THE PUBLIC INQUIRY TO EXAMINE THE COVID-19 PANDEMIC IN THE UK

CLOSING SUBMISSIONS ON BEHALF OF MIND FOR MODULE 3

INTRODUCTION

1. These submissions are made on behalf of Mind. They have been prepared with input from Mind's in-house legal team and external counsel. Mind is the leading mental health charity in England and Wales. It provides information, research, advice and support to people affected by mental health problems, which can range from those simply seeking someone to talk to, to those who suffer from serious mental health problems that may lead them to be detained under the Mental Health Act 1983.

2. Mind is grateful to have been given Core Participant status in the third Module of this Inquiry, and hopes that it has assisted the Inquiry in particular by the evidence of its Chief Executive Officer Dr Sarah Hughes and of Ms Julie Pashley, who provided both written and oral evidence about her experience of trying to secure psychiatric treatment for her daughter during the pandemic.

MIND'S UNIQUE EXPERTISE

3. Mind's expertise in this field is unparalleled. This is exemplified by the guidance issued by the UK Government on 29th March 2020[1] '*on the mental health and wellbeing aspects of coronavirus (COVID-19)*'; there are numerous links and references in that twelve page document directing readers to guidance, information and advice produced by Mind. And the people of England and Wales turned in numbers to Mind for information and support during the pandemic. In the first week of the first lockdown, there were 306,192 visits to Mind's coronavirus support pages. In 2019-20 Mind's online information pages were accessed 18 million times. That rose to 20.7 million in 2020-21, to 21.4 million in 2021-22, and then to 23.3 million in 2022-23. Mind's telephone helplines responded to around 368,000 calls over the same period. Mind also runs a network of over one hundred 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; during the relevant period, local Minds supported almost 850,000 people:

[1] INQ000348091

406,000 people in 2020-21 and 443,000 people in 2021-22. This depth and breadth of experience has enabled Mind to gain a unique insight into the state of mental health services in England and Wales, to identify what does and does not work, and to understand where reform is needed.

THE FOCUS OF THESE SUBMISSIONS

4. These submissions primarily concern the impact of the pandemic on psychiatric inpatient services for children and young people ('CYP'). It is however important to acknowledge that the pandemic and the measures designed to control and mitigate it affected the mental health of the entire population, children and adults, inpatients and outpatients, and of course frontline healthcare workers. The psychological consequences of what happened between 1st March 2020 to 28th June 2022 was profound, and continues. But there is peril in focussing purely on those 28 months: to ignore the state of inpatient CYP mental health services (henceforth 'CYPMHS') *before* that period would result in an incomplete understanding of systemic failings that caused or contributed to what happened during the pandemic. Similarly, to focus purely on *inpatient* CYPMHS would be to fail to understand that those services do not exist in isolation, but rather are a single component of what is (or should be) a cohesive system of mental healthcare provision that incorporating multiple tiers of support and treatment.

THE IMPORTANCE OF CYPMHS

5. The pandemic had a double whammy effect on CYPMHS: during the relevant period there was an *increased need* for mental health services and at the same time a *decreased availability* of those services. It is vital to understand that many mental disorders are of long duration, chronic, and severely debilitating. But early treatment can be effective in mitigating those effects and improving the prognosis. This is especially important where the patient is a child – an early mental disorder *will* affect the rest of the child's life. Hence there are features of CYP mental health which in Mind's submission should make it a priority. The reasonable apprehension is that the pandemic created a generation that is now experiencing an unprecedented prevalence and severity of mental ill health which, if it is not addressed with alacrity, will debilitate the life of the nation for decades to come.

6. This is not hyperbole. A similar sentiment was aired by MacDonald J in *Lancashire County Council v G, N* [2020] EWHC 3280 (Fam), (referring to the judgment of Sir James Munby in *Re X (A Child) (No.3)* [2017] EWHC 2036 (Fam) at [37]):

"27. Amongst the fundamental principles reflected in the foregoing passage is that the development of children and the development of society are intrinsically and inseparably linked. As was recognised in the American case of *Brooks v Brooks 35 Barb* at 87-88 in 1861, the sound development of the child in all aspects is indispensable to the good order and the just protection of society. Human society benefits from the addition of the child as a member of that society, but the child and society will also suffer if society then fails to safeguard and promote the welfare of that child where the parents have proved, by reason of circumstance or inclination, unable to do so. G's welfare is the court's paramount consideration. But amongst the reasons that this is so, is that the wellbeing of our society is dependent upon the physical, emotional and educational health of our children, including G.

28. Within this context we have a responsibility primarily to G but also to ourselves to ensure her physical, emotional and educational welfare is safeguarded and promoted. This is an imperative course not only in order to maintain dutiful fidelity to the principle that G's best interests are paramount, but also in order to ensure that society endures and develops for the benefit of each and all of its members, including G. At present, society, our society, is failing in that course with respect to G. As recognised by Sir James Munby in *Re X (A Child)(No.3)*, that failure is, and can only ever be, a self-defeating mark of shame for us all."

7. This Inquiry now has an opportunity to draw the attention of the government and the nation to this peril, and to make recommendations with a view to mitigating it. That opportunity should not be squandered. But neither should it be an unduly onerous task, because there is striking consistency across both the witness *evidence* and those witnesses' *recommendations*. Neither should the fundamentals of that exercise attract controversy: where multiple senior members of the judiciary, and the Royal College of Psychiatrists, and Mind, and the expert appointed by this Inquiry, and even the Secretary of State for Health and Social Care from July 2018 to July 2021, all broadly agree that the state of CYPMHS before and during the pandemic was parlous, then it would be anomalous for this Inquiry not to acknowledge that and follow the broadly unanimous recommendations.

FOUNDATIONAL POINTS

8. There are three foundational points to be made at the outset.

9. First, in specific relation to CYP psychiatric inpatients, it is vital to understand the reasons that a CYP will be admitted as an inpatient on a psychiatric ward. Doctors Northover and Evans provide examples of the kinds of presentations that typically require admission: "*psychosis with significant risk to self or others or severe and persistent self-harm or suicidal ideation*"[2] and "*when the individual's presentation involves either a high level of risk or a need for frequent intervention that cannot be managed in the community.*"[3]

10. Thus, inpatient admission is (or should be) a last resort, and is associated with significant risk to the child or young person from mental disorder. It is important to bear this in mind when considering the significance of the evidence set out below about what has been called the 'treatment gap' in CYPMHS during the pandemic, i.e. the ability of the inpatient sector to admit children that *needed* to be admitted to hospital. The gravity of the risks associated with CYP severe mental illness cannot be overstated and include a risk of the death of the child or young person. In an April 2020 briefing, the Royal College of Psychiatrists reported that "*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 lockdown began.*"[4]

11. Second - This module concerns healthcare *systems*. The inpatient sector represents only one part of a system for the provision of mental healthcare to CYP. To examine it in isolation is to mistake the tip of the iceberg for the whole thing. That's why multiple witnesses emphasised the importance of outpatient treatment and other community resources, including social care and early support hubs. Community services represent a typical referral route for a CYP's admission to a hospital. But if they are applied promptly they can head off a need for admission to hospital. If they are not made available promptly or at all, then there is obviously a greater likelihood that the problem will worsen, risks will increase, and the CYP will eventually require inpatient treatment. Hence Dr Northover's oral evidence that: "*We should continue to look at that community offer and how can we continue to provide the care that's required and needed in the community and potentially get ourselves to a position where we need less and less inpatient beds. We're never going to need no inpatient beds, but we can potentially have less and for it to be much clearer*

[2] INQ000474300_0008
[3] INQ000474300_0012
[4] INQ000471270_0002

and much better defined about who should be admitted and why and what that treatment looks like."[5]

12. Community support services are equally important at the other end of an inpatient admission, i.e. when inpatients are discharged. Without them, inpatient admission are likely to be unduly prolonged, or patients descend into a revolving door scenario of admission, discharge to inadequate aftercare, deterioration as a result, and readmission. Hence Dr Sarah Hughes' emphasis on the importance of support and care in the community:

> "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."[6]

13. Third, every story really does matter. Statistics and broad statements are of course useful. But as Professor Fong memorably said "*There is understandable value that we attribute to stuff that you can count. But, you know, not everything that counts can be counted*." Hence this Inquiry's impact statements, which introduce a perspective that is missed by sets of data. No statistical graph can communicate Ms Pashley's anguish at being given total responsibility for her acutely suicidal daughter in March 2020, only to discover later the same day that her daughter had gone to a bridge with the intention of ending her life. That alarming story was the direct result of the pandemic and should inform the need for clear planning and guidance for CYPMHS about the balancing of risks from infection *against* the risks arising from the mental disorder. Dr Sarah Hughes' statement contains numerous direct quotations from CYP who were detained during the pandemic, all of which

[5] 31 October 2024 p174 lines 4-12
[6] INQ000479887_0031

provide a snapshot insight into individual patients' experience of hospital admission during the relevant period. There is great value and poignancy in these voices which are so rarely heard. They speak inter alia to the isolation and powerlessness of a child on a psychiatric ward, for example: "'*Confused - 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)"[7]. The negative effect of prolonged isolation on psychiatric inpatients who are already separated from their family and friends is corroborated by a patient voice reported by Dr Lade Smith, the President of the Royal College of Psychiatrists: "*One of our patient representatives told us of her experience of being held in a mental health inpatient unit for weeks, where she was not permitted to walk to the kitchen to make a cup of tea and was left without access to reading materials or other ways to spend the time. She noted that the total lack of flexibility from the ward in their goal to keep infection levels as low as possible significantly worsened her mental health at the time. She described the experience as nothing short of mental torture.*"[8]

EVIDENTIAL THEMES

14. Mind identifies seven broad themes arising from the evidence to this module of the Inquiry, all of which emerge from the evidence of multiple expert witnesses and people with lived experience of CYPMHS. Mind submits that these themes should inform the Inquiry's recommendations in relation to CYPMHS.

15. **The first theme** is that the pandemic and the systemic response to it undoubtedly negatively affected CYP mental health. According to Dr Elaine Lockhart, the Chair of the Royal College of Psychiatrists Faculty of Child and Adolescent Psychiatry: "*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. 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.*"[9]

[7] INQ000479887_0020
[8] INQ000417461_0071
[9] INQ000472876_0004

16. The 1st December 2022 Technical Report prepared for future UK Chief Medical Officers, Government Chief Scientific Advisers, National Medical Directors and public health leaders in a pandemic recorded that "*Data in the UK has emerged on the mental health impacts of pandemic restrictions, including an observed 81% increase in the number of referrals to child and adolescent mental health services (CYPMHS) and a 4-fold increase in demand for eating disorder treatment in the period April to September 2021 compared to the same period in 2019. There is also evidence that pandemic restrictions impacted the behaviours of children and young people with evidence of poor and disrupted sleep, increases in screen time and reductions in physical activity.*"[10]

17. But these statistics do not tell the whole story. Dr Lockhart reports that as the lockdowns progressed, "*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.*"[11]

18. By March 2022, according to Dr Lockhart "*almost a third of all people in contact with mental health services across England were children and young people.*"[12] And the impact has persisted: "*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.*"[13]

19. The pandemic and its aftermath have thus seen a national crisis in the mental health of our children and young people.

20. **The second theme** is that this MH impact on CYP was foreseeable and predictable. Doctors Northover and Evans have reported that:

> "162. There is no evidence to suggest that the UK healthcare systems had specific plans for mental health inpatient services in the event of a pandemic, beyond those for

[10] INQ000203933_0274
[11] INQ000472876_0009
[12] INQ000472876_0053
[13] INQ000472876_0004

all healthcare inpatient services. Prior to the Covid-19 pandemic, it does not appear that the UK's preparedness and response capabilities considered mental health illness, either adult, community, child or inpatient.

164. Pandemics can have a significant negative impact on child and adolescent mental health. The Covid-19 pandemic exposed young people to **known risk factors for mental illness**, such as disrupted schooling, social isolation, health anxiety and economic instability." (emphasis supplied)

21. Dr Northover expanded on this failure in his oral evidence: "…*we understand social determinants of health and we should be addressing those anyhow, and I think if we don't address those then we have to expect a pandemic will make those social determinants worse and that will have an immediate impact. So for that not being in any pandemic planning is a bit of an oversight.*"[14]

22. None of this is new. Over three centuries earlier Daniel Defoe had published 'A Journal of the Plague Year', his account of the Great Plague of London, in which he recorded observations of what would now be called the mental health impact of a pandemic: "*it is scarce credible what dreadful cases happened in particular families every day […] some dying of mere grief as a passion, some of mere fright and surprise without any infection at all, others frighted into idiotism and foolish distractions, some into despair and lunacy, others into melancholy madness.*" The language is archaic, but the anecdotal message from history is as clear as the scientific message from the contemporary experts.

23. One of the known risk factors cited by Doctors Northover and Evans is school closures. The predictably negative effect of school closures on CYP mental health has been attested to by numerous expert witnesses in this Inquiry, including:

Dr Elaine Lockhart "*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.*"[15];

[14] 31 October 2024 p172 lines 1-7
[15] INQ000472876_0004

Dr Lade Smith "*The closure of schools in particular, while a necessary public health measure during the acute phases of the pandemic, had a profound effect on children. Schools are an important source of support. They give children and young people the opportunity to see friends and trusted adults, and families are able to receive support from teachers.*"[16];

Professor Stephen Powis "*Demand for CYPMH services was increasing prior to the Covid-19 pandemic. The prevalence of mental health problems amongst young people increased further during the Covid-1 9 pandemic, possibly due in part to secondary factors such as the impact on parents and families and national measures put in place to limit the spread of the virus (including lockdowns and school closures)*"[17];

The CMOs' Technical Report: "*For many children and young people, attendance at education and childcare is not only vital for learning but also for access to food and nutrition, physical activity opportunity, and health and therapy services.*"[18]

Dr Sarah Hughes "*Schools are a significant source of CYPMHS 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.*"[19]

24. That latter quotation, from Dr Hughes, is particularly pertinent because it speaks to *why* the 'oversight' in planning identified by Dr Northover matters: a cogent plan for the aftermath of national school closures could and should have recognised that referrals would be likely to surge when schools reopened, which in turn could and should have resulted in planning for how that surge could be met.

25. **The third theme** is that notwithstanding this foreseeable impact, CYPMHS did not feature in the UK's planning for pandemic preparedness. Mind considers it obvious that planning for the health effects of a pandemic should incorporate all of the reasonably foreseeable effects in all sectors.

[16] INQ000417461_0156
[17] INQ000485652_0470
[18] INQ000203933_0274
[19] INQ000479887_0029

26. The evidence set out above makes it plain that the impact on CYP mental health *was* reasonably foreseeable, and gives an indication of how, if planning had been in place, it should have made a difference, for example by recognising the likelihood of the sudden pressure on CYPMHS after schools reopened. Dr Northover in his oral evidence expanded on why planning is important:

> "When we know that that's -- that it's going to happen, we then need to start thinking about what are those protective factors within the community that we need to be considering. School is a huge protective factor for children and young people. I know there's plenty of children who don't enjoy going to school but it's another social safety net to understand when children are struggling and another route for children to start getting help. So we need to be thinking in the future what do we do with schools so we don't remove that safety net, or if we do remove that safety net what can we put in place."[20]

27. What is striking in this context is that the Inquiry has heard that the UK *did* engage in pandemic planning prior to the relevant period, but *not* in relation to the impact on the mental health of the population or on mental health services. That failure has never been explained, adequately or at all.

28. Dr Northover referred to this politely as "*a bit of an oversight*". Mind would go further, and call it evidence that mental health services in the UK are and always have been institutionally viewed as a secondary consideration. That mindset is the origin of the phrase 'parity of esteem', the principle by which mental health must be given equal priority to physical health. The core goal driving that principle is about tackling and ending the stigma and prejudice within the NHS, government and wider society, which stops people with serious mental health problems getting treated with the same vigour as they would if they had a physical illness. The evidence given to this Inquiry demonstrates that parity of esteem remains elusive and was absent during the relevant period. An aspect of the inexplicable and unexplained failure to include mental health in pandemic preparedness planning was that guidance about the pandemic's unique challenges to inpatient mental health services came either late or was absent.

29. That failure had palpable effects on individual lives. A distressing example is the evidence given by Ms Pashley about her pleading with a hospital to admit her acutely suicidal

[20] 31 October 2024 p172 lines 8-19

daughter and being turned away because of the hospital's interpretation of IPC measures. On 18th March 2020 Ms Pashley had been asked to take her daughter from an inpatient psychiatric hospital to the Accident and Emergency department in another hospital. When the family tried to take Ms Pashley's daughter back to the psychiatric hospital, they were refused because the hospital was concerned that Covid would thus be introduced onto the ward.

> "Q. Did you explain your concerns about her risky behaviour and the risk she posed to herself?
> A. Yes.
> Q. Did you explain that to the inpatient staff?
> A. Yeah.
> Q. And what was their response?
> A. "We cannot take her back."
> Q. Were you given any documentation to explain why she was being sent home at that point?
> A. No.
> Q. Did there seem to have been a formal risk assessment undertaken?
> A. Not that we were aware of."[21]
> "Q. If I can just take you back then to that point where the unit were saying they were not going to take CB back because of the Covid risk, the potential Covid risks, and CB was not feeling ready to go home at that point. Do you know whether CB communicated her views about her own state of mind and her own risks to the unit staff at that point?
> A. She wasn't given the opportunity at that point."[22]

30. CB "*knew she wasn't safe. She didn't want to come home*". She was right. Later that evening she slipped away from the family home and went half a mile up the road to a bridge. Ms Pashley recounted that "*So my husband arrived first and pulled her back off the bridge because she'd climbed over the barriers at that point and then the police arrived around about the same time.*"

31. For another, equally alarming example of the inappropriate application of IPC measures in an inpatient setting (inappropriate because it evidences a failure to give adequate

[21] 31st October 2020 p107-108 lines 24-11
[22] 31st October 2020 p109 lines 4-11

consideration to the risks caused by the patient's mental disorder, see paragraph 51 of Dr Sarah Hughes' witness statement:

> *"[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."*[23]

32. These accounts exemplify the confusion and chaos in the mental health system at the onset of the pandemic. Hospitals has not been issued with guidance, in particular concerning the balancing of risks from Covid infection with the risks to acutely vulnerable child patients from the mental disorder, the latter being the reason for their admission as an inpatient. If the mental health sector had been 'in the room' during planning, and when guidance was being issued, then these perils could and should have been taken into account, mitigating the possibility of child patients being put at acute risk by the health system whose duty it was to protect them. Instead, we have this from the statement of Dr Lade Smith, President of the Royal College of Psychiatrists:

> "RCPsych staff were receiving a significant number of messages with concerns and questions from members across the UK about healthcare systems' response to the pandemic. RCPsych Officers and staff expressed concern that there appeared to be a lack of central coordination and direction from government and public bodies relating to mental health, intellectual disability and autism services. It appeared to us that no preparation had been undertaken previously to consider how a contagious virus would be managed across these settings or for people experiencing a mental illness, an intellectual disability, or autistic people. The first time we raised concern about the preparedness of public bodies to lead, advise and support the pandemic response across mental health settings was on 13 March 2020."[24]
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> "On 16 March 2020, RCPsych staff in England had their first call with Emma Wadey, Head of Mental Health Nursing within NHSEI's MHLDA Covid-19 Response Cell,

[23] INQ000479887_0023
[24] INQ000417461_0039

during which they asked us to help prepare dynamic and brief principles, rather than detailed standard operating procedures, with respect to vulnerable patients; care pathways and patient management; and engagement strategies. We also learned of the first cases of Covid-19 on a small number of wards and were informed that appropriate actions were being taken. The MHLDA Covid-19 Response Cell at NHSEI advised the RCPsych that they were setting up six workstreams to support healthcare systems' response to the pandemic. While we were pleased with this progress, we remained concerned that this was significantly delayed compared with other sectors. By this point in the pandemic, primary care, community care and acute services all had relevant detailed operational guidance."[25]

"It is unclear whether MHLDA settings were simply forgotten, considered less of a priority or considered not to need any guidance compared with other settings. All of these scenarios are entirely unsatisfactory and undermine the principle of parity of esteem between mental and physical health"[26]

33. As late as 10th July 2020, Professor Chris Whitty told the then president of the Royal College of Psychiatrists that he "did not feel they had adequate mental health advice".[27] Despite this, Professor Whitty said in evidence that capability is more useful than planning because the characteristics of the next pandemic and the IPC measures that will be need are inherently unpredictable. But he acknowledged the "*general principle that we should take account of particularly inpatient services I completely agree with, and that's for many reasons but an obvious one is that many people living with mental health conditions find it particularly difficult to adhere to some of the very difficult things during Covid, and these are closed environments where close contact is often needed. So for many reasons I think that is an area where we could reasonably do a lot better in any future areas. So I -- basically I am agreeing with you in a rather long-winded way.*"[28]

34. Of course capability is as important as planning, because a plan is useless without the resources to implement it. But (a) if planning is useful in other areas of the health estate (which it must be, otherwise why do it?) then it is difficult to see why it should not be equally useful in relation to CYPMHS; and (b) it is important to understand Dr Smith's point that

[25] INQ000417461_0040
[26] INQ000417461_0041
[27] INQ000417461_0048
[28] 26th September 2024 p196 lines 7-17.

detailed operational guidance for the mental health sector was needed but absent in the early days of the pandemic, but was present for other clinical settings.

35. **The fourth theme** is that CYPMHS were suffering a crisis in capacity before the pandemic, during it, and since. The relevance to this Inquiry of this longstanding inadequacy of capacity is that (a) the need for CYPMHS surged during the pandemic, and (b) absent sufficient capacity, CYPMHS will lack resilience to cope with the next pandemic.

36. In relation to capacity before the relevant period, the position was pithily summarised in Dr Northover's evidence:

> "Q. Given that an increase in demand from mental health services is predictable in a pandemic, as you have set out, do you think there needs to be a surge capacity plan for mental health services as there was for the anticipated surge in demand for acute hospital services?
> A. Yes. Yes.
> Q. And in terms of the inpatient CYPMHS provision across UK, was there sufficient capacity to meet demand before the pandemic?
> A. No."[29]

37. The Chair is invited to watch the video of Dr Northover's answer to Ms Nield's second question. The transcript does not record the rather weary laugh that accompanied the doctor's one word answer of 'No'. There can be no question or controversy in the proposition that CYPMHS have been struggling with capacity for many years. Most strikingly, Saffron Cordery, deputy chief executive of NHS Providers (the membership organisation for acute hospital, mental health, community and ambulance services treating patients and service users in the NHS in England) records that "*Throughout the course of the relevant period, trust leaders highlighted to us that mental health services for children and young people faced a significant treatment gap prior to the pandemic in addition to demand stemming from the pandemic*" and, in a May 2021 survey of chairs and chief executives of mental health and learning disability trusts and combined trusts that provide mental health, NHS Providers found that "*91% of respondents agreed (41%) or strongly agreed (50%) with the statement `Presentations to children and young people's mental health services are more acute and complex than in the past*'" and "*85% of respondents said they could not meet demand for children and young people's eating disorder services.*

[29] 31 October 2024 p172 lines 7-16

Two thirds said they were not able to meet demand for community services (66%) and inpatient services (65%)."[30]

38. The effect of the pandemic was to curtail the availability of mental health assessment, treatment and support for CYP and to exacerbate the pre-existing treatment gap. Dr Lockhart reports that "*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 CYPMHS 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 CYPMHS (with a limited workforce being the ultimate arbiter of bed numbers).*"[31]

39. The reality is that this 'treatment gap' in CYPMHS inpatient services might more aptly be called a 'treatment chasm', which widened as a result of the pandemic. Others have conveyed the same message, both before and during the pandemic; they include Mind (repeatedly, for years), the senior Courts (again, repeatedly, for years), and, in his evidence to the Inquiry, the Secretary of State for Health and Social Care from July 2018 to June 2021 (see the next paragraph for that evidence).

40. The relevance to this inquiry of a long-standing lack of capacity is that when there's a predictable surge in demand caused by a pandemic, a system that lacks capacity is obviously liable to become overwhelmed, and rapidly. When asked about this, Matt Hancock said "*So this is a clear and significant problem in the NHS. It remains so today irrespective of Covid. So I would say that these services were not overwhelmed by Covid, they were already under very significant pressure before the pandemic.*"[32]

41. In one sense that is disarmingly frank, in that it could be interpreted as a concession that CYPMHS were overwhelmed even before the pandemic began. But it is also an incomplete answer. As set out above, the evidence overwhelmingly indicates that CYP mental health *worsened* during the pandemic, and *as a result* of the pandemic, so that demand increased and the treatment chasm widened: children and young people who

[30] INQ000401270_0053
[31] INQ000472876_0027
[32] 22nd November 2024 pp30-31 lines 19-3

presented to CYPMHS following the lockdowns 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.

42. Thus, a vital service that was already under "very significant pressure" before the pandemic was subjected to even greater pressure during the pandemic. If one adopts Professor Whitty's language, the 'capability' was not there. Not only were CYPMHS not capable of meeting the surge in demand caused by the pandemic and the measures adopted by the UK government to mitigate its effect, they were significantly *less* capable than before the pandemic, as a result of a reduction in available beds and workforce shortages.

43. Drawing together themes one to four, the stark evidential message is that during the relevant period there was a coincidence between an *increase* in the need for CYP mental health inpatient services and a *decrease* in the availability of those services. That is the precise opposite of a capable health service.

44. Mind welcomes the government's commitment to grow funding for CYPMHS faster than overall NHS funding and total mental health funding. But the pandemic serves as a reminder of the importance of that commitment being pursued as a matter of urgent priority. Sir Stephen Powis says in his fourth witness statement that "*A number of initiatives have been put in place over the last decade supported by additional investment (including service reconfigurations and workforce expansion), so the additional demand that arose during the pandemic came at a time that service provision was fortuitously already expanding.* ***It was acknowledged in 2019 that closing the treatment gap was expected to take a decade, there therefore remains insufficient capacity to address unmet need and it may take longer than originally planned to close the treatment gap given that additional demand***"[33] (emphasis added). Even if the surge in demand and parallel decrease in capacity during the pandemic was not foreseeable before the pandemic, it is manifestly predictable now, in hindsight. A failure now to ensure that CYPMHS are enabled to accommodate demand for CYP mental health treatment when the next pandemic hits would be an inexcusable betrayal of the generations that represent his nation's future.

[33] INQ000485652_0471

45. **The fifth theme** is that this lack of capacity, which originated before the pandemic and worsened during it, had diverse concrete effects on the mental health and well-being of CYP psychiatric inpatients.

46. There were increased waiting times for CYP who needed psychiatric inpatient admission. Dr Northover was asked about this by CTI:

> "Q. […] but we can see that by either metric the length of time waiting increased?
> A. My understanding of this is what we're seeing is we're seeing a bigger increase in the very long waits for an admission than we were seeing an overall increase in waits. And that can also be held up -- so I think that when we were looking at the very worst there was a -- I think the report identifies in one instance there was a wait of 111 days for a bed."[34]

47. In this context the Inquiry is reminded about the *reason* that a child or young person is likely to be assessed as needing psychiatric inpatient admission: "*psychosis with significant risk to self or others or severe and persistent self-harm or suicidal ideation*"[35] and "*when the individual's presentation involves either a high level of risk or a need for frequent intervention that cannot be managed in the community.*"[36] Delays to admission thus put acutely vulnerable patients at significant risk.

48. These delays to admission resulted in a parallel increase in child patients being admitted to inappropriate placement on general paediatric wards or on *adult* psychiatric wards. In this latter regard, Mind considers it to be a matter of great concern that the Chief Executive Officer of NHS England – when asked about placement of children on adult psychiatric wards – said *"I'm not aware of cases where children have been placed in adult mental health settings*"[37]. There is clear and readily available evidence that such admissions increased during the pandemic, from Doctors Northover and Evans: "*There was an increase in admissions to adult wards over the period of this report. A young person admitted to an adult ward must be reported to the CQC and, as such, there is robust data for England. The CQC received 45 notifications of admissions lasting 48 hours or more in the first three months of 2019, 56 in the same period of 2020, and 66 for the same period in 2021 (CQC, 2022).*"[38] The CQC recorded the main reason for the admission of a child

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[34] 31st October 2024 p146 lines 9-18
[35] INQ000474300_0008
[36] INQ000474300_0012
[37] 11th November 2024 p171 lines 14-15
[38] INQ000474300_0026

to an adult ward as being that "*there was no alternative mental health inpatient or outreach service available*"[39]. As Dr Sarah Hughes details in her statement, "*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).*"[40]

49. The admission of a child to an adult ward is taken so seriously by Parliament that it attracts express statutory procedural duties in s.131A of the MHA 1983, as well as the duty to notify the CQC. And in relation to the effect on the child patient, Dr Northover called the admission to an adult ward "*a double whammy of challenge, because the young person would be in an inappropriate environment, where they would have to self-isolate. And then once an appropriate bed became available they would then have to move & then would have to self-isolate again.*"[41]

50. That's the systemic effect. For an example of the *personal* impact on a mentally unwell child or young person, Dr Sarah Hughes' statement records the understandable fear and concerns for the patient's safety that it causes:

> "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."*[42]

51. The lack of capacity in CYPMHS during the relevant period is further evidenced by the increase in CYP being admitted to (non-psychiatric) paediatric wards during the relevant period:

> "Being treated in an inappropriate setting can lead to a person receiving a lower quality of care, prompting the CQC report on young children in an inappropriate setting. (CQC 2023). Being treated within an inappropriate setting inevitably has an impact on the

[39] See for example INQ000398545_0055
[40] INQ000479887_0010
[41] 31st October 2024 p148 lines 1-10
[42] INQ000479887_0024

time taken for young people to recover as, despite all best efforts to mitigate, effective and appropriate treatment would have taken longer to implement. Young people with mental health needs on a paediatric ward can also impact the delivery of non-psychiatric care on the paediatric ward, for example through presentations of challenging behaviour, the requirement to ensure that young people do not abscond and on occasions young people requiring restraint on the paediatric ward. The Healthcare Safety Investigation Branch (HSIB) published its report on August 4, 2022, investigating the provision of inpatient mental health care for children and young people on paediatric wards (Healthcare Safety Investigation Branch, 2022). The report was initiated due to the rising number of mental health crises among young patients admitted to these wards, which are not designed for such cases. Key findings included increased admissions, a lack of specialized training and inadequate facilities."[43]

52. There were significant delays to patient discharges from inpatient care during the relevant period. Doctors Northover and Evans report that:

> "After the initial increase in discharges, before the social distancing rules were implemented and when the unit and family were able to consider different options to inpatient care, there was a reported difficulty in discharging patients. Discharge became more challenging as increasing periods of leave took longer with periods of isolation on returning to the ward.
>
> 96. All mental health inpatient units for young people in the UK experienced changes in their usual discharge processes. Typically, before a young person is fully discharged from the unit, they are given a period of leave to test how well they cope outside the hospital environment. However, due to the restrictions imposed by the pandemic, the units were unable to provide this trial period of leave. As a result, the units felt compelled to keep the young person in the hospital for longer periods, until they were more confident that the patient had recovered sufficiently to manage without the need for a gradual transition through a leave period. This led to longer admissions overall, as the units aimed to ensure a higher likelihood of successful discharge without the usual opportunity to test the patient's stability outside the hospital setting."[44]

[43] INQ000474300_0029
[44] INQ000474300_0023

53. That systemic delay, directly caused by the restrictions imposed as a result of the pandemic, has obvious relevance to the issue of insufficient bed capacity. But it was also liable to achieve outcomes that were inimical to the purpose of the patient's admission:

> "Young people can struggle with the impact of having their movements and access to the community restricted and it is a known risk factor for challenging behaviour on an inpatient unit to have leave or visits cancelled, it can therefore be hypothesised that increasing these restrictions could have led to increased risk of aggressive behaviour on some units."[45]

54. More alarmingly, Dr Sarah Hughes reports that delayed discharge of a young person from an out of area placement was cited by a Coroner as a contributory factor in that patient's death:

> "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)."[46]

55. Where discharges did happen, patients often had insufficient post-discharge support as a result of the attenuation of community support services during the relevant period, with grave results:

> "In February and March 2024, [Mind] 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

[45] ibid
[46] INQ000479887_0026

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, INQ0004 71280). 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."[47]

56. This underlines the point that inpatient services cannot sensibly be considered in isolation: they are part of a network of treatment and support services, and unless there is sufficiently coordinated capacity in all nodes of the network, then vulnerable young patients are liable to fall through the gaps.

57. What this evidence demonstrates is that the lack of capacity in the CYPMHS, which was exposed and exacerbated by the pandemic, causes a healthcare system, which has as its purpose the protection of CYP patients' mental health and well-being, either delaying or achieving the *opposite* of that purpose. Thus, all of these impacts increased the risk of harm to CYP patients. A lack of capacity to meet a surge in demand means that mental health conditions are not addressed in the early stages, and so the condition worsens, and so longer, more intensive treatment (including inpatient treatment) is needed. This is particularly worrying in the case of CYPMHS, because those first two decades of life are so profoundly influential. It is manifestly to the benefit of society as a whole to ensure that their MH problems are addressed early, rather than left to fester.

58. Children are typically admitted where there is a high risk and where treatment cannot be provided in the community. It's *so* important to remember that the consequence of untreated mental illness can be sudden and catastrophic, to the child and their family.

59. **The sixth theme** is that the mental health impact of the pandemic on children and young people came down hardest on CYP from racialised communities and/or living in poverty. Doctors Northover & Evans identified a significant rise in the number of admissions from the most deprived areas of the country during the pandemic: "*Research has indicated that at the start of the first lockdown, there was a significant rise in the number of admissions from the most deprived areas of the country (Tsiachristas et al., 2024). Further studies*

[47] INQ000479887_0025

have suggested that the pandemic most significantly affected people from deprived areas and worsened health inequalities within child and adolescent mental health care (Serrano-Alarcon et al., 2022)."[48]

60. Dr Lockhart says that "*The impacts of early life exposure to childhood adversity on mental health have been compounded by the pandemic, which has contributed to unemployment, poverty, and stress among many families who were already disadvantaged, thereby further increasing socioeconomic inequalities.*"[49] And "*… 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 EU18 – IN0000268039).*"[50]

61. Children from a racialised background were hit particularly hard. Dr Frank Atherton acknowledged in his oral evidence the effect of compound inequalities:

> "Q. […] My question is whether children and young people's vulnerabilities to the harms from lockdown, which is a phrase used in a paper you presented in June 2020 for the Executive Director Team, whether that vulnerability to harms from lockdown was compounded by extant inequalities. So, for example, the risk to mental health may have been particularly acute for a child from a racialised community who is living in poverty.
>
> A. I absolutely agree with everything you're saying, that there is almost a ladder of inequalities, different steps. So if you're from a black – minority – or a minority ethnic – ethnic minority group and you are poor and you're coming from a socio-economic deprivation, in a poorer part of Wales, then your risk of both physical and mental well-being being damaged is much, much greater. This is why we try, as I have tried to describe, to address this through our approaches to inequalities, but there's no doubt that you're right. There are layers of deprivation -- sorry, layers of inequality which affect people's mental health. I recognise that absolutely."

[48] INQ000474300_0029
[49] INQ000472876_0007
[50] INQ000472876_0008

62. Mind has led the way in seeking to draw attention to the health inequalities that continue to beset the mental healthcare system. This is exemplified by Mind Cymru's February 2022 response to the Senedd's Health and Social Care Committee's inquiry into mental health inequalities[51], in which it drew the Committee's attention to "*… 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.*"[52]

63. That evidence accords with research conducted by the NHS Race and Health Observatory. Its Joint Report with the Universities of Manchester, Sussex, Sheffield, titled Ethnic Inequalities in Healthcare: A Rapid Evidence Review, dated February 2022[53], found that "*ethnic inequalities are apparent in many different mental health services, but the quantity and strength of evidence varies across services and is established for some ethnic groups than others. There was evidence to suggest that there are clear barriers to seeking help for mental health problems rooted in a distrust of both primary care and mental health care providers, as well as a fear of being discriminated against in healthcare*"[54] and "*There was evidence in the review that some of the inequalities present for adult populations were being replicated in younger populations. Parents reported the same barriers to accessing services as reported for adult mental health services. Two studies of young Black men showed that the injustices they knew of in mental health services relating to Black Caribbean and Black African populations, deterred them from seeking help. Two large national studies found that ethnic minority children were more likely to be referred to CYPMHS via social services, education or criminal justice pathways and this was particularly stark for Black children who were 10 times more likely to be referred to*

[51] INQ000471294
[52] INQ000479887_0037
[53] INQ000249828
[54] INQ000249828_0043

CYPMHS via social services (rather than through the GP) relative to White British children."[55]

64. Thus systemic racism causes understandable distrust in the communities who are subject to discrimination, which in turn prejudices the capability of the healthcare system to provide the services which it has a duty to provide. It is a grim cycle. The significance to this Inquiry is that, per doctors Northover and Evans supra, the pandemic most significantly affected people from deprived areas and worsened health inequalities within child and adolescent mental health care.

65. **The seventh theme** is that not all measures devised during the pandemic to address these impacts were successful. In particular, remote contact between CYP and mental health services is not a panacea.

66. Three sources of evidence that addressed the value of remote contact all also identified that remote appointments do not work for everybody and said that there are particular issues in relation to their use with CYP.

67. In the section of his fourth witness statement which addresses Changes in arrangements for service delivery of CYPMHS during the pandemic, Professor Powis records that "*CYPMHS providers and commissioners rapidly adapted to remote working in response to COVID-1 9, including frequent use of video consultations and digitally enabled therapy models. levels of activity reflect strong adoption of digital consultations with approximately 20% of all contacts delivered through this medium in June 2020. 68% of all CYP contacts were delivered through alternatives to face-to-face contacts by February 2021 (compared to 54% of contacts in adult and older people MH services).*"[56] However, he goes on to acknowledge that "*Although digital support is a valuable means of accessing some services, it should be seen as augmenting rather than replacing in-person support. Remote appointments do not work for everybody and there are particular issues in relation to their use with CYP. Remote assessments are not as effective as face-to-face assessments for assessing safeguarding risks, for example where the home environment or interaction between family members requires assessment, or where the young person's privacy within the family home is not assured. Some young people lack access to technology, or cannot afford it, or simply do not feel safe opening up on line. Therefore, while face to face activity*

[55] INQ000249828_0044
[56] INQ000485652_0507

reduced significantly during the earliest stages of the pandemic, services were expected to move at pace to offer a blended model which offers choice to meet needs and that is clinically appropriate."[57]

68. Doctors Northover and Evans report on the advantages of remote contact between CYP and mental health providers, but also caution that "*remotely-delivered therapies were not always the best option, for example remote therapies limit the ability of mental health professionals to observe and assess patients' body language, make it more difficult to interpret facial expression or recognise when a patient is hearing voices. Additionally, some young people find it more difficult to stay focused and engaged during remote therapy sessions*"[58] and "*Whilst there are disadvantages, and evaluations of these programmes appear to favour in-person approaches, intensive on line programmes offer an alternative, accessible step prior to admission ((Catenacci and Couturier, 2023), (Brothwood et al., 2021).*"[59]

69. Dr Northover was the author of the September 2021 Getting It Right First Time (GIRFT) report on CYPMHS[60], which examined the effect of the pandemic on CYPMHS. That report expressed a similar mix of enthusiasm and caution in relation to the value and effectiveness of remote appointments: "*Virtual appointments do not work for everybody - there are particular issues for its use with CYP. There are challenges, such as CYP who are often in crisis and have complex social situations with overcrowded accommodation, safeguarding issues in the family home or poverty. Digital assessments are not as effective as face-to-face assessments for safeguarding risks where the home environment or interaction between family members requires assessment, or for confidentiality where the young person's privacy within the family home is not assured. Some young people lack access to technology, are concerned about privacy or simply do not feel safe opening up online. Almost a third of young people lost access to mental health support after lockdown.*"[61] And "*Whilst there are disadvantages, and evaluations of these programmes appear to favour in-person approaches, intensive on line programmes offer an alternative, accessible step prior to admission.*"[62]

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[57] INQ000485652_0508
[58] INQ000474300_0038
[59] INQ000474300_0043
[60] INQ000485262
[61] INQ000485262_0033
[62] INQ000474300_0043

70. Mind submits that there is a danger here that a hurriedly developed pandemic contingency measure may come to be viewed as an answer to the capacity problem that has beset CYPMHS for years. It is at best an incomplete answer, is often inappropriate, and does not represent a viable alternative to the provision of face-to-face MH treatment. When the lawfulness of remote assessments of psychiatric patients subject to the Mental Health Act 1983 has been tested in the courts, the invariable judicial opinion has been consistent with Mind's position[63]. The Divisional Court in the Devon case considered it to be significant that "*a psychiatric assessment may often depend on much more than simply listening to what the patient says. It may involve a multi-sensory assessment for the purposes summarised at para. 43 above. It may involve a physical examination in order to rule out differential diagnoses. It is no answer to say that it should be up to the examining doctor to decide when physical attendance is necessary, because without the cues that could only be picked up from a face-to-face assessment, the doctor might wrongly conclude that physical attendance was not required.*" Factors such as these, in Mind's submission, underline the need for great caution in the use of remote consultations, and explain why per the evidence, evaluations of remote consultation programmes favour in-person approaches.

71. That caution is further justified by reference to Mind's findings in its report titled *'Trying to Connect: The importance of choice in remote mental health services'* (2021)[64]. Mind surveyed 1900 people, 244 of whom were young people aged 13-24: "*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: "/ 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.*"[65]

72. A major concern was privacy: "*AB, a young woman who received remote mental health support during lockdown for anxiety, depression and psychosis shared: "/ don't have a*

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[63] Devon Partnership NHS Trust v Secretary of State for Health and Social Care [2021] EWHC 101 (Admin) and Derbyshire Healthcare NHS Foundation Trust v Secretary of State for Health And Social Care (Rev1) [2023] EWHC 3182 (Admin)
[64] INQ000471269
[65] INQ000479887_0018

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."[66]

73. Another concern is digital exclusion. That is endorsed by the evidence of Dr Lade Smith, President of the Royal College of Psychiatrists. The College's experience accords with that of Mind, both in relation to the therapeutic advantages of face-to-face contact, and the tendency for remote clinical contact to exclude those who already suffer health inequalities:

> "171. On 10 July 2020, during an online meeting with other medical royal colleges, the President of RCPsych at the time, Dr Adrian James, asked Professor Chris Whitty, CMO for England, about any work that was happening to deal with digital exclusion. Professor Whitty said that this was an extremely important issue and something DHSC had come to realise was something it needed to address. He expanded this into a discussion about those for whom regular communication channels did not meet their needs and he expressed that he felt that the Leicester outbreak was, in part, related to this. The College also raised concerns that the health outcomes of people who could not come to hospital and whose access to digital technologies was limited would potentially be the poorest.
>
> 172. We heard from one of our carer representatives, who is a mental health carer who looks after her brother. She explained that if not been caring for her brother during the pandemic, he would not have been able to access services, such as a psychiatrist, as he is not digitally literate. We also heard from this carer that she felt that lockdowns placed extra burdens on her as a carer — she felt forced to lobby for access to doctors and to use digital communication, which was difficult for the person she cares for.
>
> 173. We heard from another carer representative that he was shocked at the reliance on digital literacy to secure appointments; while he and his mother, who he cares for, did have digital access at the time, his mother was not digitally literate, and many other people and families did not have access to appointments. As such, we heard that digital poverty rendered resources totally unavailable to many.

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[66] ibid

174. Although there is a good body of evidence which points to improved outcomes from face-to-face therapeutic relationships for patients with mental health problems, more research is required to understand the efficacy of digital and telephone therapy; specifically; there is a need to understand the impact of the digital format on the patient experience of therapy (both on a one-to-one and group basis), as well as the impact on concordance with medication and ongoing reviews."[67]

RECOMMENDATIONS

INVESTMENT IN CAPACITY[68]

74. Mind urges the Inquiry to recommend that priority be given to investment in capacity, across the board in CYPMHS, to meet the increased need that arose during the Covid pandemic, and to ensure surge capability in the event of a future pandemic. Without investment, the national scandal of inadequate provision for the nation's most vulnerable children and young people will escalate and render the CYP mental healthcare system vulnerable to future shocks.

75. There is a particularly pressing need for local and national investment in robust community mental health services, which will enable prompt intervention and thus relieve the pressure on the inpatient sector. Dr Northover was emphatic on the need for a refocus on community CYPMHS *as a means of protecting inpatient capacity*[69], as was Dr Sarah Hughes[70]. It would follow from a reduction in the need for the use of inpatient treatment that many of the problems which arose during the pandemic (out of area placement, admission to adult or paediatric medicine wards, the lack of inpatient capacity) would be mitigated. Mind asks the Inquiry to recommend that a duty is imposed on local authorities and Integrated Care Boards to ensure the needs of children can be met in their local communities, which should include multi-agency provision for young people with complex needs currently placed in unsuitable and unregulated social care accommodation.

76. As part of that focus on early intervention, the Inquiry should recommend investment in early support hubs in every community across the country.[71] These hubs will provide easy

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[67] IN0000417461_0065
[68] The need for investment is endorsed by Dr Lockart (INQ000472876_0053 - 0054); Drs Northover an Evans (INQ000474300_0043); and Dr Smith (INQ000417461_0163 - 0166); see also Professor Philip Banfield for the BMA at INQ000477304 paragraphs 397 and 398, citing INQ000433871, which details an analysis by the BMA concluding that "*mental health services are not being resourced at a fast enough rate to respond to the level of demand.*"
[69] 31st October p173-174 lines 21-12
[70] INQ000479887_0039
[71] This is also an express recommendation made by Dr Lockhart (IN0000472876_0056)

to access support on a self-referral basis for young people who don't (yet) meet the threshold for CYPMHS or who have emerging mental health needs. Currently when CYP need support for their wellbeing and mental health, services available through their school and the NHS simply do not offer it in time, as they cannot cope with the level of need. It is difficult for CYP to get a referral for mental health support, and once they are referred, they may be stuck for many months on waiting lists. The evidence is clear that the longer a CYP waits for supper and treatment, the more likely it is that their mental state will deteriorate to a level that requires inpatient treatment. Early support hubs which are embedded in the community would further serve to address the understandable lack of trust of people from racialised communities in a health sector that has a long history of discriminatory treatment, particularly of black patients. Mind welcomes the current Government's acceptance that early support hubs are necessary but emphasises that if these hubs are to fulfil a hitherto unmet need, particularly for CYP from socially deprived communities, then their focus must be on mental health support, and not simply crime prevention.[72]

PANDEMIC PREPAREDNESS PLANNING[73]

77. The Inquiry must recommend that there be comprehensive pandemic preparedness planning for the impact of future pandemics on the mental health of CYP. This is again multi-factorial, but the nation's mental health services must never again be taken by surprise by the mental health impact of a national emergency. Schools must be recognised as being vital to the mental health of children and young people, and should remain accessible and open if at all possible. But the approach of schools to CYP with mental health issues is by no means ideal. Mind recommends that trauma-informed approaches are introduced to address poor mental health in schools and welcomes proposals in the draft Equality (Race and Disability) Bill which seek to mandate specialist training on schools to address inequalities.

78. Pandemic preparedness planning should include an examination of the appropriateness of virtual assessment and treatment during a future public health emergency. There is an urgent need for clarity about when virtual therapeutic interventions are and are not appropriate alternatives to face-to-face interventions. The current equivocal messages on the use of remote contact with CYP patients is inadequate: in his oral evidence Dr

[72] Early support hubs are also an express recommendation of Dr Lockhart (INQ000472876_0056 - 0057)
[73] The need for mental health specific pandemic preparedness planning is endorsed by Dr Lockhart (INQ000472876_0054 - 0055); Drs Northover an Evans (INQ000474300_0043-0045), and Dr Smith (INQ000417461_0005 and INQ000417461_0052 -0053)

Northover said that no consideration was given to the particular issues arising in CYP MH: "[Guidance] was very much more a blanket that, you know, if you can work remotely you should be working remotely rather than thinking more closely around what would work remotely and what wouldn't."[74] There should be particular reference to the needs of CYP from disadvantaged communities and the potential for them to suffer digital exclusion: it would be a tragic irony if moves toward remote contact between CYP and MHS results in worsening health inequalities.

79. Pandemic preparedness guidance must include clarity on how CYPMHS inpatient units should respond to rules on social distancing and self-isolation. That should include clear guidance on the value to CYP inpatients of visits from family members or carers, and on how this may be enabled even during a pandemic. The Inquiry should recommend that there should never again be blanket application of isolation rules in relation to CYP on inpatient wards. The purpose of the inpatient admission of a CYP is the treatment of the mental disorder. Measures that hinder that treatment will naturally hinder recovery, resulting in the CYP spending longer in hospital than necessary. As well as being inimical to the very purpose of the admission, it causes further pressure on bed capacity. Dr Northover commented in his evidence on Julie Pashley's account of how this affected her daughter:

> "Q. What was the impact of a period of isolation on a young person's mental state?
>
> A. I was very fortunate to be able to hear the evidence provided by the impact witness earlier and I think I -- it's just building on what she said, it is a terrible time for a young person to be placed in isolation when they're at their most distressed from a mental illness that means they can no longer be at home. So to be placed in isolation at that time with a mental health nurse outside your room inevitably had an impact in terms of the distress on that young person but also the time that it would have actually taken to get them the appropriate therapeutic input and also for them to be able to be engaged within that therapeutic milieu within the unit."[75]

80. That includes isolation of CYP inpatients from their family, and from the ward milieu:

> "Q. What are the importance of -- what is the importance of family visits for mental health inpatients?
>
> A. It's crucial, family and carers. Some young people may be admitted where actually they haven't got family or don't have access to their family, but I think family and carers

[74] 31st October p167 lines 9-12
[75] 31st October p163 lines 11-25

is absolutely crucial. I think any mental health presentation within a young person doesn't just affect the young person, it affects the family and carers as well. So it's about how the treatment needs to involve those systems and not just an individual. So delaying or not enabling that to happen has a negative impact on the therapeutic delivery of care."[76]

81. CYP inpatients will inevitably suffer greater isolation where they are inappropriately placed, either in a hospital distant from their responsible Commissioning Group hub area or on an adult ward. This again is inimical to their recovery, which is the purpose of their admission to hospital. Mind asks the Inquiry to recommend the introduction of enhanced reporting duties on hospitals to notify local authorities when a child is placed on an adult ward or out of area, or if such an admission lasts longer than 28 days.

82. There *must* also be specific guidance on the balance to be struck between (a) the risks arising from exposure to a pandemic and (b) the risks to inpatients arising from their mental disorder, for example from refusals to admit or precipitate discharges. It is clear from Ms Pashley's evidence that that balance was not always achieved and that the consequences of getting it wrong are potentially catastrophic. As she says in her statement "*It was very disconcerting to see rules being applied blanketly with no regard whatsoever to risk assessing vulnerable young people.*"[77]

83. That evidence accords with Dr Northover's experience. Asked whether he could identify any measures or guidance at a national level or indeed at a local trust level which were aimed at mitigating the pandemic impacts on CYP inpatients of e.g. self-isolation periods. reduction in staffing levels, and less continuity of care, Dr Northover said:

"A. I'm tempted to say no. But I think the fact that I'm sitting here not able to recall any is probably an indication itself that if there was that the way that it was communicated was probably -- the communication of that was probably outweighed by the communication of the safety, the social distancing rules and the PPE rules."[78]

HEALTH INEQUALITIES IN THE CYPMHS SECTOR MUST BE ELIMINATED BEFORE THERE IS A FURTHER PANDEMIC[79]

[76] 31st October p164-165 lines 1-19
[77] INQ000486_003
[78] 31st October p169 lines 1-12
[79] The need to address health inequalities is endorsed by Doctors Northover and Evans (INQ000474300_0046); Dr Smith (INQ000417461_0144)

84. Heath inequalities have a concrete and wholly malignant effect on CYP patients and the CYPMHS. This has been a long-term trend marked by decades of stigma, rejection, and racism. The well-evidenced widening of inequalities during the pandemic is a mark of shame, and an indication that urgent action must be taken to address the asymmetry between CYP from disadvantaged communities, and from racialised communities. Deep racial injustices and their impact on the mental health of young people must urgently be addressed. People with African and Caribbean heritage in particular continue to face disproportionally poor experiences of mental health services, which is often driven by reinforced fear and mistrust. That this had palpable effects during the pandemic was demonstrated in Dr Northover's oral evidence:

> "Q. You also observe in that report an increase in admissions from more deprived areas, and you mentioned earlier those social indicators of poor mental health. Did you find any data on inequalities in relation to black and ethnic minority children and young people?
>
> A. So there's one report which has been done based on -- the Far Away from Home study, which did indicate that during the first lockdown that there was actually a decrease in the admission of young people from black and ethnic minorities. However, during the second lockdown there was an increase. So the hypothesis from this paper is that during the first lockdown, this was a cohort of young people who actually ended up accessing services less, so earlier intervention towards their mental health wasn't able to be put into place, and that became more apparent with the second lockdown, when the severity of their mental illness became such that it was no longer possible for them to -- it was no longer possible for them to stay where they were and they required the support at a higher level at that time.
>
> Q. At which point they were at a crisis point?
>
> A. Yes."[80]

85. Mind urges the Inquiry to recommend the introduction of culturally competent community services for racialised communities, and that *all* providers of mental health services take urgent action to embed NHS England's Patient and Carer Race Equality Framework.

20th December 2024

[80] 31st October pp152-3 lines 5-2

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