Reclaiming Quality and Effectiveness

NHS
Northern School
of Child and Adolescent Psychotherapy

# Contemporary Child and Adolescent Psychotherapy

Evidence based and cost-effective interventions
for children, young people and their families
with complex, severe and enduring
emotional, behavioural and relational mental health difficulties

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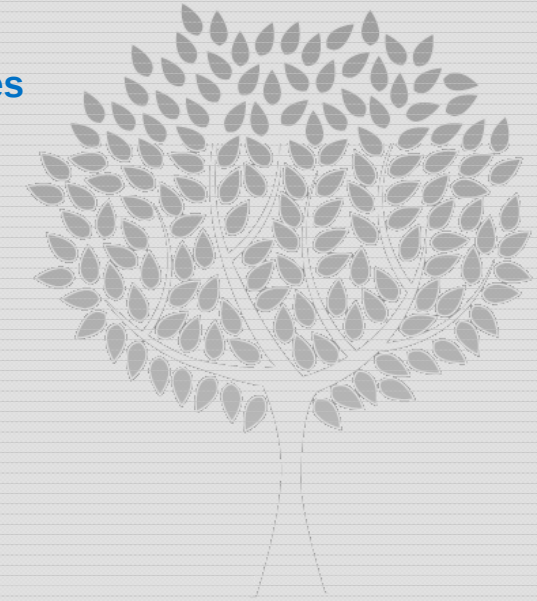
Contents





# 1 Introduction

**Are you concerned that vulnerable children, young people and families with the most severe and complex emotional, behavioural and relational mental health difficulties cannot always access the care they need, when they need it?**

Are you aware of the problematic outcomes for children, young people and their families if their needs are not met appropriately; and how this impacts on services through the inefficient use of resources?

Do you know how contemporary Child and Adolescent Psychotherapists work with infants, children, adolescents and parents and how they contribute to the complex network of care for vulnerable children?

Would you like to know more about cost-effective, timely and appropriate interventions as part of multi-disciplinary services?

**Yes? Then we hope this guide will help.**

*"In developing district level services locally, Child and Adolescent Psychotherapy has contributed significantly in the clinical, multidisciplinary team and interagency context . The psychoanalytic model has informed the ongoing development of services and has been endorsed through the support of commissioning forums and Children's Service partnerships."* **Service Manager**

# 2 The needs of vulnerable children and adolescents

**Children and adolescents with emotional, psychological and mental health difficulties represent a major public health concern.** Today, the type and level of disturbance encountered by specialist child mental health professionals will mostly be severe, enduring and complex, and may involve problems that cut across healthcare, education, social care and youth justice provision.

**Children and adolescents with these severe difficulties:**

- Require a coherent, skilled, timely, appropriate and effective response to their difficulties and to the context within which their problems are manifested.
- Are most at risk of their problems escalating if effective treatment is not provided soon enough, entering a destructive cycle of increasingly severe difficulties and expensive interventions.
- Will be involved with multiple services and professionals simultaneously and may have a long history of involvement with such services.

Providing specialist and time-defined interventions for these children, their families and the network of services in contact with them therefore not only improves outcomes for the children but enables a better, more targeted use of resources.

## 3 What happens when limited treatment options are available in local services?

**In services where a comprehensive range of treatments is not available some children's and adolescents' needs cannot be met.** The range and depth of difficulties seen by services who work with children, adolescents and families with mental health needs makes it difficult for resource-limited services to provide exactly what every individual user requires at exactly the right time. For a minority of users, a service's standard response might not be effective and this can lead to an exacerbation of their problems.

In such cases, children and families can develop increasingly complex relationships with services. For example, they might:

- **Repeatedly be re-referred back to the service following an earlier failed intervention. They then receive another ineffective intervention, and the cycle is perpetuated. This might continue over a long period of time. Such users are sometimes referred to as *revolving door clients*.**

Or, if issues of risk are more central to the user's circumstances:

- **Repeatedly cause enough concern within services that they become locked into a cycle of moving into increasingly more specialist or secure provision. Whilst these transitions might occur primarily at times of crisis, it becomes increasingly difficult for the user to then step down into less specialist settings. Such users are sometimes referred to as *escalating need clients*.**

These kinds of cycles are problematic for two reasons. From the perspective of the child, adolescent and their family, their needs have not been met and therefore are likely to become more and more severe over time. From the perspective of services, a large amount of resources can be expended on ineffective treatment and management strategies, which may continue for many years or into adulthood.

Whilst in some ways different, these two scenarios are similar in that they are the result of service users becoming *stuck* in particular cycles of problematic relationships with services.

**This is undesirable because:**

- Underlying needs have not been met and problems not addressed meaning they are likely to continue or worsen.
- There is a risk that problematic relationships might add to the child or family's existing difficulties, or contribute to the development of new ones.
- Aspects of these relationships (e.g. being serially moved from one provision to another or a growing distrust of services) may repeat and re-enact traumatic experiences from earlier in life.
- Considerable anxiety will be generated for both the child and the practitioners in the service, resulting in part from the perception that needs cannot be met.
- Long term outcomes associated with these kinds of relationships are known to be poor.
- There are significant resource implications - a relatively small number of service users can end up using a disproportionate amount of resources, despite these resources being arguably unsuitable for their needs.

# 4 The developmental view of psycho-pathology* in children and its outcomes into adulthood

Already serious emotional, social and behavioural difficulties will be compounded and escalated by further trauma, neglect, breakdown of relationships and family/foster care arrangements, lack of progress in education, self-harming behaviour and ongoing lack of effective support and treatment for underlying emotional and mental health problems

*There is no inevitably about the development of psycho-pathology. This diagram is **not** a statement that deprivation in early life will always lead to mental health problems and poor life chances. Every individual will respond differently to life events, and internal disturbances will manifest themselves in a variety of ways depending on a person's resources, relationships and the quality of care they receive when they need it. The psycho-dynamic view is optimistic that the **right intervention at the right point** will positively improve the developmental trajectory.

## Factors

- Neuro-developmental and biological factors
- Early trauma, neglect, abuse and deprivations
- Social and family factors

## Impacts

- Emotional and mental disturbance
- Delayed or damaged personality development
- Difficulties in learning, communications, relationships and behaviour

## Manifestations

- Conduct/behavioural disorders
- Depression and anxiety
- Self-harm and suicidality
- Substance misuse
- Eating disorders
- Family/foster breakdown
- Social communication/ASD
- Early psychosis
- Problematic personality development
- Learning difficulties
- Hyperkinetic/ADHD

**Double Deprivations**

## Outcomes

- Emotional and behavioural problems in later life
- Conduct/behavioural disorders
- Suicide, self-harm, A&E admissions
- Drug and alcohol, homelessness, poor physical health
- Serious mental illness in adults
- Teenage pregnancy
- Trans-generational parenting problems, neglect and abuse
- Failing education, NEET, long-term unemployment
- Crime/violence/prison
- Inpatient beds, residential placements, secure accommodation

**Individual outcomes**

**Societal**

**Pre-birth** → **Infancy** → **Childhood** → **Adolescence** → **Adulthood**

All factors will interact to influence the likelihood of a positive or negative trajectory being set in train

The child not only has internal emotional damage that adversely affects their ability to learn and grow but also problems with making healthy relationships (attachments) that might help them get back on track

Emotional and development difficulties are manifested in a wide range of disturbances and behaviours depending on the interaction of causal and psychological factors

Lack of effective interventions at the right time leads to serious long term problems for the individual into adulthood and trans-generationally, major impacts on family, community and society, and a need for escalating levels of resources from services that are largely aimed at containing the poor outcomes (such as prison) rather than the recovery of the person

# 5 Cost effective, timely and appropriate interventions

Children and young people who have complex and multiple difficulties, and may stay with services for a long time, have been identified in numerous studies (*see tables below*) as being the most costly in terms of their use of resources. They are also precisely the type of patient who can most benefit from the highly skilled intervention of Child and Adolescent Psychotherapists.

Allied to evidence (*see Section 9*) that improvements are sustained or even enhanced at long-term follow-up this means that it is possible to demonstrate cost saving in both the short and medium to long-term. The following tables show where child and adolescent psychotherapy can provide cost effective, timely and appropriate interventions to address the needs of both patients and services.

**The data identify where savings can be made across four key areas:**

- Short term impacts where local services are unable to provide an effective intervention
- Costs to commissioners where additional specialist services have to purchased
- Escalating costs where difficulties are not resolved or contained
- The impact on services and staff

| SHORT TERM IMPACTS WHERE LOCAL SERVICES ARE UNABLE TO PROVIDE AN EFFECTIVE INTERVENTION | | |
|---|---|---|
| **Where are resources being used ineffectively?** | **What is the cost?** | **What can Child and Adolescent Psychotherapy offer?** |
| **"Revolving door" patients**<br>Serial short-term interventions and repeat presentations in CAMHS or other services result in high cumulative costs of treatment and impact on the limited resources that are available. Moreover, serial short-term interventions imply serial referrals – suggesting that these individuals' underlying problems and needs are not being addressed. Over time, these needs and problems are likely to escalate meaning that further short-term interventions may be increasingly less likely to be effective. | In 2009, the average cost to the NHS of a single episode of care was **£3,735** for a tier 3 CAMHS team and **£4,648** for a targeted tier 4 CAMHS team (PSSRU, 2009). Unfortunately, re-referral rates tend not to be captured by local CAMHS meaning that it is difficult to make a precise calculation as to costs of revolving door patients; however, based on the figures above, an individual requiring three re-referrals to tier 3 due to previously ineffective interventions would cost the NHS on average **£11,205**. This also does not account for costs across public services more widely. | Whilst child psychotherapy is often the chosen treatment for complex mental health problems it is often delayed until other interventions have been tried and not led to improvements. This is reflected by NICE recommending individual child and adolescent psychotherapy as a second-line treatment for children and adolescents with depression that does not respond to less intensive treatment (NICE, 2005). Child psychotherapy should be used appropriately and at a timely point in the child's development rather than "as a last resort". |

| SHORT TERM IMPACTS WHERE LOCAL SERVICES ARE UNABLE TO PROVIDE AN EFFECTIVE INTERVENTION | | |
|---|---|---|
| **Where are resources being used ineffectively?** | **What is the cost?** | **What can Child and Adolescent Psychotherapy offer?** |
| **Complex cases**<br>The small, but increasing, number of resource-intensive children and young people with complex and severe needs are very costly in the short term to organisations and cause the most anxiety for professionals.<br><br>Often several agencies are involved in their care at the same time. These individuals also tend to have very poor long term outcomes and therefore often go on to be highly resource-intensive in adult services. | There have been relatively few attempts to calculate inter-agency costs of resource-intensive children, young people and families, reflecting the complexity of the kind of provision that such individuals receive. However, it is apparent that costs to wider society are very great. For instance, Knapp et al (1999) found in a study of children with conduct disorder that only **one-sixth** of the total cost was carried by the health service, the remainder falling to schools (special educational needs), social care agencies, families (disrupted parental employment, household damage) and the welfare system (disability and similar transfer payments).<br><br>Similarly, Scott et al (2001) followed up a group of children with conduct disorder as adults, and found that by age 28 these individuals had incurred mean costs to public services of **£70,019** (compared with £7,423 for controls) with the greatest cost incurred by crime, followed by extra educational provision, foster and residential care and state benefits. | Children with severe co-morbid conditions whose needs are complex require the input of a network of carers and agencies. The rigorous training of Child and Adolescent Psychotherapists means they are able sustain intensive work with the most disturbed children and adolescents who can have a troubling impact on individual workers and systems of care.<br><br>Additionally CAPts work across the network of professionals and carers to represent the child's experience and help contain workers' anxiety sufficiently to enable them to develop helpful relationships. |

| SHORT TERM IMPACTS WHERE LOCAL SERVICES ARE UNABLE TO PROVIDE AN EFFECTIVE INTERVENTION | | |
|---|---|---|
| **Where are resources being used ineffectively?** | **What is the cost?** | **What can Child and Adolescent Psychotherapy offer?** |
| **Learning and behavioural difficulties**<br>Children's and adolescent's emotional, behavioural and learning difficulties can have a high impact on educational resources and lead to the use of exclusion, pupil referral units and EBD schools. | School exclusion is financially costly. According to Brookes et al (2007), every exclusion costs on average **£63,851** across an individual's lifetime when the cost of alternative educational provision, lost earnings, additional use of health services, social service and criminal justice involvement are accounted for. | A psychotherapy intervention and associated liaison work with parents and teachers can hold a child in school; for example, see the evaluation of psychotherapy in primary schools in Camden (Levitt et al 2007).<br><br>Child Psychotherapists can identify and treat severe attachment difficulties in pre-school children which can lead to impairments in personality development that impact on learning and behaviour. |
| **Placement breakdowns**<br>The breakdown of foster care placements and adoptions result in the need for crisis intervention and are a drain on staff time and resources as well as impacting the child's well-being.<br><br>Multiple breakdowns are costly in the short term, but also may result in the child's emotional, behaviour and/or mental health difficulties escalating, and therefore them receiving increasingly specialist and resource-intensive placements, including out of area placements. | For example: McQueen (2008), reports on an 18 year old who in four years of local authority care had experienced 11 increasingly resource-intensive residential placements including a learning disability placement, a medium secure placement, five secure placements and 24-hour supervision in two non-secure placements.<br><br>McQueen calculated that the total cost to the local authority of this care was **£1,857,543** up to this individual's 18th birthday. | CAPts are experienced in working with traumatised children and young people who are difficult to manage as a result of disrupted and often abusive early experience.<br><br>CAPts also offer support to foster carers and adoptive parents who are finding that behavioural strategies are not enough. |

| COSTS TO COMMISSIONERS WHERE ADDITIONAL SPECIALIST SERVICES HAVE TO PURCHASED | | |
|---|---|---|
| **Where are resources being used ineffectively?** | **What is the cost?** | **What can Child and Adolescent Psychotherapy offer?** |
| **Out-of-area treatment and placements and specialist packages of care**<br>The lack of an appropriately specialist service can result in the commissioning of high-cost services from the private sector that are often not linked to the local networks of care and support that are required for the well-being of vulnerable children.<br><br>This can include specialist foster care, residential schools, secure children's home and other residential placements and the requirement for psychotherapy in Care Plans resulting from family court proceedings. | According to CAMHS Mapping, expenditure within CAMHS on individual care packages, often termed 'spot' purchasing, was £51.5 million in England in 2007.<br><br>In terms of cost to health services for the children and adolescents who are the most complex of all, our research across the North of England suggests that most PCTs have during any financial year between 4 and 15 children and adolescents in residential, inpatient or secure facilities, often run by third sector providers. Difficulties include very complex eating disorders, psychosis and/or issues of risk around challenging behaviour or self-harm. These facilities cost anywhere between **£500** and **£1000** per bed day, with length of stay varying but in some cases lasting for several years. Our research indicates that there are around 10 children and adolescents in the North of England who cost their home PCTs in excess of **£350,000 each annually**. | Child Psychotherapists can provide the specialist skills and competencies needed to sustain treatment in the community for severely disturbed children and adolescents, or break cycles of repeated breakdown of placements.<br><br>This provides significant short term savings by avoiding the requirement for highly costly out of area placements, and longer term savings in terms of improved outcomes for the young people and families in question. |

| ESCALATING COSTS WHERE DIFFICULTIES ARE NOT RESOLVED OR CONTAINED | | |
|---|---|---|
| **Where are resources being used ineffectively?** | **What is the cost?** | **What can Child and Adolescent Psychotherapy offer?** |
| **A&E presentations for self-harm and attempted suicide**<br>This is costly in the short term as it may lead to hospital admissions and is expensive for CAMHS in terms of the on-call rota and staff time in liaison with hospital services. | Self-harm can be resource intensive, potentially using ambulance, A&E, crisis team and inpatient resources. Estimates of direct and indirect costs are difficult to establish (NCCMH, 2004) but it is notable that a relatively small proportion of individuals who present at A&E with deliberate self-harm may use a disproportionately large amount of resources: for instance, one published evaluation of A&E attendance of such children and adolescents indicated that **just 9 repeat attenders were responsible for nearly a quarter of all attendances in the department** (Nadkarni et al, 2000). | The availability of regular psychotherapy sessions provide depressed and self-harming children and adolescents with a containing structure for their week. As the therapeutic work progresses it provides a benign frame of reference within the mind and patients are less likely to lean heavily on other services. For example, an audit (Robertson, 2007) of children being seen as intensive training cases by trainee child and adolescent psychotherapists showed a decrease in the level of perceived risk in 48% of cases during the period of treatment (44% = no change, 3% = increased risk). |
| **In-patient services and beds**<br>Either in hospital or specialist mental health/tier 4 in-patient treatment including inappropriate use of adult beds. | In-patient treatment can cost anywhere between **£211 per day** for long-stay NHS inpatient services, to **£590 per day** (£7,258 per average stay) for a psychiatric intensive care units (PSSRU, 2009), to **£700 to £1000 per day** for highly specialist NHS or third sector provision for the most complex and intractable difficulties in children. For the most complex individuals around whom there are serious issues around risk, a pathway may include PICU admission in crisis followed by more or less intensive stepped-down inpatient treatment, meaning that cumulative costs become very high. | CAPts can provide intensive treatment for severely ill children and adolescents and support other staff to work with complex and difficult cases in order to sustain care locally in community settings and reduce the need for admissions. They can also provide appropriate local support in community settings for children and adolescents who have recently been discharged from residential treatment. This is particularly important as adequate post-hospital services have been highlighted as a crucial factor in reducing the likelihood for 'revolving door' readmission within three months (Romansky et al, 2003). |

| ESCALATING COSTS WHERE DIFFICULTIES ARE NOT RESOLVED OR CONTAINED | | |
|---|---|---|
| **Where are resources being used ineffectively?** | **What is the cost?** | **What can Child and Adolescent Psychotherapy offer?** |
| **Transition and adult services**<br>Where problems are not resolved in childhood there will be a long-term impact on the resources of 16 – 18 and adult mental health services. | Research across mental health strongly indicates that long term adult service users with a variety of presenting difficulties frequently experienced mental health difficulties in childhood and adolescence, and may have repeatedly used CAMHS without good outcomes during this period. | Intervention in the first ten years can reduce the need for more costly adolescent and adult services. Studies show that the benefits of child psychotherapy can be maintained into adulthood. Child Psychotherapists have experience of working with late adolescence/ early adulthood and can work across the traditional barrier between child/adult services and thereby support young people through this difficult transition which can often break down in ways that are costly the individual and services. |
| **Youth justice and forensic services**<br>The escalation of mental ill-health can result in behaviour that leads to crime and violence and the intervention of services including youth offending teams, young offender institutions, secure children's homes etc. The difficulty of working with violent and troubled young people is felt across a wide range of services. | These costs impact on many services but just within the youth justice system the average annual cost of a young person is **£40,000** (Barrett et al, 2006).<br><br>In August 2008 there were 2,403 children aged 15-17 in Young Offender Institutions. The cost per annum of secure accommodation for young people (2004 prices) is:<br>- Secure Training Centre (run by private provider) = **£164,750**<br>- Secure children's home (run by LA) = **£185,780**<br>- YOI = **£50,800**<br>(House of Commons Committee of Public Accounts, 2004). | CAPts work in youth offender teams and forensic settings, offering individual psychotherapy and group therapy. They also make an important contribution in supporting other workers formally and informally.<br><br>CAPts can offer consultation and training in understanding and managing hostile and violent children and young people. |

| THE IMPACT ON SERVICES AND STAFF | | |
|---|---|---|
| **Where are resources being used ineffectively?** | **What is the cost?** | **What can Child and Adolescent Psychotherapy offer?** |
| **Staff productivity and turnover**<br>Burnout, illness and turnover can result from the emotional impact of workers' contact with highly disturbed and disturbing children and adolescents whose difficulties may be as severe as those seen in "specialist services". | According to Dawson et al (2009), improving the mental health and wellbeing of staff in an average NHS Trust providing services for individuals with mental health and learning difficulties can save that Trust between £363-£370,000 per year.<br><br>NHS Trusts providing services for mental health and learning difficulties are known to have the second highest expenditure on agency staff in the entire NHS, which is argued to provide a reliable index of absenteeism. | CAPts can provide consultation and supervision for colleagues that can support them in their face to face work with children and families.<br><br>One model is the "work discussion group" (see Jackson, 2002) that has proved effective in many settings and is recognised nationally as a good practice model (DoH/DfES, 2006). The retention rate for CAPts is among the highest of any profession. |

*"Working with a child psychotherapist has changed the way I work. I'm much more open to asking the right questions and investigating underlying problems in the family. The whole experience has been invaluable."*
**Educational Psychologist working with under-fives**

*"My son is developing better than we could ever have imagined and I am very proud to say that. He's now able to be at the local school, which we could not have imagined before."* **Father of adopted son seen in CAMHS**

*"Commissioners should consider whether what is being offered currently is likely to work for those vulnerable children who most need a high quality, effective form of treatment."* ***Service Commissioner***

*"A number of professional groups have an important and distinctive contribution to make to improve the lives of children and their families. Child and Adolescent Psychotherapists have demonstrated the capacity to think in innovative ways and broaden the application of their skills."* **CAMHS Project Lead**

# 6 Breaking the deficit cycle

**It is striking that child psychotherapy input can often break the cycle of repeated ineffective intervention**. (For a summary of the research evidence base for child and adolescent psychotherapy see Section 10). At NSCAP, we are amassing information about the service use histories of children, adolescents and their families with complex mental health needs. Below are two actual case studies to illustrate this:

## Case Study 1

- D, a three year old girl, was referred to her local CAMHS in October 2008 by a paediatrician due to her eating "a very restricted diet". CAMHS' first response was to refer her back out to a health visitor. However, by 2010 she had been re-referred to CAMHS by the paediatrician who noted that "there had been no change in her dietary habits: even if she takes a bite she would choke and would not swallow at all".

- Following an assessment by a child psychotherapist, the girl's family was offered six sessions of a combination of parent-child work and support for the parents alone. By the second session, D was asking to try new solid food, and by session 4, she was eating solid food including sandwiches.

## Case Study 2

- K, a 15 year old adolescent with a long history of mental health service use and erratic school attendance, took a deliberate overdose in 2007 and subsequently received eight sessions of cognitive behavioural therapy. However, only months after his discharge he was re-referred to CAMHS due to continued school refusal and escalation in his mental health difficulties.

- When he was assessed by a child psychotherapist in December 2008, he was not attending school at all during his GCSE year. He was offered once-weekly individual child psychotherapy for a year. By March 2010, he was no longer suicidal, described that he felt "stable", and now is at college re-sitting his GCSEs.

# 7 Infant mental health: the case for early intervention

**Positive child-parent relationships and early attachments are crucial to young children's ability to learn and develop cognitive, emotional and social capacity.** These first significant relationships have a direct impact on how a child's brain physically develops in the first three years of life and form the templates for all later attachment relationships.

There is a significant body of research to demonstrate that impairments in the capacity of parents to relate in a responsive way to infants and young children can have a detrimental impact on the social, emotional and cognitive development of the child. For example, post-natal depression, which has an estimated prevalence of up to 22% (Coates et al, 2004), has been associated with later attachment problems and with long-term social, emotional and cognitive problems in children (Murray et al, 1999).

It is in the interests of both child and society for attachment problems to be identified as early as possible, ideally within the first three months of life. Interventions at this stage should be considered urgent as serious attachment difficulties in the post-natal and infancy periods can result in potentially severe social, emotional and cognitive problems later on.

Each additional month of delay can result in the escalation of difficulties, with the risk of attachment problems and the associated developmental delay becoming entrenched and much harder for services to address.

## The impact of traumatic early experiences

It is accepted that severe neglect can lead to developmental delay as well as difficulties in the ability to empathise, regulate emotions, manage intimacy and ordinary social interaction (see Music, 2010).

Some children will have had such difficult or traumatic early experiences that staff will need training in being sensitive to how these children's perception of the world and their relationship with adults will be damaged and will require a different approach to other children. For example, children who have been physically abused may have a fear of close contact with adults or may respond in ways that are violent or dysfunctional.

An area of particular concern is the mental health of preschool aged children who are looked-after by local authorities. Around 20% of the 81,000 children currently in care in the UK are under the age of five, and according to analysis of Serious Case Reviews between 2003 and 2005, 67 per cent of children who suffer death and serious injury through abuse and neglect are under five years old. Research shows that children in this age group suffer the greatest degree of child maltreatment and that the effects of maltreatment are aggravated in infancy because of the developmental significance of this period (Dozier et al, 2002).

**Interventions in the ante-natal, post-natal and infancy period are essential to prevent difficulties from becoming entrenched and therefore more difficult and costly for services to address.**

# 8 Coherent services for adolescents with severe psychological disturbances

**Adolescents with severe and co-morbid presentations may require a range of interventions over an extended period and therefore can use a significant amount of resources within both CAMHS and adult services post-18.** There is a group of children and young people with severe psychological, emotional and behavioural disturbances who have traits consistent with aspects of adult axis II psychiatric diagnoses such as borderline personality disorder.

Young people who experience a problematic personality development trajectory place an undue burden on health, social care, education and justice services. Their presentation is high risk both in terms of the risk of harm suffered by these individuals, and also the difficulties and risks that manifest through their often dysfunctional social relationships with others.

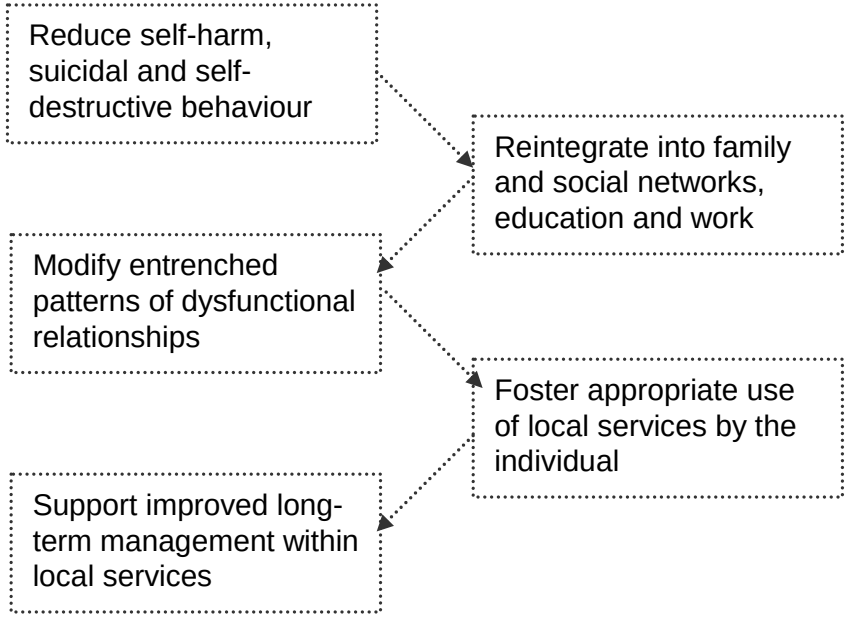
**These young people are likely to have a range of co-morbid problems such as:**

- Self Harm
- Suicidal thoughts and behaviours
- Depression and mood disorders
- Eating Disorders
- Alcohol and substance misuse
- Effects of trauma and abuse
- Relationship problems and social dysfunction
- Breakdown of everyday functioning
- Transient psychotic states
- Extensive use of health and social services

It is accepted that outcomes for young people with problematic personality development trajectories are poor and their care pathways ill defined, with long term or repeated detention in either mental health or forensic settings representing common endpoints.

Currently, there is limited availability of intensive time-defined interventions that can improve long-term outcomes and prevent a worsening of the condition that may in turn result in expensive use of out-of-district placements, secure settings, repeat in-patient stays, acute episodes and contact with criminal justice. Moreover, there remain significant concerns at a policy level regarding the adequacy of transitions from CAMHS to AMHS, and hence a coherent treatment model specifically delivered for adolescents is timely.

The development of highly specialist interventions would:



## 9 What does Child and Adolescent Psychotherapy offer?

**Children and young people with severe and long-lasting problems may respond to people and situations in ways that they do not understand and cannot control.** Their emotions can be extreme and powerful and are often expressed through their behaviour and in problematic relationships. These difficulties often extend to relationships with services and professionals. This can prevent these children from benefiting from the care and opportunities that are available to them and is in part why many programmes fail to meet the needs of the most vulnerable groups.

A Child and Adolescent Psychotherapist can help a child or adolescent to understand himself or herself through their relationship together. The problems identified in this relationship shed light on those in other relationships in the child's life, whether in the past or present. During a therapeutic session, younger children may be encouraged to play, while older children may be asked to draw or paint and teenagers to talk about their feelings. Through the relationship with the therapist in a consistent setting, the child or adolescent may begin to know and to feel able to express their most troubling thoughts and feelings.

The extensive training of Child Psychotherapist uniquely enables them to work with these very disturbing thoughts and help the child make sense of their experience and develop their own individuality and potential. Confused, frightened, hurt, angry or painful feelings can gradually be put into words rather than actions. As a result the child can begin to express their emotions in less disturbed ways and begin to return to the normal process of child development.

They are likely to feel less anxious, more able to learn and better equipped to sustain friendships. It can also improve the quality of life within the family or in relationships with carers and professionals. Significantly for the wider network, the Child Psychotherapist will also be able to represent the child's experience in relation to his/her family, placement, special educational needs and therapeutic needs.

**The areas where this approach is most needed include:**

- Co-morbid presentations particularly linked to early deficits, parental mental health difficulties and incremental developmental trauma
- Developmental breakdown including psychotic-like symptoms, gender confusion and high risk "acting out" characteristically but not exclusively seen in adolescence
- Families where there are complex trans-generational issues of mental health, deprivation and neglect.
- Moderate to severe impairments in personality development rooted in early infancy e.g. serious attachment difficulties
- Mind-body disturbances including somatisation, psychosomatic problems and the emotional/psychic impact of chronic medical conditions
- Depression – moderate and severe with suicidal ideation
- Severe, deep-seated anxiety states
- Underlying internal states in children and adolescents exhibiting challenging behaviour
- Eating disorders
- The emotional development of diagnosed ADHD and ASD children and young people

## The distinctive components of child and adolescent psychotherapy practice

- Individual state of mind assessments and contributions to multidisciplinary team assessments including infant/child and school observations
- Interpretation of the child's experience and understanding of the world inside and outside of her/himself
- Range of therapeutic interventions including leading edge developments at the Tavistock and Portman Clinics, the Anna Freud Centre and other nationally significant centres of expertise
- Brief psychotherapy (e.g. young people with depression) using flexible time-defined models of practice
- Parent-infant psychotherapy and relational parent work
- Long term intensive psychoanalytic psychotherapy where problems are severe, deep-set and enduring
- Group work (e.g. adolescents who self-harm, parents of children with eating disorders)
- Placement support for kinship carers and foster carers
- Family consultations and network/professional consultations including support to Tier 1 and 2 practitioners
- Interventions and consultation at Tier 4 severity averting the need for in-patient care and facilitating community based treatment
- Support and consultation to the multidisciplinary team and, at a senior level, service developments
- Risk assessment and management and psychoanalytically informed second opinion
- Multi-disciplinary contribution to specialist areas such as forensics, gender identity, autism, personality disorder, looked-after children or paediatric services

## The training of child and adolescent psychotherapists

Child and adolescent psychotherapy is a graduate entry profession and applicants will already have substantial experience of working with children, adolescents or families. This experience may have been gained in a wide range of settings including health, education and social care.

The pre-clinical post-graduate course includes two years of close observation of infants and young children and lays the foundations for clinical work. The training provides a thorough grounding in the emotional development of children and adolescents. It also provides an opportunity for assessment of personal suitability for working in psychotherapy with children and young people.

The rigorous clinical training includes teaching, supervision, personal psychoanalysis and, uniquely, a four-year full-time placement in a CAMHS service. This enables the trainees to develop skills in a multi-disciplinary setting from the outset. As well as the core study of individual psychoanalytic work with children and young people, work is undertaken with parents, groups, families, and consultation and supervision of other trainees and professionals.

The programme enables students to develop the clinical expertise and research skills needed to prepare them for practice as a professional Child and Adolescent Psychotherapist, eligible for membership of the Association of Child Psychotherapists.

The training at NSCAP and other centres provides an academic as well as a professional qualification with trainees registered for the postgraduate degree of Doctor of Child Psychoanalytic Psychotherapy.

# 10 The evidence that quality works

**There is extensive robust scientific evidence that psychoanalytic and psychodynamic psychotherapy is an effective way of treating a large range of mental health difficulties in adulthood (Shedler, 2010).**

An ever-growing equivalent evidence base is building a similarly robust argument for the effectiveness of child and adolescent psychotherapy. Kennedy (2004) carried out an independent Systematic Review of research into the effectiveness of psychoanalytic psychotherapy for children and young people.

**It found that child psychotherapy was effective in treating children and young people with:**

- **depression**
- **anxiety or behaviour disorders**
- **personality disorders**
- **learning difficulties**
- **eating disorders**
- **developmental issues**

It was also found to be effective in helping sexually abused girls, those who have suffered early emotional deprivation, and children with poorly controlled diabetes manage their emotional responses to their illness. Significantly, the review found that improvements were sustained or even enhanced in the long-term, with adults who had been treated as children or adolescents still feeling its benefits many years later.

This finding, which has been labelled the 'sleeper effect' of child psychotherapy, was clearly demonstrated in a randomised control trial of severely depressed young people. In the study, 30 sessions of child psychotherapy plus parent work were shown to be highly effective. This led to child psychotherapy being recommended in the NICE Guidelines on childhood depression, as part of a stepped-care approach.

## The quality of the evidence

The systematic review included six studies that met the Cochrane criteria for the highest level of evidence and a further 26 that were of a sufficiently high quality to be considered appropriate for drawing conclusions about the efficacy of this form of treatment. Moreover, the majority of studies were undertaken in clinically referred samples rather than samples recruited for research and involved children with a range of diagnoses and co-morbid problems.

This means that the findings are likely to have relevance to the 'real world' setting which is significant because many other studies used to support "evidence based interventions" are based on recruited samples with patients selected because they fit a particular diagnosis, without the complex problems or co-morbid presentations that are increasingly seen in CAMHS (Westen et al, 2004).

**"…there is now enough research evidence to claim that psychodynamic therapy is an evidence-based treatment with effect sizes similar to or superior to those reported for other psychotherapies…**it is encouraging that the benefits of psychodynamic therapy not only endure after therapy ends, but increase with time. This suggests that insights gained during psychodynamic therapy may equip patients with psychological skills that grow stronger with use." **(Harvard Medical School, 2010)**

# 11 New and emerging research

Kennedy and Midgley (2007) completed a thematic review examining process and outcome research in child, adolescent and parent-infant psychotherapy. This highlighted that child psychotherapists are widely engaged in research into the process of psychotherapy which has helped monitor and improve clinical practice and aided the development of client-focused services.

**The research reflects three important types of questions**

- how does child psychotherapy work;
- for whom does it work - which children and young people benefit with what kind of problems, and for how long do they need treatment; and
- how psychotherapy can contribute to early intervention with parents and infants, to improve sensitivity of parenting and attachment security.

These findings along with a wide variety of state-of-the-art research contributions form the basis of *Child Psychotherapy and Research: New Approaches, Emerging Findings* (Midgley, N. et al. 2009).

## Researchers gather evidence that psychotherapy works - and keeps on working

An article in the February 2010 edition of *Scientific American* outlines new research which shows the movement to establish an evidence base for psychodynamic therapy has taken a huge step forward. Written by Raymond Levy and Stuart Ablon, the article "*Talk Therapy: Off the Couch and into the Lab*", reports the strongest evidence yet that psychodynamic psychotherapy works and keeps working long after the sessions stop.

## Major new NHS-funded Randomised Controlled Trial (RCT)

Child Psychotherapists based in several areas including Manchester and the Wirral will be contributing to a major Randomised Controlled Trial of treatments of adolescent depression over the next three to five years.

The NHS has funded this very large study to compare the outcome of Treatment as Usual (psychiatric management and support and medication as necessary), Short-Term Psychoanalytic Psychotherapy (STPP) with parallel parent support, and Cognitive Behavioural Therapy (CBT). The STPP arm of the trial will be delivered by Child and Adolescent Psychotherapists. It is anticipated that the findings with have a major impact on the further development of NICE guidelines for children and young people with depression. The research aspects of the trial are being led by Professors Ian Goodyer, Cambridge University, Peter Fonagy, University College London and Jonathan Hill, University of Manchester.

**NSCAP** is in the early stages of developing a major clinical trial with partners at the University of Leeds. The aim of this study will be to demonstrate the value of time-defined child psychotherapy for children aged 9 to 14 with internalising disorders. This will be a significant contribution to current practice and is part of NSCAP's aim is to create a portfolio of complementary research findings that, when taken together, are representative of the broad range of work undertaken by Child Psychotherapists.

## 12 Providing services where they are needed

Child and Adolescent Psychotherapists adapt and apply their skills to provide patient focused care where it is most needed:

- **CAMHS:** treating complex cases and the networks surrounding them; supervising and training fellow professionals.
- **Early Years:** parent-infant work; training and supervision of nursery staff, health visitors and other professionals to identify risks to child development.
- **Schools:** supporting teachers and school staff in their work with disturbed and disturbing children, often helping to hold a child in school and prevent exclusions.
- **Hospitals:** helping children and families address the emotional fall-out of chronic, acute or long-term illness and its treatment.
- **Looked-after Children Teams:** working with severely traumatised children, supporting fosters carers and adoptive parents to help prevent damaging placement breakdown, consulting to staff in residential children's homes.
- **Learning and Behavioural Difficulties:** identifying and treating obstacles to learning and development, including work at pre-school, primary and secondary levels.
- **Youth Justice Services:** work in forensic settings offering individual and group therapy and consultation and training to staff in understanding and managing hostile and violent children and young people.

### What is missing?

**The National CAMHS Review identified variations and inequity in the availability of specialist interventions for children, young people and their families.** Local services may not always be able to provide the appropriate range or quality of psychotherapeutic interventions that are required for children and families whose needs are complex, severe or enduring.

Specifically, in spite of the important role that Child and Adolescent Psychotherapists occupy within CAMHS, this variation is reflected by the variation in local availability of these practitioners.

**NSCAP has surveyed the 158 parliamentary constituencies in the north of England and found that 100 of these do not have specialist child and adolescent psychotherapy services. Of the remaining 58, many have only limited provision.**

This has a clear implication: the majority of the most vulnerable and complex children, adolescents and families do not have consistent and local access to the full range of child mental health professionals and the treatments that are considered most effective for some of the most complex mental health problems. There are some large geographical areas in the North where there are no psychotherapists at all: for instance, in Lancashire, the East Riding of Yorkshire and Lincolnshire.

*There are similar gaps elsewhere in the UK, suggesting that the variation in the availability of child and adolescent psychotherapy is a national problem that needs to be addressed systematically.*

# About NSCAP

The Northern School of Child and Adolescent Psychotherapy (NSCAP) is a major centre of mental health learning and practice; a leading contributor to and preferred partner in training, research and service developments in the health, social care, education and justice sectors.

NSCAP was setup by the NHS in 2003 and has since established a reputation as a high quality training and development centre serving the whole of the north of England. Building on over 60 years of clinical expertise within psychoanalytic child psychotherapy we now uniquely combine three zones of activity into one interconnected vision of effective practice.


Partnerships are central to the NSCAP approach. We are hosted by Leeds Partnerships NHS Foundation Trust and work in collaboration with the Tavistock and Portman NHS Foundation Trust and the Universities of Leeds, East London, Essex and Northumbria.

We see our role as developing multi-disciplinary and inter-agency models of care and service delivery that provide whole-service solutions for commissioners, professionals and service users. We have recently established the inter-disciplinary *Northern Looked-after Children Forum* and a working group for developing *Care Pathways for Families with Complex Needs* with the Cassel Families Service.

## Contact

For further information about NSCAP and how we can work locally with you to develop effective services, please contact:

**Nick Waggett**
**Operational Director**
Northern School of Child and Adolescent Psychotherapy
Bevan House
34-36 Springwell Road
Leeds LS12 1AW

Tel: 0113 3058750
Email: nick.waggett@leedspft.nhs.uk

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