlier in March 2020 (168.4 WTE). The number of WTE CAMHS inpatient staff appeared to fall in subsequent years, with 166.2 WTE in March 2020 (a drop of 6.0%) and 161.2 in March 2023 (a further decrease of 3.0%). There

were 215.7 WTE vacant CAMHS clinical staff posts advertised at the end of March 2022, which is a subsequent increase of 196.7% in vacancies since March 2021 (72.7 vacant posts). This figure fell in March 2023 to 159.2 vacant posts, a reduction of 26.2%. (Exhibit EL/79 - INQ000442285)

130. There were 111.3 WTE child & adolescent psychiatrists in post across NHS organisations in Scotland on 31 March 2020; this figure decreased by 3.1% to 107.9 WTE on 31 March 2021 and slightly dropped to 107.3 WTE at the end of March 2022. In the two years after the start of the Covid-19 pandemic, the number of child & adolescent consultant psychiatrists in post in Scotland fell by 7.6% (5.0 FTE) from 65.5 WTE in March 2020 to 60.5 WTE in March 2022. (Exhibit EL/80 - INQ000442286)

131. As of September 2023, there were 630.1 FTE consultant child & adolescent psychiatrists in post in England, 60.5 in Scotland and 33.0 in Wales across NHS organisations. Data is not published routinely in Northern Ireland. This is a total of 723.6 FTE consultants in post across NHS organisations in the UK (Exhibit EL/77 - INQ000442283) (Exhibit EL/78 - INQ000442284) (Exhibit EL/80 - INQ000442286). For consultant paediatricians, excluding paediatric surgery, paediatric cardiology and paediatric dentistry, there were 4,028.7 FTE consultants in England, 391.7 in Scotland and 211.5 in Wales. This is a total of 4,631.8 FTE consultants across those three nations, more than six times the number of child & adolescent consultant psychiatrists. In the same month, the number of emergency medicine consultants and anaesthetic consultants across England, Scotland and Wales were four times and twelve times greater than the number of child & adolescent consultant psychiatrists, with 2,881.7 FTE and 8,647.0 FTE respectively (please refer to Figure 11). (Exhibit EL/81 - INQ000442287) (Exhibit EL/82 - INQ000442283) (Exhibit EL/83 - INQ000442289)

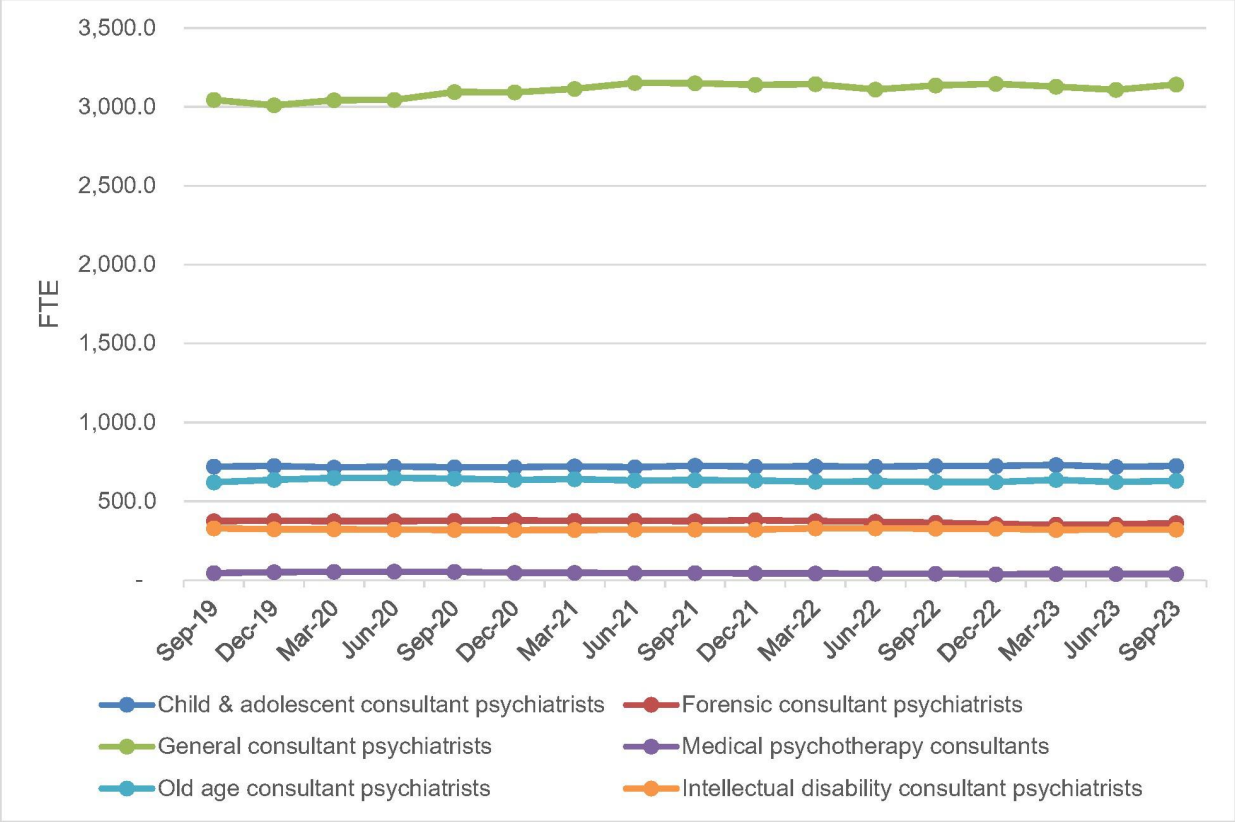
Figure 11: NHS FTE consultants by specialty, Great Britain, September 2019 to September 2023



132. Within psychiatry, the specialty with the highest FTE consultants in post across NHS organisations in the UK (excluding Northern Ireland) is general psychiatry, with 3,142.1 FTE consultants in post at the end of September 2023, more than four times the number of FTE child & adolescent consultant psychiatrists (723.6 FTE) (please refer to Figure 11) (Exhibit EL/84 - INQ000442290) (Exhibit EL/85 - INQ000442291) (Exhibit EL/86 - INQ000442292).

133. As reported in the 2023 RCPsych census, the consultant vacancy rate across the UK was 15.8%, up 6.5 percentage points from 9.3% in 2021. For child & adolescent psychiatry, 19.0% of consultant posts were vacant and 34.8% were vacant or filled with locum posts. (Exhibit EL/87 - INQ000442293)

Figure 12: NHS FTE consultant psychiatrists by psychiatric specialty, Great Britain, September 2019 to September 2023



Retirement

134. Some RCPsych members have Mental Health Officer ("MHO") status, which means they can retire from the age of 55 without a reduction to their benefits providing they are still in pensionable MHO employment on the day before they retire.

135. We have heard anecdotally from members that many CAMHS staff retired earlier than they otherwise might have done, due to additional pressures associated with the impact of the pandemic on the services they were working in, including from the rolling impact of lockdowns and the unrelenting pressure that followed.

136. More than half (57.2%) of child & adolescent specialist psychiatrists in the UK are aged between 45 and 59, under a quarter (24.3%) are aged 30 to 44, and 18.5% are aged 60 and over (Exhibit EL/88 - INQ000442294).

IT systems

137. While the move to digital appointments led to increased accessibility to a variety of technological platforms for many of our members and other healthcare professionals, we have also heard of frustrations from our members about the longstanding, unfit for purpose IT systems within the NHS. Rapidly switching to remote working and video conferencing was very challenging for many with poor connectivity, systems and hardware.

Research

138. A recent study, using data collected through the RCPsych Child and Adolescent Psychiatry Surveillance System (CAPSS), investigated the admissions of 290 young people to general adolescent mental health units far away from home, i.e. more than 50 miles away or in another NHS region, or to an adult mental health ward. From February 2021 to February 2022, 18% of 13–17-year-olds waited 7–10 days for a bed and over a fifth waited more than 10 days. The majority of these young people waited in general hospital settings (40% paediatric ward, 8% adult medical ward and 7% Emergency department) and 11% had to wait in Section 136 suites, normally located at an adult psychiatric hospital. (Exhibit EL/89 - INQ000442295)

139. Findings from NHS England's 2020 National Child Mortality Database programme summary report suggested that there were 26 likely child suicides during the 82 days before lockdown and a further 25 in the first 56 days of lockdown. Additionally, it also found that the proportion of cases under 15 years of age appeared higher, but that these differences did not reach statistical significance. In a similar proportion of pre-lockdown (33%) and post-lockdown (36%) cases, the child or young person was currently in contact with mental health or social care services. A diagnosis of autism spectrum disorder ("ASD") or attention-deficit hyperactivity disorder ("ADHD") had been recorded in six cases (25%) pre-lockdown and in six additional cases (24%) post-lockdown. Comparing 2020 with 2019 gave similar results: in 12 (48%) of the 25 post-lockdown deaths, factors related to Covid-19 or lockdown were thought to have contributed to the deaths. The report concluded that while there was a concerning signal that child suicide deaths may have increased during the first 56 days of

lockdown, the numbers were too small to reach definitive conclusions. The authors argued that, amongst the likely suicide deaths reported after lockdown, restriction to education and other activities, disruption to care and support services, tensions at home and isolation appeared to be contributing factors. Previous research has highlighted an increased suicide risk in autistic people, with a quarter of the likely suicides both pre- and post-lockdown were in autistic individuals or individuals with ADHD. Although the finding of increased risk is not confirmed statistically, it was important that clinicians and services were aware of the possible increase and the need for vigilance and support.

140. While pandemic and mitigation approaches, including lockdowns and school closures, are widely thought to have negatively impacted children and young people's mental health, the impact on those who have been clinically referred is less clear. In January 2023, some of our members published a Standardised Diagnostic Assessment ("STADIA") for children and young people with emotional difficulties in the European Child & Adolescent Psychiatry Journal ('Mental health in clinically referred children and young people before and during the Covid-19 pandemic'), which looked at the mental health of over 1,000 non-urgent, clinically referred children and young people. The study found that there were greater levels of mental health difficulties after these children and young people returned to school following lockdowns and school closures. The findings indicate that children and young people who had been clinically referred experienced higher levels of clinically significant difficulties after schools re-opened and thus may have had greater stresses in the adjustment period when re-starting school, in comparison with children who were not clinically referred.

141. There is an ongoing study demonstrating the possibility of delivering effective blended clinical services at the University of York. The national lead of the study is Professor Bernadka Dubicka, Chair of the RCPsych CAP Faculty during the pandemic. The trial will look at whether the mental health crisis affecting children and young people can be addressed through the delivery of low-cost interventions from junior mental health practitioners, with the idea being that fast-tracking training to allow newly qualified nurses and psychology graduates to provide treatments may help the NHS meet demand and address the rising levels of presentations for depression and anxiety in young people. In addition to examining whether interventions delivered by junior staff

are affected, researchers will also listen to young people's views on the benefits of online therapies in comparison to those carried out in person. The trial is recruiting over 500 participants across England, making it the largest of its kind to date.

142. During the relevant period, the RCPsych issued a range of press releases calling on the Government and relevant public agencies to implement measures to mitigate the impacts of the pandemic on children and young people, including those that were preexisting but exacerbated by the crisis. These press releases capture much of the research and analysis conducted by the RCPsych's staff and members over the course of the pandemic and include the following:

142.1. In September 2021, we presented new analysis by the College showing that 190,217 people aged 18 or younger had been referred to CAMHS between April and June 2021, up 134% on the same period the year before. We called on the then education secretary, Nadhim Zahawi MP, to make children and young people's mental health needs a top priority, including schools having plans in place to respond to pupils' mental health needs and investment in staff training to improve the roll-out of Mental Health Support Teams.

142.2. In April 2021, we warned that 400,000 children and 2.2 million adults had sought help for mental health problems one year after beginning of the pandemic. We said that the additional £500m (including £79m for children) promised for mental health needed to urgently reach frontline work to help tackle the crisis. We emphasised how children and young people were bearing the brunt of the mental health crisis created by the pandemic and were at risk of lifelong mental illness.

142.3. In February 2022, we said that years of funding cuts to youth addiction services and the pandemic were causing thousands of children and young people to fall through the cracks, and that spending on youth addiction services had fallen in real terms by £30.5m in the last eight years. The College welcomed the government's announcement of £780m in the new budget for drug treatment over the next three years.

142.4. In July 2022, we reported on a recent study which showed that emergency hospital visits for self-harm were twice as likely for boys, and three times as likely for looked-after children, compared with pre-pandemic levels, emphasising the importance of considering the impact of measures put in place during the pandemic on self-harm so that mental health services could plan for the future.

RCPsych Covid-19 Member Survey Results

143. The Royal College of Psychiatrists surveyed its membership on five occasions during the first year of the pandemic, with respondents able to select more than one specialty that they worked in if necessary or applicable. These surveys were in the field from 15–17 April 2020, 1–6 May 2020, 18–26 May 2020, 10–15 June 2020 and 1–9 September 2020 respectively.

144. Comprehensive analysis of these surveys, based on all respondents who indicated they worked in child and adolescent psychiatry at the time of the surveys being in the field, is attached as an appendix to this statement. Analysis of some particular results of note are included below.

145. 251 child and adolescent psychiatrists from across the UK responded to the first RCPsych members' survey from the corresponding period 15 to 17 April 2020. 52.2% respondents confirmed they were not currently working their normal job plan in mental health services, and 27.6% had needed to take time off from their normal job plan in mental health services during the pandemic to date.

146. 195 child and adolescent psychiatrists from across the UK responded to the second RCPsych members' survey from the corresponding period 1 to 6 May 2020. Once the 10 'not applicable/don't know' responses are excluded, only 20.0% confirmed they were 'fully equipped' to conduct their duties remotely, with a further 38.9% stating they were 'well equipped' and 'can do most tasks'. 21.1% felt 'unequipped' to do either 'some duties' (13.0%) or 'most/all duties' (8.1%). 48.2% confirmed their wellbeing had either 'suffered' (41.0%) or 'significantly suffered' (7.2%) during Covid-19 and the lockdown.

147. 134 child and adolescent psychiatrists from across the UK responded to the third RCPsych members' survey from the corresponding period 18 to 26 May 2020. 65.0% confirmed children and young people up to the age of 17 had been presenting in crisis more frequently in their services, while a mere 5.1% confirmed that young adults aged 18-25 were presenting in crisis more often over the past fortnight.

148. 82 child and adolescent psychiatrists from across the UK responded to the fourth RCPsych members' survey from the corresponding period 10 to 15 June 2020. This survey included two questions about the condition and suitability of the estates that psychiatrists were working in, as well as a section on the use of digital or remote consultations during the pandemic. Only 20.7% felt 'very positive' (4.9%) or 'positive' (15.9%) about the impact derived from the quality of buildings and estates in their organisation, compared to 46.3% who felt 'negative' (39.0%) or 'very negative' (7.3%). Once the not applicable answers are excluded, 38.6% of the remaining respondents felt their estates were 'suitable' for the co-horting of patients with confirmed or suspected Covid-19 compared to 45.6% who reported the estates were 'unsuitable' (31.6%) or 'very unsuitable' (14.0%) for this purpose. Once the four 'don't know' responses are excluded, 32.1% felt local services were 'very prepared' (3.8%) or 'prepared' (28.2%), compared to 47.4% who felt they were 'unprepared' (34.6%) or 'very unprepared' (12.8%).

149. In the fourth survey, members were also asked to respond on the quality of training provided to support the use of digital tools to conduct remote consultations and therapy sessions. 39.5% rated the training as 'very good' (8.6%) or 'good' (30.9%), while 25.9% rated it as 'poor' (23.5%) or 'very poor' (2.5%). Respondents were then asked the extent to which they agreed with the following statement: 'remote sessions are clinically appropriate and therapeutic'. 65.9% answered that they 'strongly agree' (11.0%) or 'agree' (54.9%), compared to just 11.0% who 'disagree'. When given three options to choose from for the future of care delivery they most strongly endorsed, 79.3% selected 'Following the pandemic, I would like to return to face-to-face consultations as default, but would like to have continued recourse to digital tools where appropriate', with 18.3% selecting 'Following the pandemic, I believe we should move to a new approach of using digital tools as default and only seeing patients face-to-face when completely

necessary'. Just 2.4% chose 'Following the pandemic, I would like things to return to exactly as they were.'

150. 101 child and adolescent psychiatrists from across the UK responded to the fifth RCPsych members' survey from the corresponding period 1 to 9 September 2020. Once 'not applicable' is excluded, almost half of respondents (48.4%) were conducting between 81-100% of their consultations remotely. A further 19.4% responded that they were conducting between 61-80% of consultations remotely and a mere 9.7% confirmed they were conducting 20% or fewer consultations remotely. Members were also asked how confident they were about 'gathering the right amount of information and reaching an appropriate clinical decision' through remote consultations. 47.5% were 'very confident' (8.9%) or 'confident' (38.6%), whereas 20.8% were 'unconfident' (18.8%) or 'very unconfident' (2.0%). Once 'not applicable' is excluded, 64.5% felt some of their patients were subject to digital exclusion. Those members were asked to estimate the proportion of their caseload that this affected. While 57.6% of that group reported the proportion as 1 in 5 or fewer, 15.3% reported the proportion as 31% or more.

Recommendations

151. **The Government must provide investment in mental health services that is proportionate to the level of demand for mental health services, and the NHS and its ICBs need to ensure that children and young people mental health spend increases as a proportion of mental health spend, with funding reaching the frontline**. The proportion of overall health spend on mental health services is not commensurate with, or proportionate to, the level of demand that mental health, learning disability and autism services are experiencing, nor is the proportion of mental health spend allocated to CAMHS proportionate to the level of mental health need in this population, with spend for children and young people's eating disorder services in particular not sufficient to meet demand. In England, almost a third (32.7%) of people in contact with mental health services in March 2022 were children and young people, while only 7.8% of the total spend for ICB mental health services in real terms was invested in children and young people's mental health services in 2021/22; and in Wales, 29.2% of referrals to mental health services in March 2022 were for child &

adolescent psychiatry services, however, only 9.5% of the mental health budget in cash terms went towards CAMHS in 2021/22. In the most recent spending data for Scotland, only 8.8% of mental health spend in real terms was invested in CAMHS in 2022/23.

152. **DHSC and NHSE should continue the Mental Health Investment Standard to ensure that every ICB invests an increasing proportion of its spending on mental health services, and maintain the NHS Long Term Plan commitment that an even greater proportion is invested year-on-year on support for children and young people**.

153. **The UK Government should commit to a real terms increase in the Public Health Grant budget as part of a multi-year settlement**. This will ensure local authorities can continue to restore total expenditure for specialist drug and alcohol use disorder services for children and young people. The social care budget for children, young people and adults needs to be increased, with a ring-fence for early years funding.

154. **Devolved Governments should ring fence and direct any Barnett Consequentials arising from increased UK Government mental health funding for their own mental health services**. The Scottish Government, for example, received a total of £14.564 billion in Barnett Consequentials from the UK Government in respect of the Covid-19 response; £9.752 billion in 2020-21 and a further £4.812 billion in 2021-22 (Exhibit EL/90 - INQ000442296).

155. **In planning for another pandemic, or similar event, guidance for CAMHS inpatient admission must be prepared.** Guidance should set out how, at different stages of such an event, a balance is struck between:

155.1. a higher inpatient admission threshold for the purposes of preventing infection spread and limiting the number of children placed under additional restrictions; and

155.2. ensuring all children and young people receive mental healthcare that is safe, appropriate, timely and therapeutic..

156. **In planning for another pandemic, or similar event, advanced consideration must be given to, with planning and guidance prepared for, keeping schools, other educational settings and specialist support facilities open for as long as is safe and practicable to do so.** Schools are an important source of support, offering children and young people the opportunity to engage with friends and trusted adults and their closure during the pandemic has had a profound and detrimental impact on many children. It is often people in schools and the community who identify young people who may be struggling; the initial decrease and subsequent increase in demand for CAMHS may be in part due to school closures and restrictions around social activities, as these would have made it difficult to identify those who were in need of care, making the development of, and exacerbation of existing, mental health conditions were less likely to be picked up on. Similarly, the closure of specialist support facilities for children with intellectual disabilities only compounded the disadvantage faced by this group and, with children and young people's intellectual disability education services not being provided in special schools, families struggled to care for their children safely at home.

157. **The NHS should prepare messaging for a future pandemic, or similar incident, on the NHS remaining open for those with a mental illness, including for children and young people in particular.** While NHSE successfully launched its '*Help us help you*' campaign in May 2020, which included messages about the NHS being open for those with a mental illness, starting this earlier might have helped to avoid the significant drop off in presentations of children and young people to mental health services via A&E, primary care, and schools.

158. **Should another pandemic or similar emergency level event occur, children and young people in mental health, learning disability and autism settings must be at the forefront of considerations when guidance is first drafted.** Any guidance must include age-appropriate language for young patients and be clear about what to do in situations where patients cannot understand the need to social distance, including, for example, young children and those with intellectual disabilities. This will better ensure that children and young people have continued access to mental health

services, and that local partners understand referral routes, particularly in a situation where children and young people are not at school.

159. **Researchers should seek to understand the efficacy of the therapeutic relationship for patients in both digital and telephone formats.** This research should have a particular focus on children and young people's experiences of therapy, as well as the impact of these treatments on concordance with medication and ongoing reviews.

160. **The UK Government must implement reforms to mental health and capacity legislation to ensure adequate and transparent access to mental health treatment for children and young people**. When a young person is admitted to inpatient care, mental health legislation provides a level of protection that is not otherwise afforded under informal, voluntary admission, bringing a degree of rigour, scrutiny and transparency to their admission.

161. **The UK Government and Devolved Governments must invest in the retention and recruitment of the psychiatric workforce to ensure that the child and adolescent psychiatric workforce receives funding commensurate to the level of mental health need in the population they serve.** CAMHS were not staffed or resourced sufficiently to meet the level of mental health need in the population during the pandemic, and demand has only increased since. National funding should be made available to support psychiatrists with continuing professional development ("CPD"), as is already the case for nurses and midwives for example. SAS doctors should have support to become educators. Consultants and SAS doctors must also have time in their job plans to deliver training.

162. **The Government should allocate further investment to the rollout of Early Support Hubs to establish them in every local authority in England and expand their remit to include younger children**. The Children and Young People's Mental Health Coalition estimation that an additional £125-£205m is required to establish these hubs in every local authority, with running costs of between £114 to £134.5 million per annum. The £5 million announced in October 2023 to improve access to ten existing Early Support Hubs across England for children and young people aged between 11-

25 years, and the recent announcement of an additional £3 million to expand the support to a further 14 hubs across the country, is a positive step and will improve timely access to mental health support, but a longer term, sustainable funding commitment is needed.

163. **The Government should increase investment in staff training to accelerate the rollout of Mental Health Support Teams in schools in England, committing funding for the period beyond 2023/24 to ensure all educational settings have clear plans in place to respond to pupils' mental health needs.** Welcome progress has been made in establishing Mental Health Support Teams in schools, with 398 operational teams covering 35% of pupils as at spring 2023. 500 teams are expected to be operational by April 2024 and 50% of pupils in England are expected to be covered by March 2025. It is important that operational teams cover every primary and secondary school, with sufficient resourcing and training to provide additional support to children and young people with complex mental health needs.

164. **The Government should ensure that Early Support Hubs and Mental Health Support Teams are able to refer children and young people on to well-staffed specialist services when necessary**. Early Support Hubs and Mental Health Support Teams are not a substitute for investment in specialist mental health services. As such, these services must be robustly connected with CAMHS.

165. **Government across the four nations of the UK to prioritise the mental health of under 5s through the delivery of a cross-government strategy with designated ministerial responsibility.** This should be accompanied by an implementation plan which is underpinned by appropriate funding to meet the scale of need, and a multi-agency workforce capacity and training strategy.

166. **Regular prevalence surveys should be commissioned for children and young people.** It is particularly important that any routine, regular government-funded prevalence surveys on the mental health and wellbeing of children and young people collect prevalence data on under 5s and their families, as well on the prevalence of severe mental illness in young people more broadly. This will inform regular assessment of the public mental health implementation gap, including for higher risk

groups, in order to monitor progress towards agreed coverage targets and outcomes. It will also allow for better understanding on the scale of mental health need in the population and on which interventions require a greater proportion of investment.

167. **The Government should commit to guaranteeing access to a range of universal, targeted and specialist services in every area, tailored to specific age groups from conception to 5 years.** These services will be provided by different sectors that can deliver evidence-based interventions to promote wellbeing and resilience, prevent mental health conditions and associated impacts, and treat mental health conditions at the earliest opportunity, proportionately targeting higher risk groups.

168. **Government and multi-agency stakeholders to transparently agree on the level of population coverage of different public mental health interventions for children and young people.** This is particularly important for age groups that often fall through the cracks of specialist provision, namely infants and children under the age of 5 years, and young people between the ages of 18 and 25 years. Stakeholders should include children and young people, parents/carers, primary care, secondary care, secondary mental health care, social care, health and social care leaders, early years childcare, preschool and primary schools, public health, voluntary sectors and government. When agreeing level of coverage, stakeholders should consider the mental health impact and economic cost of implementation failure; the broad impacts and associated economic benefits of improved coverage; the statutory duty to protect children and families and prevent harm under the respective children, families, education and equality legislation in the four nations of the UK; and the UN SDG target of universal health coverage which includes parents and children under 5 years of age.

169. **The Government should invest in high impact, evidence-based public mental health interventions to catch behaviours indicating a neurodevelopmental condition or a developing mental health condition at the earliest possible stage.** Investment should be in line with an agreed level of population coverage for different public mental health interventions for children and young people.

170. **Mental health services should ensure that young people transitioning between specialist CAMHS and adult provision are offered developmentally appropriate and holistic care**. Staff with different expertise and approaches should be enabled to provide proper support. Variances between CAMHS and adult services need to be identified and the needs of young people considered when models are developed and implemented to ensure seamless care, no matter the speciality or severity of mental illness.

171. **The UK Government, as a matter of urgency, should provide the necessary investment in the mental health workforce to deliver both the ADHD and autism diagnostic pathways, reduce waiting times and provide support and treatment if required**. Funding is required for both new posts and education and training, while also supporting retention and development among existing staff in these services.

172. **Researchers should seek to understand the impact of Covid-19 on levels of self-harm, suicidal ideation and suicide among children and young people.** This will allow the UK Government and Devolved Governments, public agencies and arms length bodies to take mitigating action to ensure that appropriate support is available.

173. **Mental health employer organisations across the UK should address racism and discrimination in NHS workplaces by implementing worthwhile actions such as those set out in the RCPsych Tackling Racism in the Workplace guidance.** In England, mental health employer organisations should also implement actions from the NHS equality, diversity and inclusion (EDI) improvement plan. The risk to healthcare workers from minoritised ethnic groups becoming unwell and dying while working in mental health, intellectual disability and autism settings during the pandemic was not satisfactorily mitigated. Addressing racism and discrimination in the workplace should be recognised as central to retention, as well as to recruitment. The NHS must be supported to create a more diverse representative workforce that reflects the populations it serves, ensuring that data on the diversity of the workforce is shared routinely and publicly; this is especially important given the well-evidenced discrepancies in experiences of people from racialised communities, and it is a core element of the Patient and Carer Race Equality Framework ("PCREF").

174. **Forecasts should be developed for growing workforce specialties such as psychiatry, broken down by specialty, including for child and adolescent psychiatry.** Forecasts would better incentivise growth and help track progress and demand. We note that there is a mental health workforce review in Northern Ireland and recommend that funding be provided in line with the mental health strategy.

175. **The UK Government and Devolved Governments should fund mental health and wellbeing initiatives that have demonstrated effectiveness.** It is important that there a commitment to provide all mental healthcare staff with access to comprehensive mental health support, not simply 'wellbeing support.' We note that Northern Ireland has a 10 year mental health strategy and recommend that funding be provided to support its implementation.

176. **The UK Government and Devolved Governments must invest in improving working environments and support for staff, including essential improvements to digital infrastructure.** There must be a focus on retaining the workforce by improving working environments and support. All staff need to be able to access working technology and have adequate space to carry out daily duties, including confidential consultations and admin support. We note that Northern Ireland has a 10 year mental health strategy and recommend that funding be provided to support its implementation.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: Personal Data

Dated: 24.04.2024