Appendix 2 - Response document

Please return your response:

By email: consultation@skillsforhealth.org.uk

Or by mail: FAO Musrat Amin, Skills for Health,
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If in doubt, call the Helpdesk

The Helpdesk will be open 9am to 5pm, Monday to Friday, from 1 to 21 December 2006 and 3 to 31 January 2007. Phone 0845 121 4741 or email sfhhelpdesk@dial.pipex.com . We will try to respond to enquiries within one working day.

Please tell us something about how your response was arrived at
The Association of Child Psychotherapists is the professional body representing child psychotherapists eligible to work under that title in the NHS. As a body, we are moving towards making an application to join the Health Professions Council, and have formed a working party to facilitate this process.

This working party is made up of child psychotherapists and includes: the Chair and Vice Chair; members involved with at least two of the trainings (both accredited as doctorates and based in the NHS: the Tavistock and Portman NHS Foundation Trust, and the Northern School of Child and Adolescent Psychotherapy); as well as senior members of the profession involved with our Ethics Committee, Membership Committee, and national Strategy Group . The group has broadened its remit to respond to the consultation on NOS as this is closely connected to our work on regulation and moving forward the process of statutory registration for the profession.

Because we work in the NHS, we are familiar with the KSF structure, and its framework of competencies and knowledge. In addition, members of the working party were involved in defining and operationalising this set of standards and so are well placed to see the possible links between this model and the NOS. As members of the group are also involved in the development and provision of training, both at an access level and for the six-year postgraduate clinical training, we are familiar with the task of creating a framework of learning outcomes and practice standards, and these experiences have stood us in good stead in thinking about NOS.

We have found the process of this consultation to be an interesting and positive one, where we were genuinely left feeling that development is in progress, and that our input is of interest.

Questions 6 - 8 will allow us to elaborate further on our ideas about the development process for NOS, but we did want to emphasise that, while we take the point that the model is very much a draft, there were two issues that kept emerging for us:

1) That the distinct and specialised processes undertaken in engaging therapeutically with children, young people and their families require a great deal of work to be done outside of the consulting room and, in addition, mean that issues of consent, the reality of a complex legal framework around the work, and the importance of government policy across a range of areas are a central part of the work in a way

that is distinct from those working with adult patients. Children and adolescents inhabit a world in which both families and statutory structures are very much present, and the resulting need for liaison and network communication is not an addition to our professional activity but very much part of it.

2) That, while it is important, our work is less about a particular modality of therapeutic activity (ie how a child or young person is worked with in the therapy room) and more about a professional role – so that a more global job analysis would reflect our standards of activity rather than an emphasis solely on those standards which apply to work in the room with a patient.

Having said this, the questions posed in the consultation, focussing as they do on what takes place 'in the room', are interesting and relevant to our experience, and we have answered them as clearly as we can, while wanting to emphasise that they only give a partial view of the work we undertake.

We have therefore answered the questions not just with 'Yes' or 'No', but have added comments we hope will help in formulating a meaningful structure of competences. **We have also added an * where the specific difficulty of describing work with children and adolescents means that adaptations are needed.**

Q1. Do you see the things therapists and counsellors do in this model? Specifically, which do you do?

Preparation – starting the therapy

1.1 – 1.4 are hard to relate to in our practice, as this model means that the uniqueness of each referral is by-passed in favour of a single therapeutic model.

1.5 to 1.10 Yes. These competences would fall within our practice with children of all ages and their families/carers.

The therapeutic work and the working alliance

2.1 ***Yes.** We maintain a consistent external setting with regular sessions, boundaried time and attention to materials appropriate to the child's age and with due regard for safety, making as few changes as possible in order to maintain a focus on the child's inner states and changes.

2.2 **Yes.** We use a range of recognised and standardised measures, e.g. CGAS, ESO, Honosca, SDQ and Under 5 measure.

2.3 ***Yes.** We discuss concerns with the family, but not always directly with the child – this depends on age, cognitive capacity, level of deprivation and disturbance. Reviews are built into the framework of treatment.

2.4 ***Yes.** Children and young people often test and explore the boundaries and we have to manage their aggression, anger and negativity and maintain boundaries to keep the room, the child and oneself safe. Work with children, adolescents and their families often involves holding a lot of anxiety and facilitating ongoing contact despite 'attacks' or missed sessions.

2.5 **Yes**

2.6 Not in this form -please see response to Q2

2.7 Yes. As a profession supervision is part of the process as is keeping sessional notes/proper records of each meeting; understanding the impact of the patient on the therapist is a central therapeutic tool.

2.8 Yes. This is part of each session in which we monitor shifts in the child's states; children often indicate these shifts through their behaviour, demeanour, play, rather than through direct conversation.

2.9 Yes. This is a fundamental part of the work of every session.

2.10 *Yes. Regular reviews take place with the child and family and other relevant professionals, e.g. school, social worker, health visitor.

2.11 Yes. The entire process is one of constant evaluation.

2.12 *Yes. We have a holistic approach on the whole, but there might be a need to bring in specific other approaches from the multidisciplinary team e.g. anger anxiety/management, parenting programmes, or adaptation of technique to facilitate change.

2.13 Yes. As the method of treatment in our work is the relationship with the therapist, patterns of external relationships are reproduced within the treatment, and, as such, have a real life element of emotional reality.

2.14 Yes. Supervision helps with self reflection and consideration of the use of the self and its impact on the child or young person, and in understanding the emotional exchange between child and therapist in the room, often taking place at an unconscious level.

2.15 ***Yes.** Risks and benefits are constantly assessed, especially with Child Protection, risks of suicidality and self harm.

Ending the therapy

3.1 ***Yes.** A great deal of preparation goes into preparing for endings and separations for both the child and the family. When treatments are long-term (i.e. one or two years), as they often need to be in order to deal with the complexities of seriously damaged and deprived children and young people, and in the short-term work we do, endings are an important area of work as they are crucially linked with central issues in development, such as separation and managing loss.

3.2 ***Yes.** The ending would be negotiated, preferably

agreed, although the end of treatment for children and young people can sometimes be more influenced by the needs or difficulties of the network or family than in adult work, and this needs to be worked with carefully.

1.3 Not in this form. Please see response to Q2.

3.4 *Yes. There may be a necessity to refer a patient, for inpatient treatment, e.g. eating disorder, suicidality, psychotic episodes. This may not be at the end of treatment, but might happen concurrently with ongoing work.

3.5 *Yes. We have reviews after treatment to see how progress has been maintained. Taking the developmental span into account, it may be that a child will need to be referred at a later stage.

Evaluation

4.1 *Yes. Closing summary, CGAS, and ESQs and other measures; letter to referrer; review meetings with network; reports to GPs, education, Social Services, as appropriate.

4.2 Yes

4.3 Yes

4.4 Yes. We supervise other professionals and, when sufficiently experienced, provide supervision for other CAPTs and trainee CAPTs.

4.5 *Yes. Particularly in work with children and adolescents.

Q2. What needs to be added?

Preparation – starting the therapy

1.1 – 1.4 This approach is a modality-based approach. It is better suited to adults and does not cater adequately with the complexities of the referral process for psychological therapeutic work with children and adolescents, particularly in an NHS CAMHS setting. Cases of complex co-morbidity, which also involve other agencies, (e.g. Social Services, Education, Family Courts, YOT services, residential settings) are not catered for. With child and family cases, Child Protection and Family Law are structures within which we need to operate.

In our profession we <u>do</u> differentiate between assessment and treatment phases of our work. Most of us work as part of multidisciplinary teams doing generic assessments. After this process we would then undertake, as appropriate, a specific assessment of the need for and the capacity to use child psychotherapy.

The therapeutic work and the

2.6 This is highly oversimplified. We don't use problem-specific guidance, as our highly specialist in- depth training enables us to respond to a range of problems and ongoing

Q3. Which ones are not relevant to you? Please give the numbers

Preparation – starting the therapy	
The therapeutic work and the working alliance	
Ending the therapy	**3.6** This is more appropriate for cognitive-based treatments with adults, e.g., addictions, depression.
Evaluation	

Q4.What changes in the model or developments of it would you suggest?

Preparation – starting the therapy	**1.1 – 1.10** need to be adjusted to reflect the work done before psychotherapy starts ie the work with network, family and MDT colleagues; this is a particular feature of work with children and young people but the model at the moment does not include standards for this crucial part of the intervention.
The therapeutic work and the working alliance	Many of the competences in **section 2** need to be adapted to reflect the nature of psychotherapeutic work with children; our responses to **Q1** have expanded on this.
Ending the therapy	**3.4** and **3.5** are again limited by the focus on what takes place in one clinical intervention; our expanded responses suggest the different needs for children and young people where statutory requirements, as well as the reality of ongoing development, means that continued contact with child and family is likely to be important, even when individual treatment has ended.
Evaluation	The questions in **section 4** suggest that the trajectory assumed in this model is over simplistic - i.e. from illness to recovery/health. In work with children and adolescents there are shifts involving both progression *and* regression in different parts of the self; a key feature of development and one which we would expect to see also in the consulting room.

Q5.Is any part of the model specific to work with a particular client group?

Preparation – starting the therapy	We would suggest that there probably need to be separate models for work ie one for work with children and young people, and another for work with adults. Although a limited number of competences might be held in common, there are too many areas of variation to make an entirely unified system both meaningful and easily employed.

The therapeutic work and the working alliance	**See above**
Ending the therapy	**See above**
Evaluation	**See above**

Q6. What are the aspects of practice and professionalism that you see the greatest need to improve or promote? Are they already in the model or do we need to add something?

Preparation – starting the therapy	Our response to this question is given below, as it did not feel possible to break this down to these headings. We would identify 'core therapeutic functions' (detailed below) but they would be shared across all 'stages' of contact with a child or young person, their family, and the networks around them.
The therapeutic work and the working alliance	**See above**
Ending the therapy	**See above**
Evaluation	**See above**

Q7. What do they derive from – increased demand for therapy and counselling services or a need for higher quality in service provision?

Our primary concern is that we work to maintain a high quality service which takes account of the particular vulnerability of the client group given their age, the nature of the difficulties they face, and the complexity of the contexts in which these difficulties occur. We do feel that core therapeutic functions (such as a highly-developed capacity to be receptive to non-verbal communication, to observe, and to be capable of a sophisticated level of self-reflection, as well as a capacity to tolerate high levels of anxiety within the work setting) are vital to differentiate: they are core parts of our training, and are utilised in all areas of our work, within and outside the consulting room.

We also recognise that there is an increased demand for therapy and counselling services, and that part of the task of creating national standards is to create a structure of standards in the face of this growth, as well as to ensure safety and equity of access to services. We would like to find a way, within the NOS,to reflect the need for both highly specialised practitioners able to support, train and consult to others, as well as a solid core of practitioners skilled in certain key competencies.

Q8. How would you like to contribute to the development process? You could, for example, give us access to practitioners, form a working group, conduct some research, offer to pilot some of the draft standards

We are very keen to be involved with the development process, and the first port of call would be the working group responding to this consultation. We would be in a position to facilitate any of the processes mentioned above, and would also be interested in thinking further about the need for a focus within the development of the NOS on work with children and adolescents specifically, as there is so much that is shared by practitioners working with children and young people, that is distinct from those working with adults.