Witness Name: Dr Sarah Hughes
Statement No.: 1
Exhibits: 44
Dated: 22 May 2024

UK COVID-19 INQUIRY

WITNESS STATEMENT OF DR SARAH HUGHES, MIND

I, Dr Sarah Hughes, will say as follows: -

1. I am the Chief Executive Officer of Mind (the National Association for Mental Health charity no: 219830). I make this statement in response to the Request for Evidence by the Chair of the UK Covid-19 Public Inquiry under Rule 9 of the Inquiry Rules 2006 (reference M3/MIND/01). This statement is intended to address matters within the scope of Module 3 of the Inquiry.

2. I have held the role of CEO at Mind since January 2023. I have over 30 years of experience in mental health and social care. I originally joined Mind in 2004 as Chief Executive of Cambridgeshire, Peterborough and South Lincolnshire Mind, a role I held for 12 years before becoming CEO of The Centre for Mental Health. I previously trained and qualified as a social worker.

3. Although I was not employed by Mind between March 2020 and June 2022 ('the relevant period'), I was actively involved in coordinating the mental health sector's response to the Covid-19 pandemic as Chief Executive of the Centre for Mental Health. This witness statement has been prepared with the assistance of colleagues from Mind's policy and campaign's team and Mind's legal advice service 'Connect Assist'. I am grateful for the opportunity to address matters pertaining to the impact of the pandemic on children and young people's mental health services (CYPMHS) in my statement, as requested by the Inquiry.

About Mind

4. Mind is the leading mental health charity in England and Wales, with national offices in London and Cardiff (Mind Cymru) where over 500 staff are employed. Mind does not operate in Scotland or Northern Ireland. Our mission is to give advice and support to empower everyone experiencing a mental health problem. This ranges from those seeking someone to talk to, to people who suffer from lifelong and serious mental health problems that may lead them to be detained under the Mental Health Act 1983.

5. We enact our mission through a variety of front-line services; information and advice, policy influencing and public campaigns, and by operating a legal team that intervenes in cases that can affect our beneficiaries.

6. We operate four staffed helplines dealing with welfare benefits, emotional support, general information about available mental health assistance and legal advice. We only provide information and advice through our helplines to young people aged over 18 and adults aged 25 and over. In 2022-23, Mind's helplines responded to approximately 131,000 queries. In 2021-22 and 2020-21, Mind responded to c118,000 queries through our helplines. In 2019-20 Mind's helplines responded to 119,000 queries. We also provide comprehensive information on our website - our online information pages were accessed 23.3 million times in 2022-23; 21.4 million times in 2021-22; 20.7 million times in 2020-21 and in 2019-20 the figure was 18 million. In the first week of the coronavirus lockdown, there were 306,192 visits to our coronavirus support pages.

7. Mind runs a network of 104 affiliated 'local Minds' across England and Wales that provide frontline support to people experiencing mental health problems; including support with counselling, employment and benefits advice, supported housing and advocacy services in hospital and community settings. Some of these services are commissioned by the NHS or local authorities. In 2022-23, our local Mind associations provided mental health services to around 470,000

individuals which made Mind the largest mental health provider after the NHS. During the relevant period, our local Minds supported almost 850,000 people in total - 406,000 people in 2020-21 and 443,000 people in 2021-22.

8. Mind is committed to campaigning for accessible, effective and accountable mental health services across England and Wales. We gather data from our helplines, local Minds and lived experience volunteers to inform our work. These multiple sources of information provide the basis for our policy and campaigning work, such as our recent campaign to 'Raise the Standard' of inpatient mental healthcare services, which I believe are currently not meeting the basics of being safe or therapeutic.

9. Mind has three strategic development priorities which are (1) supporting those in poverty, (2) tackling the endemic racism in the mental health system and (3) fighting to ensure that all young people have prompt access to mental health support. In our literature, we refer to 'young people' as those aged from 11 and up to 25 years. Any reference to 'children' in our literature and in this statement should be taken to mean those aged under 18. Our advice services commonly hear from young people aged over 18 who are being assessed for detention or being discharged under the Mental Health Act 1983. We receive frequent calls from young people aged over 18 who say they feel misunderstood and ignored by professionals during the assessment process, highlighting the urgent need for a stronger focus on patient autonomy to improve mental health services. Such accounts are especially concerning when data shows that today, one in five young people have a mental health problem compared with one in nine in 2017 (SH/01, INQ000478214). Services available through schools and the NHS simply cannot cope with this rising demand for mental health treatment.

10. Mind has a long history of engagement in mental health law reform, including sitting on the advisory panel for the Independent Review of the Mental Health Act, responding to the Mental Health Act White Paper (April 2021) and providing written and oral evidence to the Pre-Legislative Scrutiny Committee (September 2022), including evidence from young people about the importance of listening to

and empowering patients undergoing assessments under the Mental Health Act, which I detail at [23] and [79].

Providing information and advice to children and young people during the pandemic

11. Mind provided information, advice and support to children and young people (CYP) to address their mental health needs during the pandemic. This included providing Covid-19 specific information and advice for CYP on our website and in print (alongside our standard legal rights guides for 11- to 18-year-olds), covering topics such as 'rights in hospital' and 'advocating for yourself'. Over the relevant period, our Covid-19 information received a total of 3,214,410 views, with information specific for young people being accessed 128,831 times. On 2 August 2023, Mind provided the Inquiry with a summary of our research on children and young people's inpatient care during the pandemic, and I include this research within this witness statement.

12. During the relevant period, members of Mind's Youth Voice Network (YVN)[1] co-produced separate mental health information for young people and spoke to the Department for Education. The YVN recommended that early interventions in schools and community settings should be a campaigning priority for Mind. Members of the YVN spoke at a conference titled '*Transforming mental health in schools and colleges: the impact of COVID-19*', which was organised with the Royal Society of Medicine and attended by MPs, policy makers and professionals working with young people (SH/02, INQ000471271). The webinars looked at the impact of Covid-19 on mental health in schools and on the mental health of teachers and children from racialised communities.

Mind's research into the pandemic's impact on young people's mental health

[1] Mind's Youth Voice Network was established in January 2020 for young people aged 11-24 years living in England and Wales to help guide and drive Mind's work. In the relevant period the network had c3000 members.

13. Mind carried out its own research during the pandemic and produced a report titled *'The mental health emergency: how has the coronavirus pandemic impacted our mental health'* (2020) (SH/03, INQ000471282), to better understand the experiences of people with mental health problems during lockdown as people lost their support networks overnight. We looked at those who had existing mental health problems and the general population. We wanted to gain insight into how people were coping with the exceptionally challenging and uncertain times they found themselves in, and in turn this was to inform us how best to advise and support those people. We conducted in-depth interviews with our lived experience volunteers discussing their experiences during the lockdown period and surveyed 1,917 young people aged 13-24 years between April and June 2020.

14. Overall, more than 16,000 people from England and Wales shared their experiences as part of this research. We learned that many people who were previously well, developed mental health problems, and existing mental health problems worsened. It is well established that protected characteristics and socio-economic disadvantages have an impact on both the incidence of mental illness and prognosis and outcomes. Our research showed that women, disabled people, people living in social housing and frontline workers had disproportionately deteriorating mental health.

15. Our key findings in relation to young people who responded to the 'Young People's Coronavirus Survey' that informed our report (SH/04, INQ000471293) were:

    a. Over two thirds of young people with pre-existing mental health problems said their mental health had got worse during the first national lockdown, and 46.6% of young people we surveyed said their mental health was poor or very poor at that time (see exhibit SH/04, INQ000471293 for our full findings).
    b. One of the key factors driving experiences of poor mental health among young people was the loss of support networks; with over two thirds of young people saying it worsened their mental health. Further, young

people reported that not being able to go outside (affecting 72% of young people), not being able to go to school or work (68.4%), and concerns about the health of family and friends (62%) also contributed to their poor mental health. Young people aged 18-24 years were most likely to have loneliness affect their mental health compared with young people aged 13-17 and adults over 25.

c. Our findings also show young people were most likely to find it difficult to access mental health support and were least likely to feel comfortable getting support over the phone or video-call, compared with adults over 25. Almost a quarter of all CYP surveyed did not feel their struggles warranted getting support for their mental health during lockdown, and some CYP who did try to access support faced multiple difficulties getting in contact with mental health services such as services not running and cancelled appointments. As I reference later in this statement, we have other findings from research showing the extent of young people's negative experiences of remote assessments as it became widespread during the pandemic, with issues of rapport building and privacy being particularly very difficult, which we highlighted in a recent High Court case that Mind intervened in; *Derbyshire NHS Trust v SSHSC* [2023] EWHC 3182 (Admin) which outlawed the use of remote assessments for certain parts of the Mental Health Act 1983.

d. Further, young people were the most likely to use negative coping mechanisms, with 31% reporting self-harming to cope with lockdown restrictions, making them more than twice as likely to have coped by self-harming than adults over 25.

16. For our follow-up research in 2021, we set out to understand the ongoing impact of the pandemic on people's mental health. We heard from 12,000 people in England and Wales with mental health problems between March and May 2021, of whom 1,756 were young people aged 13-24 years. Including from voices that are often underrepresented in research, such as young people from rural areas and young people living in poverty; 15% of all young people surveyed were receiving free school meals. Young people from racialised communities made up 12% of the young people surveyed. We published our findings in '*Coronavirus:*

the consequences for mental health' report (2021), showing that 91% of young people who responded to our survey had experienced mental distress or accessed mental health services. We found the decline in people's mental health had become more severe one year later, with over half of young people saying their mental health had got much worse since the first national lockdown. Around one in five of the young people we surveyed accessed mental health services for the first time during the pandemic (SH/05, INQ000471299).

17. Similar to findings from research in 2020, we saw that nearly nine in ten (88%) young people reported that loneliness caused by the lockdown worsened their mental health (SH/06, INQ000471300). Young people struggled with limited private space at home and restrictions from seeing friends and family. Despite this clear need for mental health support, 42% of the young people who accessed mental health services told us they had to wait several months to get support. We saw mental health inequities being reinforced, with the economic consequences of the pandemic falling hardest on people who were struggling financially before the first lockdown. Our findings show that people receiving benefits were most likely to see a decline in their mental health. We saw again that young people were most likely to use self-harming and under- or over- eating to cope with the pandemic, including dealing with the closure of sporting and leisure venues.

18. What would help to ensure the inequalities exposed by the pandemic don't continue to disadvantage young people is the UK Government ensuring people can access the right support when they need it. Young people told us they want to see more self-referral options to mental health services, more information and education about mental health in school, college, university or work and more accessible counselling in person.

19. In June 2021, we launched '*Not making the grade: why our approach to mental health at secondary school is failing young people*' – Mind's report into mental health in secondary schools (SH/07, INQ000471301). Based on the insights of 2,800 young people, parents and school staff, the report paints a bleak picture; demonstrating that pupil behaviour in school was a common response to

underlying mental health conditions, often rooted in negative traumatic experiences in their personal life. Several of these trauma-related symptoms have contributed to the inability of some young people to concentrate for long periods, follow instructions or engage with their learning, however schools continue to dismiss this as 'bad behaviour' rather than addressing the underlying mental health causes. We identified that racist and ableist practices in schools are also key drivers and maintainers of poor mental health. Our report sets out a series of recommendations on how to provide better support. We also joined with partners to call for early support hubs for 11 to 24-year-olds across England and Wales. Through our 'Whole School Approach to Mental Health', local Minds reached over 10,000 young people in 14 schools.

20. Mind, alongside partners from the Children and Young People's Coalition, has long campaigned for a CYP 'hub model' of service delivery (SH/08, INQ000471302). As I indicated at [19], currently when young people need support for their wellbeing and mental health, services available through their school and NHS simply do not offer it in time, as they cannot cope with the level of need. It is difficult to get a referral for mental health support, and once young people are referred, they may be stuck for many months on waiting lists. Mind's view is that early support hubs provide easy access to mental health support to any young person who needs it, in their local area without an appointment or referral, which would give people the help they need earlier.

Inpatient CYP mental health services during the pandemic

21. Data from NHS Digital shows that the number of young people in contact with CYPMHS has roughly tripled in the five and a half years between January 2016 and June 2021. In June 2021 alone, around 340,000 children and young people were in contact with CYPMHS - the highest figure up until that point (SH/09A, INQ000478222 (pg3)); compared with c105,000 in January 2016 (SH/09B, INQ000478218 **(pg2**)). See page 6 of exhibit SH09/C; INQ000478219, for a visualisation of the drastic increase of young people in contact with CYPMHS in England. Despite this the NHS is far from meeting the needs of young people, due to the challenge posed by long waiting lists and high thresholds to access

specialist CYPMHS among many other issues that I reference throughout this statement.

22. Between April and May 2022[2], Mind surveyed 403 young people aged 14 to 25 who were admitted to hospital in England and Wales for their mental health when they were under 18. Further, between January and June 2022, we ran co-production sessions, focus groups and interviews with 25 young people who were (i) care experienced, (ii) identified as having Black or Black British heritage, or (iii) aged under 16 with experience of being admitted to inpatient units. All experiences reported pre-date June 2022. We wanted our research to be shaped by young people, and to identify areas of reform that Mind should focus on. We published our findings in Mind's report '*Our Rights, Our Voices: Young People's views of fixing the Mental Health Act and inpatient care*' (May 2023) (SH/10, INQ000478215) outlining serious failings in hospitals that placed young people at risk of harm; for example, being routinely placed in adult wards far away from home, lack of appropriately trained staff, not given adequate information about their rights, and being unnecessarily medicated and placed in restraints (with young autistic people being particularly affected by this). Most young people (69%) told us their experiences of inpatient care were poor and consisted of multiple admissions; 45% were sectioned five times or more. Young people enter hospital at a very vulnerable point in their lives, so it is very concerning to hear they are not getting the care and support they need at a critical time.Young people and social workers told us that the practice of discharge from services and placement without appropriate support or communication became more acute at the height of the pandemic, a dangerous practice that greatly increased distress and risk of harm; see paras 60 and 61.

23. Over 80% of young people we surveyed wanted more say in decisions about their care and treatment plans, saying they felt "bypassed" and "disempowered"

[2] We note that the original draft of the report published on Mind's website incorrectly states that the survey opened in June 2022 when the survey in fact ran from April to May 2022. We have updated the report to reflect this.

in their own care. Our report highlighted more areas of concern in CYPMHS, including:

a. Too many young people being placed inappropriately on adult wards. Guidelines say young people must only be admitted to adult wards in exceptional circumstances, but there's data from the CQC showing a 32% rise in the number of under 18s being admitted to adult wards between 2020 to 2022 due to the lack of "alternative mental health inpatient or outreach service available for young people" (SH/11, INQ000442280).
b. Too many out of area placements: young people are still being placed in hospitals far from home despite the UK Government saying they would stop placing under 18s 'out of area' by 2020/21, see page 12 in 'Our Rights, Our Voices' report. Such placements can result in young people getting further harmed and traumatised, and in some cases, dying; for example, the out of area placement of Lauren Elizabeth Bridges was listed in her coroner's report as contributing to the deterioration in her mental health that led to her death at Priory Hospital in February 2022 (SH/12, INQ000478216).
c. The disproportionate sectioning of Black young people, who are overrepresented in acute inpatient services, making up over a third of all young patients sectioned despite representing only 11% of that population. These young people face the double whammy of racism and discrimination due to having mental health conditions.
d. Subjecting young people in hospital to excessive restrictions: many of the young people we spoke to said they were routinely subjected to restrictions over phone and internet use, use of outdoor spaces and visiting times. Mind has raised concerns about the issue of cameras in bedrooms (SH/13, INQ000471264).
e. Lack of appropriate support in the community: many young people told us they want their care to be met in community settings, eliminating the need for admission to inpatient units. Mind has called on the UK Government to expand community provision to accommodate more young people with complex needs who are often left in unsuitable and unregulated social care accommodation. One young person shared: *"Use of sectioning for young people with autism or similar learning difficulties needs to change.*

It did more harm than good. It kept me alive, but it wasn't an appropriate place for me to be. The alarms, the banging, the screaming and restraints are absolutely awful for anyone to go through – but especially a young person with autism. The staff need more training on autism and special needs, and the system desperately needs changing." [emphasis added]

24. Mind's view is that CYPMH inpatient units are failing and putting young people at risk. Some units are failing so badly that patients have died, which I detail and reflect on more fully at [25-26] and [47-49]. Mental health units should be safe places where professionals can assess and help vulnerable people, not places where repeated failures can lead to fatal consequences. It is deeply worrying that families are being let down by a system that is supposed to protect their loved ones when they are most sick.

Supporting young people in hospital during the pandemic

25. Many of the young people we spoke to between January and July 2022 told us it is vitally important to access independent support in hospital. Mind has called for the Mental Health Act to be reformed to ensure that all inpatients can access advocacy, and children should be offered one without needing to ask. We asked local Mind Independent Mental Health Advocates (IMHAs) in England and Wales who supported young people to understand their legal rights when sectioned about their experiences of working during the relevant period. Ten Mind mental health and mental capacity advocates told us their mental health worsened during 2020-21; they experienced anxiety, stress, exhaustion and burnout. Causing most impact to their mental health were 'feeling bad for young people isolated on wards', 'feeling isolated while home working', 'frustration with service provision', 'working long hours' and 'staff shortages'.

"I and the rest of my team suffered through the [p]andemic not only [at] a personal level but on a client level either not being able to support them as we should be doing or watching them die with little intervention in the first wave. As a [Relevant Person's Representative] I lost 23 clients in the first wave. These are

people I had worked with for many years; I had lost 40 clients by December 2020. I had a burn out and was off work for some time due to the stress of the [j]ob the pandemic had caused and the ways of working we were under. I felt shame as those I classed as front line, Doctors and nurses were struggling and I had fallen unable to help." (local Mind advocate supporting mental health patients in care homes)

26. Two thirds of advocates whose mental health worsened during the relevant period told us they were unable to access mental health services during that time. One advocate shared ***"On the wards/units we witnessed NHS staff overwhelmed and undervalued leading to long term sickness and staff shortages, agency staff in situ are better able to [choose] what work they take therefore creating further shortages in other areas. Due to burnout/overwhelmed/unprotected and lack of support remaining staff struggled to maintain their own wellbeing and behaviours and we have seen an increase on staff on patient assault reports or complaints that these have been raised with ward staff and ignored."*** [added emphasis]

27. In relation to concerns about patient care during the relevant period, most IMHAs said they were most concerned with the lower quality standard of service provided to inpatients due in part to staff shortages and limited access to personal protective equipment (PPE). The lower quality standard of care observed in CYPMHS during the relevant period is especially concerning in a population already facing a substantially reduced life expectancy - up to 15-20 years of potentially lost life than the general population – due to often suffering poor physical health related to the consequences of certain treatments for their mental health. The legacy of one of the greatest health equality gaps in England and Wales persisted during the pandemic, prompting the NHS to produce guidance on improving the health of adults living with severe mental illness.

28. Half of the IMHAs said they were furloughed during most of 2020, then had to work remotely to offer support by phone and video-call before returning to services in late 2020. One IMHA based in Rochdale and District Mind shared her experience of providing advocacy in CYP inpatient units during 2020-21:

"[Y]oung people, especially with eating disorders, said they were able to hide their issues better when doing only virtual visits with their community workers, so therefore they were past crisis point when they finally got admitted. Others struggled with things when lockdown ended and things opened up again and led to admissions onto the unit.

The other big impact was young people having to isolate in their rooms when first admitted onto the ward while awaiting their covid result and if tested positive had to remain in their rooms for nearly 2 weeks. This was so difficult for young people in crisis and made support on ward much harder, which impacted on their mental health."

29. Advocates also observed during therapy sessions that the lack of access to support networks during lockdown was badly affecting young people, telling us "*it became clear the impact of not going to school and not seeing friends had set children back in their education and general life skills and resilience*".

Impact of visiting restrictions on young people

30. NHS Wales announced a national suspension of all hospital visits on 25 March 2020. NHS England (NHSE) followed suit on 8 April 2020. While NHS Wales allowed safe visits to hospitals to commence on 20 July 2020, it wasn't until 22 September 2020 that NHSE and NHS Improvement instructed providers to take all steps possible to enable safe regular visits to all hospital and mental health services including inpatient CYPMHS The Children's Commissioner Anne Longfield found that 71% of wards in mental health hospitals stopped visits from families for at least some of the lockdown period during 2020-21 (SH/14 INQ000231349). It does not appear that there was ever an equitable assessment of the risks posed by stopping visits altogether balanced against the risks of contracting and dying from Covid. In 2022-23, Mind made Freedom of Information (FOI) requests to 36 NHS mental health trusts in England and seven NHS health boards in Wales asking about visiting restrictions. All 24 respondents told us they introduced restrictions on visits during the relevant period. In general, visiting was restricted or totally banned during national lockdowns (up to December 2021) and during Covid-19 outbreaks (SH/15, INQ000471266). When visits resumed with social distancing rules in place, young people struggled to

adjust; one child shared how hard it was that "everyone else can hug their parents, but I can't."

31. Mind asked mental health trusts and boards if "any policies or rules for visits var[ied] for different age groups and groups of patients". Twenty-four responded to this question, with 10 making exceptions or having a separate policy for young patients, for instance, a Health Board in Wales said they did not vary the policy, but a NHS Trust in England said, "visiting was generic". I find the variation in approach for how visits were allowed concerning as it means many young patients were deprived of visits, despite young people being particularly vulnerable to the negative effects of stopping visits. Some trusts recognised this, such as a NHS Foundation Trust in England who said "For children and young people being in hospital and away from their family can be very distressing, therefore visiting will be permitted for parents and carers." Many others did not. The restrictions on face-to-face visits were hugely detrimental on young people. One local Mind advocate described the compounding impact of isolation amid visiting restrictions: "*It was a hard time for residents in care homes and patients in hospital. They were not able to have visits from relatives etc or leave in the community….**visits stopped so we [were] unable to pick up on mental health issues until in crisis. Visiting restrictions on the ward impacted on mental health as family visits and leave [were] very important during admission for young people**.*" [emphasis added]

32. The lack of face-to-face visits due to Covid restrictions was raised as a concern by the coroner during the inquest into the death of 17-year-old Chelsea Mooney, who died by suicide at Cygnet Hospital, Sheffield, in April 2021. Chelsea was admitted to an acute 'Tier 4' inpatient CYPMH unit providing care and treatment to young people with more severe conditions. In March 2020, according to their website Cygnet Hospital, an independent provider of mental health services, 'restricted all but essential visitors' to their sites. Mind made an FOI request regarding Cygnet hospital asking about their visiting policy and when in-person visits resumed, but we have not yet received a substantive response. In her report, the coroner highlighted *"the impact of the cessation of face-to-face visits*

on anyone detained under the Mental Health Act, but particularly young people like Chelsea appears to have been underestimated" (SH/16, INQ000471267). I will provide more details on the safety failures that the coroner says contributed to Chelsea's suicide at [49].

33. One young person from England told us: "***From my own experience in the ward I was in at the time, we were not allowed any visits for about 4 months and then from that point on we had to sit on opposite ends of a meeting room to the point we could barely hear each other. For about 6 months it was one person allowed, the same visitor, as well as social workers and you were allowed 1 visit every 2 weeks for 30 minutes***." [emphasis added] (I&S 16-year-old)

34. For young people with learning disabilities and mental health conditions (LD/MH) who were living in care homes during the relevant period, restrictions were even stricter as many care homes were shut to visitors for the entire period of the pandemic. A local Mind Independent Mental Capacity Advocate (IMCA) for young people observed that when residents tried to re-engage with their families after two years, many couldn't recognize their loved ones and advocates had to do a lot of work to try and get residents back into routines and re-connecting with their families.

35. Being detained for their mental health is an acutely stressful time for young people, as Mind's own research has shown - see [22]. Face-to-face visits provide an opportunity for the mental health team to physically interact with the patient and their loved ones, which can facilitate better communication and relationships between staff, children and their parents. According to the National Institute for Health and Care Research Themed Review, such therapeutic alliances are the strongest predictors of good clinical outcomes in inpatient settings (SH/17, INQ000471268). One young person told us good communication between their mother and staff helped them after being moved to an inappropriate ward for adults over 25: "***there weren't ensuite bathrooms or showers, so as a trans young person I was really uncomfortable using the communal ones. In the end my mother had to contact them because I was too frightened to and***

ask them if I could use the staff shower. *They did let me use the shower but not the toilet so I would hold it or wait until no one was in there before I went."* [emphasis added] (I&S 20-year-old from Wales). This illustrates the importance of positive dialogue between staff and loved ones of young people in hospital. In the case of another pandemic, it would be helpful to learn from this and ensure both state-run and private providers consider this importance and make extra effort to facilitate visits for CYP and facilitate communication between loved ones, patients and staff if face to face visits aren't possible.

Impact of restrictions on leave

36. Another major detrimental impact for young people in hospital was restrictions on going on leave under s17 of the Mental Health Act. A young person shared during the relevant period, she couldn't "go outside for over one month, secure garden [was] locked as well as no forms of leave." (I&S 16 years old). The combined effect of restrictions on leave and visits could deny young people a routine and compound their sense of isolation – see [27] and [30]. For young people in care homes for their LD and/or severe Autistic Spectrum Disorder who couldn't access day centres; disrupted routines over the relevant period caused them to start self-harming on a wide scale. An IMCA explained: "*The restrictions on people with LD/MH conditions were severe – many residents couldn't see their loved ones or get the hospital treatments they needed* [over a long period]."

37. For Mind's FOI request we asked NHS mental health trusts 'Did you have any updated policies and procedures on s17 leave during [the pandemic]? For example, was s17 leave routinely cancelled?' The negative effects on mental health were recognised by most trusts, with some NHS Foundation Trusts in England telling us there was an increase in incidents reported on wards during lockdown due to cancellation of leave in line with legal national requirements. Eleven mental health trusts said they made changes to their approach to s17 leave (SH/15, INQ000471266). A Health Board in Wales told us: "*There was an initial period early during the first lockdown where Home Leave was not routinely undertaken by young people.* ***This impacted on the ability to work towards young people returning home and***

extended admissions." By contrast, **a NHS Foundation Trust in London said,** "[We] *did not put forward any updated s17 during COVID. However,* **wards adopted their own procedures around whether to use s17 over the period** [our emphasis] *along with who could attend the ward. What was different was the practice of allowing and authorising leave during that period. During the initial Covid period to control risk of infection,* ***patients were not being granted leave*** [our emphasis] however as the crisis eased, *leave was re-introduced and normal policy and procedures recommenced."*

38. **A NHS Trust in England** did not amend its s17 leave policy during the relevant period, *"...however the Trust implemented a local instruction that time spent outside, including Section 17 leave, should be consistent with national guidance.* ***Patients were allowed one hour exercise, in line with national guidance, and ideally only within hospital grounds except in exceptional circumstances.*** [our emphasis] *Patients could be granted unescorted leave subject to risk assessment, including their understanding and likelihood of adhering to covid guidance."* The limits on contact with the outside world increased isolation, trauma and distress and which can damage recovery and relationships with loved ones. Restricting leave and visits creates more of a closed culture on wards where human rights abuses often flourish. It is clear from the CQC report that leave was often cancelled due to staffing shortages (SH/11, INQ000442280 (pg12-13)), so I propose that facilitating leave, which requires adequate staffing, should be a priority for the Government and NHS going forward.

Impact of remote consultations on young people

39. During the relevant period, most appointments moved to being remote, i.e. over phone or video call, to avoid the risk of infection transmission. In Mind's submissions to the Health and Social Care Committee on the UK Government's commitments towards expanding the provision of mental health services in England, we noted that although a slight expansion in services was evident when services had to swiftly shift to remote delivery to curtail the spread of Covid in 2020, many young people who accessed remote mental health support during

winter 2020-21 told us remote services did not work for them and even worsened their mental health. See paragraph 78 for our submissions. During that period, Mind was gathering people's experiences of accessing NHS mental health services by phone or online. We conducted an online survey of 1900 people, 244 of whom were young people aged 13-24. We also conducted in-depth interviews by phone or video call, which informed Mind's report '*Trying to Connect: The importance of choice in remote mental health services*' (2021) (SH/18, INQ000471269).

40. Our findings indicate that young people would have benefited more from face-to-face support than adults over 25, with almost two-third of young people who took up the offer of remote mental health support preferring to have support face-to-face (72%). One young person said: "*I don't think it's the same and wouldn't work for me. I would prefer face to face and for someone to be there with me that I trust for support.*" (13-17 year old). Our findings show also that nearly half of young people who took up the offer of remote mental health support found it difficult to use (as compared with 32% of adults over 25), and nearly a third of young people felt their mental health got worse having used this support. They told us one key barrier to accessing mental health services remotely was being digitally excluded due to lack of access to the internet or devices; highlighting the importance of choice in meeting the mental health needs of young people. An IMCA for young people with LD/MH conditions told us that many non-verbal residents she supported couldn't communicate via i-pads when care homes shut, so they were left unable to talk to loved ones at all.

41. A key vulnerability for young people was concern about being **overheard** at home or where the health professional was working, as young people often lacked a private space in which they felt comfortable or safe to share in. AB, a young woman who received remote mental health support during lockdown for anxiety, depression and psychosis shared: *"I don't have a space where I feel safe to talk about what I need to as I am worried other people in the house will hear… I have a physical disability which makes holding a phone for prolonged periods difficult but due to the aforementioned lack of private space I can't put it on speaker."*

42. Young people who were able to use digital means to access mental health services said they felt unable to connect with professionals through a computer screen, and struggling to express how they felt caused them distress. EM, a 17-year-old young person who had phone and video calls during lockdown with a clinical health psychologist also raised the issue of lack of privacy, explaining: "*I **don't find it as easy to talk over the phone** [...] I was thinking, my family can hear everything I'm saying and how do I know who's in the room with her? **I just think it's harder to show how I was feeling over the phone.** I think that it overwhelmed me [...] I **think that if I'd been able to see her in person I would have just said how I was actually feeling**."* [our emphasis]

43. These findings track with what local Mind advocates we spoke to have told us - that services shifting to remote delivery during the first national lockdown had a big impact on the mental health of young people in hospital and on provision of inpatient advocacy services, talking therapy and wellbeing services. One IMHA said "*Engagement [from young people] dropped by as low as 20% during March to October 2020. [It was] difficult having ward staff bring patients to the phone [due to a shortage of staff]. Remote hearings or [mental health tribunals] and [mental health review tribunals] replaced face to face - this still remains an issue with MH [as of January 2024].*"

Impact of wearing PPE on young people

44. A Royal College of Psychiatrists survey in April 2020 indicated a significant proportion of psychiatrists shared concerns that they were not able to access the level of PPE set out in the guidance (SH/19, INQ000471270). The survey indicated nearly one in four psychiatrists in the UK didn't have access to correct PPE during 2020, which represents a risk for patients. Mind have spoken to an individual, I&S whose father, NR died from Covid on 31 March 2020 after contracting it from staff on the mental health ward where he was detained. A post infection review for her father showed that PPE masks were not routinely worn, and in her impact statement she says "*I knew Covid was around and took personal preventative measures ... why weren't preventative and safety measures in place in these settings?*"

45. One impact of staff wearing PPE was that it disorientated and confused young people using inpatient services. A child on a children's mental health ward told the CQC they could not really see staff properly because they were wearing full personal protective equipment, and this added to the fear they experienced whilst in Covid isolation (SH/20, INQ000398531). Other young people shared there wasn't any communication about the PPE to prepare or warn them about the changes: "C*onfused - we were not told anything about covid until lock down so woke up one day, everyone was in full PPE with no context. Then had ward meeting after hours of questions, 'there's a global pandemic that's killing people so the whole country is in lock down. No one is having any visits, leave or phone calls for the duration of the lock down.*'" (I&S 16 years old)

46. IMHAs have reported that staff wearing PPE "*was difficult for young people too especially those struggling with paranoid thoughts and voices. It increased the difficulties they already had."* Some types of PPE contributed to clinical environments feeling "inhuman", making already frightening experiences such as being restrained or fed via a nasogastric tube feel even less personal and therefore scarier. Better communication about why staff were wearing PPE could have helped young people.

Unsuitability and safety of placements of young people in CYPMHS

47. Mind has sought to raise awareness and challenge the dangerous rise in young people with acute mental health needs being held in unsuitable and unsafe placements. Our concern over these placements predates the pandemic, as demonstrated in our submissions to the Health and Social Care Committee (SH/21, INQ000471289 [CYP0054]) and our work on the mental health bill, though data shows the number of young people held in unsuitable and unsafe placements increased during the relevant period; see paras 23 and 53 for more detail. We think this is caused by a dearth of holistic support for young people who often have complex and multiple needs. It is also caused by a shortage in resources and ineffective intervention at an earlier stage, so young people end

up in situations that cause trauma, isolation and exacerbate their mental health problems.

48. The Children's Commissioner has said an increasing number of children experiencing mental health problems are being deprived of their liberty in settings other than hospitals. These children are often hidden from view so do not appear in any official statistics, but research carried out by Nuffield Family Justice Observatory shows the significant increase in court applications that seek to deprive young people of their liberty, a 462% increase from 2017-18 to 2020-21, due to severe national shortages of safe and suitable placements to meet complex needs (SH/22, INQ000478217). In August 2023, Mind intervened in a case concerning the placement of young people with high needs in unsuitable placements due to the lack of appropriate alternative care and treatment for their mental health conditions: *Manchester University Hospitals NHS Foundation Trust v JS* [2023] EWCOP 33. Long delays in accessing appropriate care in the community, made worse by scarce resources, often necessitates vulnerable young people remaining in inappropriate settings over long periods. The poor availability of tier 4 CYPMHS beds nationally has been cited as causing avoidable deaths of young people (SH/11, INQ000442280).

Safety failings on inpatient units

49. Further to [31], Mind has seen the notification of death for Chelsea Mooney (SH/23, INQ000193420) which was disclosed to the Covid Inquiry and Module 3 Core Participants. The document was sent from NHSE to the Secretary of State for Health and Social Care in relation to her suicide in hospital, noting "*Since January 2013 there have been 28 deaths in CAMHS inpatient units, with this death the first in 2021. Previous years have seen between 2 to 4 deaths per year; with a peak in 2019 of seven deaths.*" Chelsea's death is the second of a young person registered to that Cygnet Hospital in Sheffield during the relevant period, the first being that of a 15-year-old female patient from an overdose during a period of unauthorized home leave. Moreover, the BBC has found that between 2019 and August 2022, at least 20 children have died in NHS or privately run mental health units (18 in England, one in Northern Ireland and 1 in Scotland)

(SH/24, INQ000471274). Mind is seriously concerned that the notification of death omitted to include that Cygnet Health Care is linked to serious repeated failings in care leading to the deaths of 11 other patients at Cygnet's mental health units since 2012, as revealed by the Guardian in April 2022, yet the NHS continues to commission services for vulnerable individuals from Cygnet and other private mental health providers (SH/25, INQ000471275).

50. Additionally, I note that in March 2022, an inquest jury found that misjudgement of risks and failures of observation by staff contributed to the death by self-ligature of Emma Pring while she was an inpatient at Cygnet Hospital in Maidstone, also during the relevant period. Emma had told several members of staff that she was having strong urges to self-harm, was suicidal, and wanted to die just days before, but there was insufficient observation and failure by staff to adhere to the hospital's policies. In April 2022, a coroner issued a prevention of future death report regarding risk assessment and information sharing failures at Cygnet hospitals (SH26, INQ000471276). I note also that in September 2023, Cygnet Health Care pled guilty of failing to provide safe care and treatment, leading to the death of a young woman using their mental health services in Ealing, London. Cygnet was fined a record £1.53 million by the Care Quality Commission.

51. A young person told Mind about her experience of being in an unsafe inpatient unit where staff routinely neglected to act over serious and at times dangerous safety failings: "*During my stay in hospital,* ***I was frequently assaulted by other young people and received no protection or reassurance of this being controlled. I was taken to a&e on multiple occasions due to injuries caused by another patient who struggled with psychosis. In multiple hospitals I was medically neglected leading to life threatening malnutrition and severe concussion due to collapse to name a few. On multiple occasions staff forgot to give me my medication, re-dress wounds and provide my fortisip meal supplement. Self-harm incidents were responded to coldly with no empathy or concern, often meaning wounds that needed stitches etc were not treated, leading to infection.***" [emphasis added]

…

"[The] whole ward had covid - everyone alone in room for 2 weeks, food left outside door, no conversation at all for the duration, bedroom stripped so nothing to do. ***Staff not noticing risk behaviour, eg I flushed my food down toilet, was written down I'd eaten as plate was empty, didn't drink for 4 days toward end of isolation and ended up in critical condition as no one knew (1day without fluids actually being 5 etc)****. No physical health monitoring during the 2 weeks - no way to monitor the effects my eating disorder was having on my body."* [emphasis added]

52. NHSE has reiterated its commitment towards improving the quality and safety of mental health services and achieving 'zero suicide', referencing the work of the National Quality Improvement Taskforce, the Mental Health Safety Improvement Programme and NHSE's commitment to supporting mental health trusts to refresh and expand their Suicide Safety Plans in inpatient and community settings by 2022, which formed the basis for 2023's National Suicide Prevention Strategy (SH23, INQ000193420). Any progress on this remains to be seen.

Placing young people on adult wards

53. During the relevant period, there was an increase in the number of young people who had acute mental health needs being held on wards for adults over 25. The Mental Health Code of Practice states that under 18s may only be admitted to adult wards in exceptional circumstances, but during the relevant period, this number increased to an extremely worrying level. In their report '*Monitoring the Mental Health Act in 2021 to 2022*' (page 41), the CQC reported a 32% rise in the number of under-18s being admitted to adult wards between 2020-21 and 2021-22. They said the "main reason given for admitting the child to an adult ward was because there was no alternative mental health inpatient or outreach service available for young people" (SH/11, INQ000442280).

54. Launching the '#SortTheSwitch' campaign on 13 May 2022, Mind Cymru teamed up with young people from across Wales to highlight the biggest problems in switching to adult mental health services (SH27, INQ000471277). One Children and Young People's Manager at Mind Cymru said: "*Young people have told us that their needs, thoughts, and feelings about moving to adult services are often unheard or ignored*". Mind Cymru's report is the result of interviews with young

people about their experiences of moving to adult services which highlights the five key areas where services are failing young people:

a. Poor information offered to young people, particularly on their rights
b. Inconsistent use and follow through of care and treatment plans
c. High thresholds for specialist CAMHS and adult mental health services referrals to be accepted
d. Feeling abandoned / cut off from specialist CAMHS
e. Age still dominates decision making process for moving from specialist CAMHS to adult mental health services.

Most CAMHS (or CYPMHS) provide comprehensive care to children and young people for moderate to severe mental health problems where specialist teams do not exist in the local area. Specialist services support children and young people with severe, persistent or complex mental health problems facing urgent circumstances; the eligibility criteria for referral to these services is strict.

55. A young person told us they didn't feel safe after being transferred to an unsuitable ward for adults with addictions, most of whom were two or three times their age. They shared: ***"While on the ward I received comments about how young I was and looked. One member of the ward even complained to staff about his concerns for my safety.***

…
I was told I could go for a walk but must be back by a certain time, ***I was actually gone a lot longer, looking for a shop in order to purchase something to hurt myself with as I was in a very difficult place emotionally. When I returned the staff weren't aware****."* [emphasis added]

56. In October 2023, Mind published data showing the full scale of the emergency in mental healthcare, with staff reporting 17,340 serious incidents in 12 months. We reported on figures from the Care Quality Commission (CQC) showing staff across England are so concerned about the situation in mental health settings they reported an incident once every half an hour between 1 April 2022 and 31 March 2023 (SH/28, INQ000471278). We knew this was a crisis – we now know the scale of this crisis. It is clear these failings are systemic. But it does not have

to be this way - good mental health hospitals do exist, and people can be given a say in their treatment, but proper care must be available across the board.

57. It is not right that those who are most powerless within the mental health system because they are detained for treatment should endure in this way. The public has lost confidence in mental healthcare, with YouGov polling showing more than one in three British adults said they don't have confidence that a loved one would be safe if they needed inpatient mental healthcare (SH/28, INQ000471278). A third also said they are not confident that a mental health hospital would treat their loved one with respect or compassion. The UK Government must raise the standard of mental healthcare.

Issues with discharging young people from detention under the Mental Health Act

58. In the period approaching the date of discharge from hospital, young people often experience apprehension linked to the variability of adequate care and support in the community. We know from Mind's 'Our Right, Our Voices' report (SH/10, INQ000478215) that some young people go from having lots of support at hospital to almost nothing in their community, which puts them at risk of their mental health deteriorating.

59. In February and March 2024, we conducted a mini survey of members of the British Association of Social Workers (BASW); comprising of social workers and related practitioners who support young people in CYPMHS. Of the 33 social work practitioners who responded, 35% said they frequently observed inappropriate discharge from hospital during the relevant period (SH/29, INQ000471279). One practitioner said "*the practice of discharging people from hospital without a proper social care assessment became the norm, [as] did an indifference to the risks…. It was hard to believe and was in direct conflict to best practice or social work values*." The period straight after discharge is a critical time. Data from the Clinical Practice Research Datalink shows there were an estimated 180 deaths by suicide in the three months after discharge from inpatient mental health services in 2019. The highest risk was in the first two weeks after discharge, with the highest number of deaths occurring on the third

day after discharge (SH/30, INQ000471280). Therefore, the reports of discharging without appropriate assessment and support reveal a colossal failure in safeguarding which underscores the urgent need for more provision and robust discharge risk-assessment procedures.

60. We have heard from young people on the opaqueness of the discharge process, with instances when community teams were not made aware by hospitals that the young person had been discharged, and parents were not given instructions on how to continue their medication (SH/10, INQ000478215). Some young people were discharged from hospital with no support plan in the community. One young person said in our survey: "*It felt like the doctors in particular shared very little information, especially about discharge, with myself and my parents. My discharge was brought about so suddenly (a matter of hours) that I had to be medicated with sedatives just before leaving. This wasn't made clear to my parents who then had to take me to A&E once we'd returned home and their effects had worn off.*" This highlights the urgent need for standardized procedures for communication between teams and the young person's support network, along with providing more support in the run up to and in the period after discharge. Information sharing via discharge meetings with community mental health teams and staff from the young person's school or college should become the norm. We are calling on the Government to introduce a statutory process to ensure multi-agency planning for discharging young people from inpatient settings.

Consequences of delayed discharge from hospital

61. We have noted two deaths by suicide related to delays in discharging young people from hospital during the relevant period. Twenty year old Lauren Elizabeth Bridge died in hospital in February 2022 after a five-month delay in discharging her, which was listed as a contributing factor in her death. The coroner stated, "*this is the second inquest I have heard where the delayed discharge/repatriation of an Out-of-Area patient from an independent provider's hospital has been a contributory factor in that patient's death....the other inquest involved a 15 years old patient – 115 miles away from home.*" (SH/12, INQ000478216). These cases

illustrate the issues of (a) underfunding of local mental health beds, and (b) over-reliance by the NHS on independent providers for mental health beds, the consequences of which I address below.

62. A further consequence of austerity and sustained underfunding of mental health services is that young people are not getting the help they need with their mental health until it is much too late or it is judged necessary for them to be hospitalised. The Children's Commissioner estimates there is a pool of 1.4 million young people who have a probable mental health disorder, and the NHS Five Year Forward View dashboard shows that there were 661,000 young people who received at least one contact with CYPMHS in 2021-22 (SH/31, INQ000471283). From this we have estimated the rate of young people who were in need but couldn't access mental health services was 52% in 2021-22. **These** figures demonstrate the extent of the epidemic on mental health that young people are facing. It is therefore very important to consider the young people who are not yet in contact with mental health services and those who did not receive timely or effective support and intervention when they needed it while on waiting lists to be seen. As referenced above, many of the young people who have experienced inpatient care in hospital did not have positive experiences.

63. On the 27 March 2021 the government published its 'COVID-19 mental health and wellbeing recovery action plan' (**SH/32**, INQ000372784) in which it addressed the mental health of children and young people and announced £79 million of funding to improve access to young people's mental health support. For the avoidance of doubt the £79 million were funds that had been announced as part of the 2020 general spending review and were not new funds instigated by the recovery action plan report. These funds were used to bring forward the expansion of mental health support teams in schools ahead of the schedule in the NHS Long Term Plan.

Provision of and referrals to community CYPMHS

64. Many young people we surveyed for 'Our Rights, Our Voices' said they would prefer to be looked after in their communities if provision was adequate across

the board (SH/10, INQ000478215). As I outlined in the para above, a key problem with more young people spending longer on waiting lists is their mental health got worse the longer they went without support. Forty-three percent of social work practitioners we surveyed said that service users frequently or at all times experienced significant delays in assessment or treatment. One social worker said there were "*extended periods of time where children didn't have a diagnosis, and then access to the treatments they needed, exacerbating their needs and potential for adoption disruption*" and "*access to CAMHS was awful. Post covid the waitlist is 2.5 years in my area. Mental health referrals increased ten-fold* (SH29, INQ000471279)." Data from the Children's Commissioner's report on 'Children's Mental Health Services 2022-23' showed that 32,200 children experienced a wait of over two years for treatment following referrals, and many do not get the help they need even after self-harming or attempting suicide (**SH/31**, INQ000471283 (pages 16, 26-27)). The data also shows there were 10,000 more emergency referrals in 22-23 compared to 2019-20 (**SH/31**, INQ000471283 (pg26). This illustrates clearly there is still an urgent need to adequately fund provision of CYPMHS in community settings, through supporting the voluntary sector or local authorities.

65. It is not surprising that waiting lists for support are up to four years, as the majority of BASW members we surveyed said their caseload was unmanageable, and 67% said they were understaffed during the relevant period (SH/29, INQ000471279). One social worker said there were "less staff [doing] more work", which resulted in "deadlines/timely service [going] out the window". Another person said: "*social work during COVID was hell. Working from home, managing high risk domestic abuse cases, child abuse cases sitting in personal, home spaces. The lines were completely blurred and workers were left to manage horrible situations on their own, away from the safety of senior management support and expected to deal with duty calls, CP concerns, phone calls and home visits without the regular, helpful contact with management that is usually available in an office.* ***My experiences caused significant anxiety and led to severe burnout***." [our emphasis]

66. Referrals for CYPMH eating disorder services skyrocketed during the pandemic. Mind's research during the pandemic found that nearly one in eight young people (78%) have been over or under-eating to cope with the pandemic. One young person told us "*Around October 2020, I started experiencing symptoms of anorexia nervosa. I became preoccupied with food and my days now revolve around eating and exercise*." (SH/10, INQ000478215). The Royal College of Psychiatrists stated right at the beginning of pandemic following an APPG appearance: *"Mental Health Services are more needed than ever during the CV crisis. It's critical that people know that NHS mental health services are still open. Our members in the front line are reporting significant reductions in patient referrals – especially in child and adolescent services.* ***Those who fail to get the help they need now, will inevitably become more seriously ill. This is particularly concerning for deadly mental health conditions such as Eating Disorders, which have a higher mortality rate than many cancers.*** *The College is also monitoring early signs that child and adolescent suicide rates may have risen since the lock-down began.* (SH/19, INQ000471270)." [our emphasis]

67. This is also reflected in the number of referrals to services. 2021 and 2022 were the first and second year that annual cumulative referrals to community mental health services for young people totaled over one million a year. This is why Mind has said alongside the Covid-19 public emergency there is a mental health emergency that needs urgent addressing. By way of illustration, in January 2020 there were 84,624 referrals to CAMHS. This nearly halved when referrals dropped in May 2020 to 47,876, then spiked and climbed ever since. In March 2022 there were 126,857 referrals. The Power BI visualization of NHS data shows that more young people experienced mental health problems than ever before during the relevant period (SH/09D, INQ000478220).

68. Schools are a significant source of CAMHS referrals, and the closure of schools meant that referrals dropped off then exploded to 2-3 times what they had previously been with no services there to meet them. This 'explosion in need' was explicitly stated by the coroner following the death of Robyn Skilton, who was 14:

"Covid heightened the level of complexity across many services but there were many failings in the care provided to Robyn. It became very clear during the Inquest that there is significant under funding of the local mental health Trust who like many mental health Trusts have seen an explosion of referrals to their Children and Mental Health services (CAMHS). By way of an example [...]

a. *West Sussex CAMHS Duty caseload has increased by 112% from May 2021 (492) to May 2022 (1494) Mental Health A&E presentations, in period April 2021 - March 2022, have increased by 40% on previous year (April 2020 - March 2021). Additionally, across Sussex CAMHS, as a whole, the referrals data shows:-*
    i. *May 2022 was the highest number of referrals the service has ever received (1350). Of those 1350 referrals, 80% (1,081) were accepted into the service.*
    ii. *In comparison, in May 2019, 579 were accepted (65% accepted), so, an additional 502 young people have been accepted in May 2022 compared to May 2019. Despite the increase in numbers accessing CAMHS there has not been any relative increase in resources to meet this demand and therefore the current position is unsustainable and it is putting many young people's lives at risk."* (SH/33, INQ000471285)

69. It is very worrying that there are still no clear Government plans to tackle the waiting lists for treatment nor announcement of funding, and regional variation is not being tracked officially. The increased demand for CYPMHS was easy to spot, even if there wasn't a wealth of evidence predicting this would happen, so there is no reason explaining why the Government failed to make the necessary investment and plan for this outcome. The National Medical Director and Chief Nursing Officer noted in their policy document on capacity in Community Health dated 18 March 2020 that *"isolation may increase requirement for services for some individuals"* (SH/34, INQ000048137). Further, Mind, along with partners made various submissions to parliamentary and government bodies raising concerns on this issue, stating we need to see more money earmarked to improve access to CYPMHS [74-81].

Support and care in the community

70. The above data indicates that provision of support and care in community CYPMHS would also be massively affected by the pandemic. We've found that after leaving hospital, many young people were not provided with adequate support in communities, with some leaving hospital without a care plan (SH/10, INQ000478215). Several young people mentioned they were never told they were entitled to aftercare services under section 117 of the Mental Health Act. Mind heard that the assessment process used to determine the type of bed needed before a young person is detained under the Mental Health Act is now being used to overrule assessments, which means that young people are ending up in unsuitable and unsafe placements. As indicated at [47-52], these types of placement result from the systemic "*lack of understanding of the nature of resources needed to be able safeguard children and young people*", as one social worker put it to us, which places an onerous burden on social workers and other mental health professionals who have to "hold" that risk until a suitable and safe placement is found for the young person (SH/29, INQ000471279).

71. One social work practitioner said of the relevant period: "*Children basically stopped receiving any services at all. Clinics closed their doors. [in the early days] online appointments were unheard of and waiting lists became even longer because referrals weren't accepted. The waiting lists for CYPMH services are still horrifically long as a result.* ***No children returned to the service post COVID and several of them ended up moving on from stable placements because the mental health support for them and their carers disappeared overnight, leaving them with no outlet to work through behaviours and nowhere for carers to seek emotional support.***" Consequently, one learning for a future pandemic must be ensuring there are well-funded and joined-up services providing social, health and education support so that young people can feel secure when they return home. Improved resources could also facilitate better communication and input from different teams.

The consequences of withdrawing face-to-face CYPMHS

72. I am not currently aware of any evidence directly linking the exacerbation of mental health conditions of young people in CYPMHS to (i) the reduction of face-to-face consultations and appointments, or (ii) an increased number of referrals for inpatient services, but data from NHS digital shows that in June 2022, just over half of young people's contacts with mental health services were face-to-face, compared to nearly three quarters (73%) in June 2019 (SH/09E, INQ000478223; SH/09F, INQ000478221). This maintenance of high levels of remote delivery of services compared to pre-pandemic levels is bound to mean particular groups of young people will be less likely to get the support they need, as it's not delivered in a way that works for them. One social work practitioner noted: ***"...the children I had attending services had zero ability to engage with online appointments and the relationships they had slowly built up with practitioners were instantly severed."*** [added emphasis]

73. Findings from Mind's original research produced in the 'Trying to Connect' report (2021) shows that young people, more than adults over 25 years, preferred face-to-face support for most types of interactions (SH/18, INQ000471269). The move to online service delivery during the pandemic was particularly problematic for some young people using eating disorder services. Cambridge University surveyed CYPMH clinicians in one NHS Trust for their experiences of giving remote consultations (for assessments, reviews and treatment) during the relevant period (surveyed in 2020; report published in 2021). Twenty six percent of clinicians surveyed said remote consultations negatively affected rapport with young people – this was worse for eating disorders teams (39%) (SH/35, INQ000471287). Clinicians reported that young people from the eating disorders and neurodevelopmental pathways mostly perceived remote consultations to be neutral (61% and 64%, respectively), whereas two-thirds (65%) of reports from the substance misuse team suggested that young people and families perceived the remote consultations positively.

74. Evidence from a local Mind advocate corroborates this based on what young people told her: *"[Y]oung people, especially with eating disorders, said they were able to hide their issues better when doing only virtual visits with their community*

workers, so therefore they were past crisis point when they finally got admitted..." Some eating disorder services were fully remote well into 2022, which is especially concerning, given that eating disorders have the highest mortality rate of all mental disorders (SH/19, INQ000471270). More research is needed to understand which other groups of young people may have been most negatively affected by the move to more remote delivery.

75. More than half of the social worker practitioners we surveyed drew attention to the fact that government guidance during the relevant period on working remotely or doing face-to-face visits was very unclear; 80% of those surveyed said the guidance didn't cover what they *needed* to know (SH/29, INQ000471279). This finding raises significant ethical issues which I illustrate with a point made by a practitioner on how difficult it was to risk assess young people for discharge from CYPMHS without seeing or speaking to them when service provision shifted digitally: "*children were not seen and often discharged without being spoken to, even on the telephone. This caused further an escalation in mental health issues. Children suffered increased upset and harm*."

Mind's submissions on the impact of the pandemic on CYPMHS

76. Mind has liaised with and made representations to the UK and Welsh Governments and departments either on our own behalf or within coalesced groups such as the Mental Health Policy Group. The government also made Mind custodians of a modest fund of £5 million pounds to distribute to other mental health charities and projects during the relevant period (SH/36, INQ000471288). I am not aware of any submissions made by Mind to the DHSC specifically concerning the impact of the pandemic on children and young people's mental health services, but as mentioned at [10], Mind made significant contributions to reforming the mental health system for children and young people. In June 2020, Mind made oral submissions to the DHSC Covid recovery working group, of which Mind was a part, on CYPMHS, outlining the UK Government's key priority areas in the sector from Mind's perspective:

a. A fuller plan for meeting the growing mental health needs of young people now and in the medium term is needed; we said the current focus only on providing information & 24/7 crisis lines was woefully inadequate.
b. Proactively targeting young people who are most at risk via mental health support hubs in the community [19], instead of waiting for young people to present to hospitals in crisis, and implementing a screening programme to identify those with trauma. We noted that if community MHS were adequately funded then less young people would reach crisis point requiring inpatient care.
c. A national programme for parents in supporting their child's mental health and wellbeing including on managing family relationships and challenging behaviour.
d. Culturally informed mental health interventions for young people in communities disproportionately impacted by Covid.
e. A longer-term commitment with impact in practice, pushing back on short-term initiatives. We wanted to see a concrete plan for delivering on the NHS Long Term Plan (LTP) commitments, looking at bringing forward funding or going further given the increased need and disruption to care and treatment young people have had.
f. Refocus on existing commitments from the UK Government's Green Paper on transforming young people's mental health provision, including pilot mental health support teams.
g. Continuing work to build capacity between CYPMHS and schools via the 'Link' programme: mental health and wellbeing must be central pillars to any plans for schools reopening.

77. Additionally, in July 2020, Mind participated in a joint ministerial roundtable meeting on children and young people's mental health, co-chaired by Nadine Dorries MP, who was then Minister of State for Patient Safety, Suicide Prevention and Mental Health, and Vicky Ford MP, the Parliamentary Under Secretary of State for Children and Families. Mind addressed the following key points in our submissions:

a. Supporting the mental health of children and young people is one of the 'five tests' that Mind has identified the UK Government must meet to protect and improve the country's mental health after the pandemic. We said now is an opportunity to make the right choices and build up services and support, prevent mental health needs from rising, and invest more money and resources into CYPMHS. We want to see urgent progress from the Government on the ambition of CYPMHS to have a comprehensive offer for young people up to 25 setting out how the NHS LTP target to reach 100% of young people who need specialist mental healthcare over the coming decade will be met. We wanted clear guidance about when face-to-face support can be provided.
b. Mind wants to see a comprehensive cross-governmental approach with coordinated action from the NHS and every domestic Government department and welcome the news that Nadine Dorries MP is leading a cross-governmental group with Penny Mordant MP.
c. Mind called for a refocus of CYPMH to the heart of the education system: concrete action that equips schools to deliver better pastoral and mental health support, plus immediate and long-term funding to support the 'whole school approach' to promote wellbeing. An immediate emergency finance support package can increase access to mental health support beyond schools and the NHS into communities via youth organisations, charities & local authorities.

78. In March 2021, Mind made written submissions to the UK Parliament's Health and Social Care Committee's inquiry into CYPMH on the following points (SH/21, INQ000471289 [CYP0054]):
    a. The extent of the pandemic's impact on young people's mental health was unclear, but we did know that young people have been amongst those most impacted. We referenced our findings from Mind's coronavirus survey (2020) (SH/03, INQ000471282; [15]).
    b. Areas causing most concern to Mind include the widening of pre-existing inequalities in mental health. The same groups who have been hardest hit by the pandemic – young people (specifically young women), people from

racialised communities and people living in poverty – already experienced the worst mental health prior to the crisis.

c. The Government has gone wrong in addressing CYPMHS by (i) insufficient funding across CYPMHS and an (ii) uncoordinated approach across Government and the NHS in providing mental health support for children and young people. I raise the biggest barriers to meeting the growing demand for CYPMHS at [21].

d. Inpatient care: refocus needed on the high number of young people being sectioned under restrictive interventions. We remain concerned that inadequate funding of CYPMHS is leading to inappropriate care including placements to unsafe general wards or adult wards.

In the same month, Mind gave oral evidence to the Health and Social Care Committee (SH/37, INQ000255829).

79. In April 2021, Mind responded to the Mental Health Act White Paper, calling for stronger commitments to protect the rights of all young people in inpatient care. We argued new rights and safeguards should be effective for under 16s detained under the Act (SH/38, INQ000471291). Mind recommended introducing a statutory presumption against children being placed on adult wards, improved CQC oversight over CYPMHS, and a notification system to alert local authorities when a child or young person is placed in an adult ward or out of area for more than 28 days. We expressed concerns about the report by the Commission on Race and Ethnic Disparities whose recommendations fall far short of the changes needed to address institutional and structural racism in the mental health system. Mind called also on the Secretary of State to ensure that national data on the experience of young people as mental health inpatients is regularly collected and published. We stressed the urgent need for concerted and sustained action across the mental health system, focused on tailored services that respect patient wishes in assessment, care, treatment and during reviews.

80. In October 2021, Mind submitted written evidence (SH/39, INQ000471292 [MHS0005]) to the Health and Social Care parliamentary committee's expert panel evaluation of the government's progress against its policy commitments

around mental health services in England. In relation to CYPMHS, we highlighted the importance of ensuring that existing funding commitments for the LTP and Mental Health Act Review are met. Considering the pandemic, we described how it was critical that additional funding be provided to plug the backlog and increase provision.

81. In February 2022, Mind Cymru responded to the Senedd's Health and Social Care Committee's inquiry into mental health inequalities (SH/40, INQ000471294). In relation to CYPMHS we set out our evidence on the impact and consequences of the pandemic on mental health in Wales, including its disproportionate impact on young people and minority communities. Mind Cymru's research shows that more than a quarter of young people in Wales aged 16-24 experienced the largest deterioration in their mental health at the beginning of the pandemic and many did not feel like they had the mental health support they needed (SH/41, INQ000471295). We addressed the influence of poverty and social disadvantage on mental health, referencing data which shows that young people in the lowest income bracket are 4.5 times more likely to experience severe mental health problems than those in the highest. More than twice as many people in Wales (aged 16+) experience mental health problems in the most deprived quintile (16%) than the least deprived quintile (7%). On the impact of the pandemic on racialised communities, we referred to Mind's research (as referenced above) showing that existing inequalities in housing, employment, finances and other issues have had a greater impact on the mental health of people from racialised communities than White people during the pandemic. People from racialised communities were more likely than White people to be referred to mental health services via 'involuntary' routes including social services and criminal justice than they through 'voluntary' routes such as their GP (SH/07, INQ000471301). These insights demonstrate the importance of addressing socio-economic issues alongside the particular mental health issue a young person may be presenting with.

82. In September 2022, Mind gave written and oral evidence to the Pre-Legislative Scrutiny Committee on the Draft Mental Health Bill, jointly with Race on the Agenda (ROTA), an organisation that works with communities impacted by

systemic racism and drives change to promote race equity; including evidence on the importance of empowering young patients undergoing assessments under the Mental Health Act (SH/42, INQ000471296). Mind endorsed strengthening and shifting the Act towards a stronger focus on patient autonomy [10].

83. In January 2023, Mind responded to the final report from the Joint Committee on the Draft Mental Health Bill by calling for a national statutory inquiry into systemic failings of inpatient mental health services and a dedicated and independent Mental Health Commissioner role to steer such inquiries amplifying the voices of people with lived experience of mental health (SH/43, INQ000471297).

84. I am not aware of any concerns raised by Mind directly to NHS Trusts or healthcare providers about inpatient mental health services for young people during the pandemic.

Mind's recommendations on improving CYPMHS

85. Informed by the findings from Mind's research carried out in consultation with evidence from our lived experience volunteers and from local Minds, we are under no doubt that mental health services are failing, with young people bearing the brunt of this failure. But these problems did not start with the pandemic; they have roots from sustained cuts to services for almost 20 years.

86. We've known for some time now that the treatment gap for children and young people's mental health is long, meaning that the majority of children and young people with a diagnosable mental health condition do not receive the treatment they need in a timely manner. Over a third of parents and carers we surveyed for '*Not making the grade*' (2021) told us that thresholds for accessing NHS support is a huge barrier for young people getting the support they need (SH/07, INQ000471301; [19]). We think a more ambitious target is needed to ensure that all young people with mental health problems get timely and appropriate specialist NHS care and fully-equipped crisis services. That means that more funding is required to meet the access target. We urge the UK Government to

maintain its commitment to grow funding for CYPMHS faster than overall NHS funding and total mental health funding.

87. More must be done to make sure that no one falls through the cracks in service provision. Young people who are transitioning from childhood to adulthood must be able to access high-quality, age-appropriate mental health services. Some young people aged 16-18 fall between the gaps and aren't accepted into either CYP or adult services.

88. Deep racial injustices and their impact on the mental health of young people should be urgently addressed. African and Caribbean people continue to face disproportionally poor experiences of mental health services [23], which is often driven by reinforced fear and mistrust. We urge the UK Government to reverse the decision to reject the recommendation of the Joint Committee on the Draft Mental Health Bill (SH/44, INQ000471298) on introducing culturally competent and relevant community services for racialised communities. This will require investment in initiatives to address the cultural barriers to certain groups seeking support for their mental health.

89. Wider reforms to promote social justice, equality and inclusion are also urgently needed to reduce the social determinants of mental health problems. Thousands of young people are still feeling the lasting effects of the pandemic, and severe economic pressures are contributing to this trauma. As we've set out above, insights from young people themselves demonstrate the importance of addressing alongside mental health diagnoses social-economic issues such as experiencing poverty, living in poor quality housing and having limited availability of green spaces. Mind's view is that more often than not, multiple inequalities weave together to exacerbate poor mental health.

90. As addressed within my statement; I would like to see the following key improvements made to CYPMHS:
    a. The UK Government must speed up the shift to young people being looked after in their communities. We want to see the expansion of community alternatives to inpatient admission throughout the UK.

b. The UK Government must set a new deadline for eradicating the use of inappropriate out of area placements and admission to adult wards.
c. The UK Government must address digital exclusion from CYMHS: young people who are most disadvantaged are also the most likely to face digital exclusion [39].
d. The UK Government must ensure that people are only discharged from hospital when it is safe to do so, and, conversely, young people are not left languishing in hospital due to delays in implementing support packages.
e. Safer and more holistic CYPMHS.
f. Urgent improvements must be made to staffing, which needs to be more consistent with reduced usage of agency staff and improved training.

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

22 May 2024

Dated: _____