Transcript of roundtable with practitioners for the Health and Social Care Committee Mental Health Expert Panel on Tuesday 12th October 2021

Group 2: Children and Young People's Mental Health

Participant A: I work for a forensic CAMHS service, a community service which covers six counties. It's a tier 4 service.

Participant B: I'm Head of Commissioning in my county council, and I have responsibility for children and adolescent mental health.

Participant C: I'm Director of Nursing and my main focus in the trust is mental health.

Participant D: I'm a Principal Counselling Psychologist. We work in community CAMHS.

Participant E: I've got a myriad of titles, so I apologise before I start going through them. I'm a Child and Adolescent Psychiatrist, primarily focusing on early intervention in psychosis I'm also the Trust's Lead Clinical Director. I'm also the CCIO within my trust.

Participant F: I'm a consultant psychiatrist and I work in a perinatal psychiatric practice. I'm really interested in the early years, so from conception to 2 years, and the life chances of those little people and how we prioritise that in everything that we recommend in terms of strategy.

Peter Fonagy: So a distinguished group. I have three questions that I've got to ask, and if you want to come in on these questions, or respond to any comments, then please speak up. What you say here will be pooled into a range of views, but it's incredibly important and I can assure you of that. So the first question I have is if you think the commitments set by the government are sufficient to meet the mental health needs to children and young people. And just to remind you that the commitments were 70,000 additional children and young people each year will receive evidence based treatment. That by 2021 a target of 95% of children and young people with eating disorders will be able to access treatment within one week for urgent cases and four weeks for routing cases. And finally ensuring that there is a children and young people's crisis response that meets the needs of under 18s. So crisis response, eating disorders and access to 70,000 additional children and young people. Do you think the progress of these commitments has been sufficient to meet the mental health needs of children and young people?

Participant E: I think one of the challenges is that there is a difference between meeting the commitments and whether the commitments are good enough. Because I think that we have to take into consideration all of the changes that have happened across the health economy since those commitments were made. And the commitments weren't particularly outcome focused. If we're thinking about at least 70,000 additional children and young people each year will receive evidence-based treatment, I think we could say that at least 70,000 children a year receive treatment, but we don't really have an outcome to identify whether they're receiving evidence-based treatment, and we don't really break that down to see whether the treatment they're receiving is effective or not. One of the examples that I'd put in here would be that our largest provider of child and adolescent mental health services right now is KOOTH, as an online platform which feeds all of it's data into the MHSDS. So my guess is that whenever we look at this figure of how many young people are accessing services, we are also including KOOTH into that and it's just a question of where that actually fits in terms of the principles behind the commitments rather than that figure fitting the commitment.

Participant D: I was just going to add what Participant E said when talking about evidence-based treatment, are we talking about the quality of that treatment as well. I'm really mindful that we have KOOTH and it's accessible to some families, but I wonder if there are some issues around equalities of accessing that. I'm equally mindful of the fact that we have MHST trailblazers being rolled out nationally across different patches, but it's still in the early stages where we have people being trained on it, who are only able to pick up certain interventions and offer those, and again how much are getting in terms of outcomes if these, and that would be reflected in the quality that we're offering. It's just in the context of referrals increasing in CAMHS as well, and that's been since Transformation in Services. From what I understand nationally, just from a neuro-developmental perspective, the referrals have increased by 104% which is a huge increase. So for me it feels that these perhaps has been a touch into mental health in offering interventions, but perhaps we need to review where the target needs to be now, because as Participant E said, this was outlined at a time when things were perhaps a little bit different, and it needs to be reviewed a little bit.

Peter Fonagy: Thank you. That certainly makes a lot of sense. So far, we are focusing on the 70,000 pretty much. What about the eating disorder issues and the crisis response?

Participant F: I'll raise all three, but in a slightly different way in which we have these targets that need to be met, but there's no triangulation of that against anywhere in the age range. We have no sense about what's happening with our younger citizens because they're largely invisible in the systems. We don't have a shared understanding about whose responsibility the mental health of 0-5 years olds lies. We know that the number of referrals through primary school age increases incrementally as you get towards the latter years, with fewer in the earlier years, but yet I think all us that work clinically know that when we take our histories you can trail back and you can see the early determinants of the child's mental health deteriorating happened in that age range. So within that 70,000, or within any of the numbers that we're talking about, have we got any levers or teeth to try and influence the fact that within the age range we need to be thoughtful about our younger citizens, and if they're invisible then how on earth can we turn off this top of increasing referrals.

Participant E: I think that's crucial from a couple of points of views. I think the other point of view is, when we look at the data, and we do try to break it down looking at access in the different age groups we notice that the discrimination against ethnic minorities is greater the younger the child. We also know that the adolescence that are most likely to be using the high intensity, are most likely to be from ethnic minorities, particularly when you go into the secure setting. So I think the fact that we're not collecting that data and we're not looking at what's being done in early life is clearly having a significant impact later on.

Participant A: I just wanted to add a bit extra about the early life. With CAMHS we go from age 0, but obviously we don't see babies that have got forensic needs, but sometimes we get some quite young referrals which is surprising. They can be 7,8,9 years old, and there's no real space for them, because CAMHS might say that they don't really meet our criteria, or they're too complex, or it's more social care and social care may not have the skills to work with complex needs within the family and parental mental health. Sometimes the child is displaying some really severe aggression or sexualised behaviour at that young age, so there is a lot of bouncing back and forth. The safeguarding leads, the obvious things might have been dealt with, but there are still all of the other emotional and distressing- I don't like the word behaviour, but you know what I mean- external displays that distress. Those children are really lost in the system and it feels like until a child can sit in a room and have talking treatments on their own, often without any family support around that treatment that they don't really get so called evidence-based intervention.

Peter Fonagy: Thanks. I'm hearing quite a bit about people getting lost in the system and not being seen because they're too young, or cases too complex. They're minoritised.

Participant B: So I have a couple of reflections. Something that Participant E said right at the beginning, I get frustrated with access targets because I think that it's hitting the target, missing the point. You're not focusing on the outcome, so I find that a little bit frustrating. I think the other thing, in connection to what others have said, is we don't focus enough on early intervention and prevention. Because it's about hitting an access target, that infers that we've already got to a point where we haven't been able to focus on the early intervention, because we've waited until we've got to a point where somebody hits a threshold to trigger an access target.

Participant C: I was just going to add, thinking about what everyone has been saying. I'm not sure we're set up for the complexities that we're currently seeing, and I think that the young people what we're seeing don't fit into the boxes that we've created. I spend a lot of time in collaborative meetings, trying to work out where various young people are going to go, and a lot of the services, because they're so overwhelmed since the pandemic (not that it's finished) that they're using their criteria as almost an exclusion to safeguard their own services. And we hear a lot of discussion about what we can't do, rather than what we can do. To really highlight that point on eating disorders, we've seen an exponential rise in young people with eating disorders, and certainly for our trust, we don't have the capacity in terms of eating disorder services for young people, but this is what we're now seeing. We're seeing a requirement for out clinical staff to have completely different skill sets around that physical health arena and we're really playing catch-up in terms of trying to deliver that. So I think there is something about, certainly in nursing, about how we train nurses and certainly we don't train CAMHS nurses as there are very few speciality courses for nurse in CAMHS in the way that there are for other professions. I think that's what we need to look at. And we need to look at that the skill set needs to look like given the young people and the presentations that we're seeing.

Peter Fonagy: So it's a training issue that you're highlighting as well as yet another gap in the system.

Participant E: First of all, Participant C it seems amazing doesn't it, how you can work in an area for so long and things just slip from our mind. I'd forgotten that there's no specific child and adolescent mental health training for nurses. It's such an oversight, it really is. What I really wanted to comment on was eating disorders and the way that the targets have been set and worded, which are not necessarily helpful for the real world. It's to achieve a target of 95% of children and young people with eating disorders accessing treatment within 1 week for urgent cases, and 4 weeks for routing cases. So the easiest way to meet that target it to not diagnose people with an eating disorder at assessment, because then it is about accessing your service rather than who has an eating disorder service. And in my mind, this is what has driven this whole conversation around ARFID, an ARFID isn't an eating disorder because if it was an eating disorder then our targets would be totally messed up. So we call it disordered eating and say we need to devise a whole new ARFID pathway so we can still look good. I think we've got to be really careful about how these targets are framed in the future so that we don't inadvertently cause game in the system and potential harm for children and young people.

Participant F: Another element of that is that I certainly see pregnant young people who have disordered eating as a manifestation of greater trauma, and because they come from a trauma experience in their early lives they don't fit anywhere. And there is a real temptation for young women particularly, to be signposted down a personality disorder pathway at that point rather than a holistic view od their past trauma and thinking about what can best meet their needs. And once

that label has been attached within adult services, they then can't access a bunch of other therapies. It not just that we game the system, we create categories which then bar some people, young people, from getting into areas of therapy that might have been helpful for them down the line.

Participant E: Absolutely. I personally quite like specialist pathways, but they need to be designed around a central care coordination team that pulls in the expertise rather than creating site pathways. And again the desire to have facts and figures, and referral numbers, and not outcome measures has driven us into this siloed position, and I think it's a great shame that we never talk about the proportion of children and young people who are going to be getting better.

Peter Fonagy: I think these are all excellent points and I want to encourage you voicing them. If you can give specific examples, because the more specific you can be the easier it is to use in a report that feeds back. We're not going to abandon the first question, but I want to twist if slightly because you will have thoughts and feelings about this one as well. Do you think the funding has been sufficient to make progress on these commitments?

Participant E: Again, the question is open to interpretation. Has there been sufficient resource and is that resource appropriately targeted is a different question to funding. I know that within most of the trusts, and in my trust, that we cannot use all the finance that's coming into child and adolescent mental health services, because there are not the staff to be recruited, the third sector organisations aren't there to ask to do the roles or even finding people to do the digital offer. So targeting the resource to child and adolescent mental health services, is perhaps not giving us the outcomes we want and that perhaps it needs to be thought about where else the resource can be targeted that would also drive improvement across the whole system. I would be thinking in particular social care here and I think the impact that social care has on the rest of the system.

Participant A: Yes, social care is a big area. I come from a youth offending background and worked a lot with social care, and mental health support in a setting like that, or mental health practitioners sitting in social care settings helping social workers and youth offending worker and looked after children social workers to navigate their way around young people's mental health and parental mental health as well. It's so valuable, but it's so lacking. It's very patchy and lots of places have nothing at all, and these are often the most vulnerable and high- risk children in society, and high-cost children in society.

Peter Fonagy: I want to say this is an import point, what you see as an improvement in the system is a genuine integration of social care and CAMHS and children and adolescent mental health funding.

Participant F: Could I stretch that even further to say that it would be an integration into public health nursing. So we have expertise that sits in health visiting services looking at early years, in-school nurses and in public health nursing which gives us another thread which is accessible, acceptable to lots of families for whom mental health interventions or social care interventions aren't necessarily seen as helpful. But public health nursing is a real thread that should sit as the third leg in the stool of what we're describing, I think.

Participant E: And actually if we think about health visiting in particular the change in the health visiting funding, and the removal of protection of that. Within our county we've seen the caseload of health visitors, has become absolutely enormous. I think at the moment the contracted caseload for a health visitor is over 700 young people- I don't want to be quoted on an exact figure- but it's gone up from around about 200 when it was provided entirely through NHS CCG funding to probably well over 700 now.

Participant F: And Peter, you asked for specific examples and I can tell you that five years ago, if I was doing complex birth planning with a mum who had complex mental health needs, and toddlers or pre-school children in the household, the health visitor would have come to the birth planning. They would have gotten to know that family antenatally, would know them already from their previous contact with the other children and would be an integral part of the prevention agenda for that little person and their older siblings. And now health visitors have no capacity to get involved in that pre-birth meeting, they have barely got the capacity to go the statutory visits in the post-natal phase. And we know that the targets for just meeting the physical health requirements in health visiting are through the floor. So very practically on the ground, I see families not having that access to health visiting that they had 5-10 years ago.

Participant D: I was going to add, that there are gem pockets within CAMHS services where there are lots of integration that is happening. I used to work in another CAMHS, and they have a service that works across health visiting and sits in CAMHS as well, where they work with the under 5s and also with mothers before they have given birth. They used to have a service which was a social care liaison service, that would link in with social care but sits in CAMHS. But again, because of investments and cuts, and almost a bit of defragmentation of CAMHS moving away from social care, those things have fallen. In the past CAMHS services would have sat jointly with social care services, whereas in the last few years it feels like we've moved away a lot more. In terms of the question that you asked Peter about whether the funding and investment is sufficient, it's yes there has been some investment there but actually the issue is more around recruitment. I think that is something that's been experienced national by a lot of child and adolescent teams, where they just cannot recruit people. That's partly because a lot of people, from my experience, a lot of people are going into private practice due to staff wellbeing and equally, I think it's also skillset. It's one of the areas that unless you choose to go into learn about CAMHS, it's really hard. I'm just thinking from a counselling and psychology perspective, it's really hard to actually get a CAMHS placement, and one of the things I'm trying to do at the moment is trying to create posts that allow trainees to join so that we can have a throughput. There are two angles to it in terms of what the investment that's coming in, but also the difficulties in recruiting the right staff.

And there's so much talk at the moment about increasing the service from a 0-25 service in my trust, and I'm sure that's across other teams as well. And what I'm thinking is how are we going to get the skillset to meet that 0-25 demand, because some people aren't trained to work post-18 so we would have to do joint work with adult services. So I think there is a lot of thinking that needs to happen about where that investment is going. There's lots of investment going into early intervention, for example the MHSE and things like that, but we're also getting such an influx into tier 3 where even though we have that exclusion criteria most of the referrals that we get are deliberative self-harm, they're overdosing. Only yesterday I was talking to someone and they said that now you even have to wait to be seen if you're self-harming. The service is really crippled at the moment which is really sad to see. And I'm just really concerned, just from my neuro experience of working with autism and ADHD, because the referrals are increasing, and they're almost boxed in a little bit in terms of no one can really work with them unless you're in the specialist area of working with this cohort of individuals because they're a separate ND pathway. As Participant E mentioned unless you work with a holistic person it just makes it so tricky to work with these individuals.

Participant F: I wanted to speak about estates. I think that when people think about estates, they're thinking about more tier 4 beds, but we know that post-pandemic there are fewer areas that we're allowed to work clinically into. GP surgeries have shut their doors, schools don't want people coming in and from my perspective the midwifery services don't was us using the rooms that we used to

used in the antenatal clinic. We have children and young people who need to have a really important, incredibly respectful and thoughtful conversations and we're shoehorning them between different venues without a real home. I think about our staff, and staff wellbeing as well, working with these really complex young wellbeing and before they could meet up and have lunch or a coffee with a member of their team. But when people are meeting more remotely, and in less of team way, we run the risk of our staff having real moral injury and sickness levels going through the roof, because they don't have the team support. So if we're thinking about investment, we need to not only think about what we're delivering, but where we're delivering it and how we're delivering it and how we're looking after our people, and how we're looking after these young people who are coming in during this very difficult time in their lives. What does the estate that we see them in say about how much respect we have for them and what does it say about how much respect we have for ourselves and for our colleagues.

Participant A: It's that trauma informed approach isn't it, that attachment informed approach. It's talked about a lot, but whether it's really practised, or whether it's able to be practised in something quite different.

Participant B: From a social care perspective, can I just add a few bits to various things that people have said. So, Participant F picking up on what you just said about estates, we would like to see a lot more home treatment, and I think we don't think about home first. From the financial perspective, there's a couple of points that I wanted to make. One is that we're trying to work more in partnership and collaborate, but it's not just about health and social care as education plays a really big part in this as well, so we're trying to strengthen that relationship because it's a really important one. And just a really small point on the funding side, I think that funding doesn't feel like it allows for innovation. And it's quite prescriptive, and this links back to my earlier comment about hitting the target but missing the point, because it doesn't allow for innovation, it doesn't allow for whole system transformations across the departments and beyond that I was just talking about. And it's not sustainable. So very often funding comes down and there are examples where we are asked to spend that and asked to find ways to work as a system to spend that in a year, or in two years, and then it will go into baseline budgets. It doesn't allow us to be innovative, it doesn't allow us to work together as a whole system. It actually divides us in some cases because there are examples where we all come together and say "yes, this is a really good idea, but how are we going to fund it after 1 year?" And then it becomes divisive because we then have to try and come together and say 'should health fund this or should social care fund this?" We're all doing the jobs that we do because we care passionately about the people that we serve, and what's important to us is outcomes, it's not how many people. NHS England drive me bonkers around target this, target that, but actually what difference are we making to children and their families.

Participant A: I think the youth offending team's a really good example of where you have an entire service with all the different partners there. So you'd have health, social care, education, probation, police all things that are part of youth offending teams. It was so helpful just having all of those agencies under one roof, in one service, and you could key back into those wider agencies if you needed to. Obviously, that's the way it's legislated under the Crime and Disorder Act, but it shows that it can be done when it's in a legal framework that says actually you all have to work together, you're all trying to achieve the same thing and it's a shame that that can't be replicated really.

Participant B: Absolutely. I'm constantly reminded that nobody comes to work to do a bad job, nobody wants to cause harm, but it's so frustrating when we get locked into conversations about 'who is going to pick up the bill?' Because that's not what we're about, we're about trying to make people's lives better.

Participant E: I think that one of the challenges that we get through being target driven is that the value gets lost. So within child and adolescent mental health services, particularly inpatient care, but across the whole of the patch we're constantly hit over the head with the fact that we're really expensive. Adolescent inpatient beds are the second most expensive bds within mental health and the productivity within CAMHS services in one of the lowest in mental health, although actually CMHT do seem to have dropped below us now. But to me that doesn't take into consideration the complexity. The only beds that are more expensive than CAMHS beds are mother and baby units, and mother and baby units are more expensive because you've got the nursery nurses in there. In CAMHS, it's the systemic working, the multi-agency working and the complexity that goes alongside that take the cost and time which isn't taken into consideration. As long as the Government sees child and adolescent mental services as just adult services for younger people, we're going to be constantly missing the point and constantly getting targets that are not actually driving efficiency or effectiveness.

Participant F: And also Participant E, for those tier 4 services, I know a bit about this from my time at NHS England, but somebody will put in a tender to run a CAMHS tier 4 services that has a welfare and psychological therapy service and somebody else puts in a tender and the day rate cost is significantly cheaper because they've not included an integrative psychological model for their inpatient youngsters. The finance team makes the call and chooses the product which seems to be better for value for money, as opposed to the product that had the biggest day rate costs but had something really interesting therapeutically to offer.

Participant B: The irony about all of this is that if we get children and young people's mental health right, we will save money in adult services. It's a really difficult case to put together, but we think that if we invested more in children and young people's mental health, I think we would see a reduction in adults coming through, because it's about that whole early intervention and prevention. I'm not saying that we would eradicate it all, but it would seem a much more efficient way and we would try and break down that barrier, that missing middle that we keep talking about where people fall between services because that's not helping people.

Participant C: I worry that when CAMHS funding comes down and when it comes down in that past, everybody thinks about CAMHS services, but not at investment in key integration programmes such as school nurses. Most children go to school, and those school nurses are absolutely vital in terms of health and wellbeing and picking up emergency issues. And there's very little investment there, and I think they're our eyes and ears on the ground. And skilling them up and putting some real investments in school is really useful. Certainly around eating disorders, we've had to really look wider than out CAMHS services, because we haven't got the skill set, so we're working with complex children's nursing teams in the community and looking at the skills that they've got. If you speak to people like school nurses and children's nurses they will tell you that they know nothing about mental health, but what's interesting is that though they possible know little about mental illness, they know a lot about mental health, and what health and wellbeing looks like, and the things that are really important to health and wellbeing. And I think that when we look at funding for CAMHS we need to look wider across the health economy as well as into social care and education. We've actually got these people sitting within our health services and there's something about bringing them in and using their skills. We should also look at how we are using out wider AHPs group in terms of their work with children, often with very complex physical health needs. And that whole family support piece, and I don't know about the trusts where you work, but we routinely forget about carers. There are some pockets of good practise, but it's not something we're routinely good at. So thinking about how we support those carers, be they family members or the case of the

looked after children etc. How many resources are we putting in their to actually support them when things start going wrong, so that we don't end up with young people in tier 4.

Participant F: Peter, you asked for some specifics, and just on what Participant C was saying about school nurses I made an animated film 2-3 years ago with three 10 year olds called 'My mum's got a dodgy brain.' So it's children who've grown up with parents with mental illness and there is a lovely bit in the animation where this 10 year old talks about their school nursing sorting them out. It's a really lovely example, and straight from the words of a young person talking about the absolute value of having a school nurse to give them some special time in school and what difference that made to them.

Peter Fonagy: I'm all for school nurses. My daughter was greatly helped by her school nurse at school, so you don't have to sell them to me personally. Let me get to the last question then, but we'll come back to this. You're all speaking with one voice. You're saying to me that there may be more money, but the targets are not really well directed. There is a fragmentation of services that is in a lot of ways unhelpful. There is a lack of people to actually deliver the services and the fragmentation of services leads to unhelpful outcomes where people who should be seen are not seen, and the WHO definition of health is lost in a barrage of symptoms and criteria that forgets about the whole system and the context in which individuals live their lives. I think it's coming together, but I want to get the third question out there which is: has the Government's progress on their commitments to children and young people's mental health changed the workforce experience for better or worse. So, we're talking now about your colleagues, as well as yourself, their experiences. We've already heard that some are leaving, voting with their feet, and creating part of the crisis of workforce, but I really would like, if you could, hear a little more about the experience of the colleagues that you're working with.

Participant E: It's gotten worse because the team working has worsened, and we're being driven more and more towards individuals working in the same area. Again, it's partly the targets driven approach that says if you've got five young people waiting for an intervention and you've got five clinicians then each of them picks one. You might be able to be the expert to the one that you've picked up, but it might just be totally random and something that you don't know too much about. And the integrated, coordinated multi-disciplinary working approach around young people has been very much lost, and most people who have ended up in child and adolescent mental health services do so because of their systematic thinking and their systematic outlook on life.

Participant D: Completely. I was going to say that it feels like the targets have also driven out clinicians as well. Working in two different services, I've had the same experiences in both of them, which is that people's caseloads are growing and growing, and they actually feel that quite a lot of time they are quite clinically unsafe. People are just running from one appointment to the other and that's because it's all become target driven. We need to see these people, we have a timeframe for that, that there's actually no space for thinking clinically, reflecting, using our team to think about things. We have these MDTs, but you have five minutes to discuss your case because you've got 30 other cases that need to be discussed with an outcome. It doesn't feel fulfilling for individuals who come into this work because they have clinical expertise and it's an opportunity for them to develop and learn and do the best that they can. Like Participant E said, because they've got such huge caseloads, they're kind of left to make decisions on their own rather than it feeling like it's multidisciplinary, and that can be really tricky a lot of the time especially when you've got new people joining who are newly qualified who need that nurturing and support. There's almost a bit of an expectation that you hit the ground running, which can be really tough. But equally, people who've been in teams for so long, that are also voting with their feet and leaving because they don't

have that integrated working with social care as much. Linking with EPs is always a no, that we can't even ask them to consider doing a cognitive assessment because there are no no's with that, there are a lot of barriers that make the communication that's really important really tricky. It comes back to commissioning where we're told that we're only allowed to make these recommendations and so forth, whereas my previous experience it's been so lovely when you've got that integration and being able to work with your colleagues from other sectors. I think that helps make the team work quite well. And the targets are very adult driven as well, and I'm curious as to whether a lot of time the Government is aware of how CAMHS works. It's not just working with the young person in their room and offering them a therapy. A lot of the work is consultation with the schools, working with social care and a lot of that data gets missed. Where do you record that unless you have a system that takes that into account? You're only counting that one-to-one session that you had with the young person and the outcome from that and actually that's not what CAMHS offers. The services are systemic because we work systematically with children.

Peter Fonagy: So it's not quite what you signed up for is what I'm hearing, but a slight bit of nostalgia for olden days.

Participant E: There is something as well Peter around the increase of complexity, that means that when you've got your caseload you don't have a complex young person, followed by a young person who's slightly less complex followed by somebody you're on the point of discharging. You go from one complex high-risk young person to another complex high-risk young person. There was a fantastic quality improvement project in America, where the mental health service stopped seeing the people who'd been on the waiting list the longest and started seeing people who'd been on the waiting list the shortest. They reduced their waiting lists about four times as quick as any other initiative that's ever been done.

Peter Fonagy: I think I know that the study that you mean and it's interesting and complex.

Participant C: Can I come in on that point? You've raised quality improvement and Participant D talked about that chance to step back and reflect and I just think that we've lost that ability to innovate. I think people are really scared. We've got really long waiting lists, we've got a lot of complexity, high-risk young people and certainly when I've been on these collaboration meetings where you're talking about an individual young person it should be the time when, if nowhere else, you can discuss something in depth and really reflect and you've got everybody round the table. You should be able to be quite innovative and say, 'well what about this' or 'what if we try this.' And what I've found is people are quite scared, they're quite scared of actually being innovative and creative because of the risks, and because of the systems that surround us in health and social care if something goes wrong. I've was in adults for a very long time, and I've only really been closely associated with CAMHS for three years now, and I think what you've said is correct. I came in thinking that it was like adults but it's a completely different beast. But yes, I do think that it's a real shame and that kind of quality improvement and thinking about our own waiting lists would be incredible, but who's going to be brave enough to do that. That's the thing isn't it, it's a time when new need to be brave and creative but we're not surrounded by structures that support that.

Participant E: That's a shift from quality assurance, which we live in at the moment to quality improvement. As a clinical director part of my job is quality assurance which is so frustrating because nothing gets better when you're assuring the quality of what you're doing.

Participant F: I totally agree with Participant C, about the idea that we stifle innovation by our systems. We've got so much assurance framework, and that has to be there, I understand that, but I

volunteer for an organisation for youngsters with emotional and social problems. And looking at this charity sector, it's interesting to see how they implement their safeguarding processes and their governance and their outcome measures, and how light and easy it is, and how child focused it is, and how it doesn't get in the way of young people feeling swamped in an adult system. It's a fascinating different culture that if you start from scratch, you wouldn't start with the foundations that we're starting from in the NHS. That's why the third sector flight of tech-savvy, child focused organisations can do much more easily than we can in the NHS. We've got a lot to learn from that approach.

Participant A: I agree about the reflective practise. People are so busy doing, doing, doing that often with our CAMHS we're trying to get people to stop and think. Often you'll go into situations and there are not even the basics, like a positive behaviour support plan or a formulation around a child that people have been working with for ages, because they're busy trying to do something useful that they haven't started at the beginning of the process. And people lose interest in the work because they're just so overwhelmed and stressed, they're not getting the job satisfaction of really thinking about children and I think we've also lost an awful lot around systemic thinking. So how do we help a child in a school, how do we support carers and foster carers, because it isn't just about sitting children in rooms and giving them evidence-based treatments. And I'd also like to say that a lot of people are making a lot of money out of really complex children. Some of these residential placements costing hundreds of thousands of pounds every years for providing a poor service to children with significant mental health needs. And there aren't places where children can get a learning disability diagnosis anymore as in lots of places educational psychologists don't do cognitive assessments. CAMHS are rarely doing them from my experience in my region, so where does a child get a learning disability diagnosis which would open up pathways for treatment and transitioning into adult social care. There are so many gaps, I think, so plugging more money in to do the same feels really unhelpful.

Participant B: I think there is a real willingness across the system to work together. I recognise what Participant C was saying about risk, and that sits within the organisation and stifles the ability of people to come together to pause and reflect on what would be the best outcome for the child or young person. Also, picking up on what Participant F was saying, there is a massive chasm for that reason between the third sector and other provision, and how are we going to get the system all working together if we are constantly hiding behind our organisation's risk. People have to carry a certain amount of risk and the buck stops with someone, and until we can get to a place where we can work together to support one another we're not going to get that job satisfaction and people are just going to leave.

Peter Fonagy: I think a couple of you have touched on the blame culture. If something goes wrong, somebody has to be held accountable and it makes people weary of taking any kind of risk. It varies geographically how bad it is, but I've seen some pretty bad examples. Anything more on the experience of the workforce?

Participant A: I guess the workforce doesn't involve lots of co-production doesn't it. You might get a token peer support worker or something like that in the workforce, so I suppose when you say workforce whether that should be widened to think about co-production. It's often very lacking in children's mental health.

Participant E: Just one thing I wanted to add that we haven't mentioned, is COVID. In my view, none of the situation that we're in within children and young people is due to COVID and very little of it is due to social media. So whenever we hear that there is a crisis because of COVID, or because of

social media, to me that is just hiding the root causes that we've been discussing today. And that's the same with workforce.

Participant D: It's kind of magnified it. These issues were there 2-3 years ago, and I think all the people here would agree with that. It's just that COVID has magnified it, and almost put a limelight on them and identified those areas that have been really tricky in terms of the integration of services because we're not doing it the way that we were doing before. I think COVID has had some impact, but it's not the whole picture. There are so many undercurrents that have been there for some time, and it's just exacerbated it.

Participant F: I know that we're supposed to be apolitical, but I think there has been something about the culmination of Brexit and the unwelcome atmosphere when we're looking at staffing and workforce, and how valued European colleagues have continued to be so but there has been a real challenge.

Peter Fonagy: I'm glad that someone said that. I just want to thank you all for being very open and very informative and I hope that we'll be able to do justice to the points that you have made. If I can just summarise in two words, there have been more resources, but they've not necessarily been directed in the best way. Some of the intrinsic weaknesses in the system have been highlighted, not just by COVID, but even interestingly by the extra money that has been poured into the system. Some of the ways that the system doesn't work and the targets that are not set leave some children and some young people and some families without optimal services. And some of it from what you've said can be fixed, but some of it has not been right for quite some time. Thanks everyone.