

‘Silent Catastrophe’

RESPONDING TO THE DANGER SIGNS OF CHILDREN AND YOUNG PEOPLE’S MENTAL HEALTH SERVICES IN TROUBLE

A Report from the Association of Child
Psychotherapists on a Survey and Case Studies about
NHS Child and Adolescent Mental Health Services

June 2018

Silent Catastrophe: Responding to the Danger Signs

EXECUTIVE SUMMARY

- Children and young people are facing serious and possibly increasing challenges to their mental health. Many fail to get the treatment and care they need and deserve. Along with many others, the Association of Child Psychotherapists (ACP) has been concerned for some time about the quality of services available to children and young people with mental health difficulties.
- Whilst a lack of resources has been a major factor, this report demonstrates that an equally significant issue is the transformation and re-design of services in recent years. These have led to inefficiencies that mean that resources, principally the skilled workforce, are not used effectively and services can end up wasting resources on managing risk and high levels of re-referrals, rather than offering effective assessment and treatment.
- Evidence from an extensive survey of ACP members with frontline experience of NHS CAMHS shows that:
 - 61% said that the main NHS service they work in was facing downsizing
 - 72% said that the threshold for access to services has increased in the past 5 years
 - 33% described services as mostly inadequate or completely inadequate
 - 64% reported negative changes in the number of practitioner posts, 62% in sessions per client and 65% in the frequency of sessions
 - 38% felt there had been a large negative change in staff morale
- There is much good practice currently taking place across the UK and a desire on the part of clinicians, managers and commissioners to provide high quality services for children, young people and their families. The ACP wants to shift the debate from a recognition that there is a crisis in the mental health of children and young people to an understanding of the factors and forces that lie behind our collective failure to respond to it.
- In the report we identify danger signs that may indicate a service is heading towards providing ineffective services. The signs highlight worrying changes in CAMHS as specialist services disappear and it becomes increasingly hard to provide effective care and treatment for children and young people. The purpose of identifying these danger signs is to inform a debate about what needs to be done to address the danger signs and thus enable delivery of high quality, safe and effective services in all areas.
- The report aims to offer ways of working towards better services that meet the needs of all children and young people. We outline what a high-quality service looks like and put forward some initial thinking about the ways in which services can respond to the danger signs. The report also suggests that there may be scope to do better even with existing levels of resourcing as service re-designs can be ineffective in cost terms as well as in outcomes for children and young people.
- The report is a call for action to renew mental health care and treatment for children and young people through a whole system response including public health and treatment components. We need early intervention in the community as well as access to highly trained clinicians, working in multi-disciplinary teams, who have the skills and experience to respond to the complexity of emotional, behavioural and developmental difficulties that many children, young people and families are experiencing in 2018.

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INTRODUCTION TO THE REPORT

There is no doubt that our children and young people are facing serious and possibly increasing challenges to their mental health. It is equally clear that many fail to get the treatment and care they need and deserve. Along with many others, the Association of Child Psychotherapists (ACP) has been concerned for some time about the quality of services available to children and young people with mental health difficulties. Mental health care and treatment in general, and for children and young people in particular, has been historically been the 'poor relation' of the NHS¹. The lack of comprehensive services is evidenced in the extent to which children and young people with poor mental health harm themselves, use A&E and other services inappropriately, become NEET² or are caught in the youth justice system, and often continue to suffer into adulthood from conditions that should have been met with an effective treatment at the appropriate time in childhood.

The ACP recognises that there is much good practice currently taking place across the UK and a genuine wish on the part of clinicians, managers and commissioners to improve and provide high quality services for children, young people and their families. This report helps us to understand the ways in which this aspiration is being severely tested for many, under the dual pressures of chronic under-funding and high levels of demand.

Whilst a lack of resources has been widely recognised as a major factor, this report demonstrates that an equally significant issue is the transformation and re-design of services in recent years. These have led in some cases to services which increasingly offer a limited range of treatment options, and also to inefficiencies that mean that resources, principally the skilled workforce, are not used effectively and can be wasted on managing risk and high levels of re-referrals, rather than offering effective assessment and treatment.

We do not think enough attention has been paid in many areas to *what* services are provided, and *how* they are provided. This report provides robust and powerful evidence which one respondent called the 'silent catastrophe' of CAMHS. The catastrophe is that many years of investment and hard work in developing good services, expertise, knowledge, professionalism and training can be wiped out in a very short time. It is also a catastrophe for children and young people whose lives are blighted by the lack of effective treatment at the right time.

The aim of the report is to shift the debate from a recognition that there *is* a crisis in mental health of children and young people to an understanding of the factors and forces that lie behind the failure in many parts of the country to respond to it. We can then have a better-informed debate about what needs to be done to address this and enable delivery of the high quality, safe and effective services that children, young people, families and carers, and the professionals who work with them, know are needed. We set out some initial thoughts on how we can respond to the danger signs and what high quality services might look like.

¹ 6% of the NHS budget is spent on mental health and 6% of the MH budget is spent on CYP, despite CYP being 20% of the population (Source: Children's Commissioner 2017)

² Not in Education, Employment or Training

Our concerns about how children and young people are being failed

The Children's Commissioner report *'Briefing: Children's Mental Healthcare in England: October 2017'* identifies children's mental health as the issue that has most often been raised with the Commissioner. She has heard from many young people *'about their desperate attempts, sometimes lasting years, to access support, and even primary school children raised concerns about anxiety. I also hear from parents, teachers and carers about their repeated frustrations when trying to get help for children who need it.'* She raises concerns, which we share, that *'children's inability to access mental health support leads to a whole range of additional problems, from school exclusions to care placements breaking down to children ending up in the youth justice system'* and that there is *'a postcode lottery of fragmented support'*. A recent investigation³ on preventable deaths linked to mental health services, including those for children and young people, is powerful evidence of the systemic failures we are trying to raise awareness of. In this report, we identify many of the factors that lie behind the fragmentation of services and their inability to meet the needs of children and young people, and their families and carers, who desperately need timely and effective treatment from skilled professionals working in well-managed and supported services.

In January 2017, the Care Quality Commission (CQC) were asked to conduct a review of Children and Adolescent Mental Health Services (CAMHS) by the Prime Minister. The CQC examined the care and support available in ten local areas across England, and reviewed how well local health care and public services worked together. The CQC found⁴ that many children and young people were at 'crisis point' before accessing mental health care because the local services in their area were not working together as effectively as they could. CQC rated 39% (26 services) of specialist community child and adolescent mental health services (CAMHS) as requires improvement and 2% (1 service) as inadequate against CQC's 'responsive' key question, which looks at whether people access care and treatment in a timely way. They also found considerable variation in the quality of care between specialist CAMHS services with safety as a significant area of concern. CQC rated 3% (2 services) of specialist community services as inadequate for safety, and 39% (26 services) of specialist community services as requires improvement for safety. The data in this survey, and the case studies in particular, provide a more detailed understanding of what may lie behind the difficulties in those services found to be inadequate or requiring improvement.

Our concerns about service design and delivery

There is widespread recognition that mental health care, especially for children and young people, has been historically underfunded, but this is only one factor. Many reports have identified increasing demand on services and how they are struggling to meet this. The Time to Deliver report⁵ found that two thirds of young people aged 16-34 who had attempted suicide had not subsequently received medical or psychological help. Their research also identified that specialist mental health services are on average turning away nearly a quarter of the young people referred to them for treatment. Under the Five Year Forward View for Mental Health⁶ the government has committed to a significant expansion in access to high-quality

³ <https://www.theguardian.com/society/2018/mar/05/hundreds-of-mental-health-patients-dying-after-nhs-care-failures>

⁴ <http://www.cqc.org.uk/publications/themed-work/are-we-listening-review-children-young-peoples-mental-health-services>

⁵ http://epi.org.uk/report/time_to_deliver/

⁶ <https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf>

mental health care for children and young people. At least 70,000 additional children and young people each year will receive evidence-based treatment – representing an increase in access to NHS-funded community services to meet the needs of at least 35% of those with diagnosable mental health conditions. The government's recent Green Paper⁷ rightly highlights the need for an increased focus on early intervention and preventative measures, in schools and elsewhere, to address the development of mental health difficulties at a much earlier stage. This should include services for parents and infants that address the first 1001 critical days⁸. These measures might, over time, reduce the demand for costly specialist services that are often only offered when young people have reached a crisis and are therefore less effective than they could be.

However, what none of these reports and initiatives seem to recognise or address is that serious difficulties have developed *within* the services that are tasked with delivering specialist mental health services for children and young people; what were previously called Tier 3 CAMHS. Whatever additional services or preventative measures are put in place, there remains a need for comprehensive NHS services that are resourced to meet the needs of children and young people who are unwell, and whose emotional, social and behavioural difficulties may be severe and enduring. Our view is that a drive towards short-term solutions that appear to meet the immediate pressures services are under misjudges the complexity and intensity of the needs of some children and young people and therefore the nature of the services required to meet them, and the potential risks related to this. As a consequence, the ability of services to provide specialist care is threatened from a number of directions. This could be read as a criticism of management or other professionals involved in CAMHS: on the contrary, both management and clinicians of all disciplines are faced with the problem of struggling with the demands of an under-resourced and over-burdened system.

This report goes behind the headlines of children and young people in crisis to try to understand, from the perspective of one frontline profession, how the redesign and restructuring of services has undermined their capacity to meet the needs of the most vulnerable, disturbed and distressed children and young people. It also identifies that the pressures on services have resulted in a workforce increasingly unable to do their job due to worsening pay and conditions, and because services are increasingly rarely clinically led, and the expertise of different professions working together in multi-disciplinary teams is undermined.

In addition, service re-designs which respond to the dual pressures of high demand and under-funding can in fact be ineffective even in cost terms as well as in outcomes for children and young people. The survey results and case studies highlight hidden waiting times, and services that can end up wasting resources on managing risk and high levels of re-referrals, rather than offering effective assessment and treatment.

Transforming children and young people's mental health provision

The ACP supports the proposal in the government's recent Green Paper that schools and colleges should be at the heart of efforts to identify mental health problems in children and

⁷ <https://www.gov.uk/government/consultations/transforming-children-and-young-peoples-mental-health-provision-a-green-paper>

⁸ Transforming infant wellbeing — research, policy and practice for the first 1001 critical days (2017). Leach (Ed). Routledge, Oxford

young people and as a way for them to access high-quality mental health and well-being support. The experience of our members working in and with schools is that such services can prove highly effective and can provide a graduated approach to mental health difficulties. However, we also agree with the Education and Health and Social Care Select Committees' joint report⁹ that the proposals lacked ambition and in many areas underestimated the scale of change required. As clinicians with direct experience of working with children and young people with, often, severe and long-standing difficulties, we also expressed concerns about specific aspects of the proposals that we believe mis-judge the complexity and intensity of the needs of some children and young people, and therefore the nature of the services required to meet those needs, and the potential risks related to this.

Our hope is that the government, in their response to the consultation on the green paper and the ongoing implementation of the Five Year Forward View for Mental Health, listens to the responses of frontline professionals, as well as children, young people and families themselves, in developing proposals that genuinely address the crisis in childhood mental illness that requires a whole system response including both public health and treatment components. An extension of mental health services into schools is to be welcomed, but will only be effective if it is part of a comprehensive, properly funded and well-designed system.

What does a high-quality service look like?

Before focussing on what has gone wrong, it is important to hold in mind that many services, and professionals, continue to provide timely and effective care. There have been many reports and recommendations over the years that draw on available evidence and expert opinion to describe the types of services that are required for children, young people and families who are experiencing a range of mental health, emotional, social and behavioural difficulties. The most comprehensive is perhaps the 2004 CAMHS Standard of the National Service Framework for Children, Young People and Maternity Services. This includes 10 markers of good practice which seem to us to still be useful and relevant, though in need of update in some areas. They include key factors that all frontline staff recognise as indicators of a well-run service: staff having sufficient knowledge, training and support; access to urgent mental health care leading to a specialist mental health assessment; flexible services in order to improve access to high levels of CAMH expertise; a multi-agency approach to meeting the needs of children and young people with complex, severe and persistent mental health needs; specialist multi-disciplinary teams of sufficient size and skill-mix to function effectively; and in-patient services available as part of a continuity of care. The ACP's report adds to that picture with examples of excellence in local services, as well as highlighting the dangers when they are absent.

Markers of Good Practice

1. All staff working directly with children and young people have sufficient knowledge, training and support to promote the psychological well-being of children, young people and their families and to identify early indicators of difficulty.
2. Protocols for referral, support and early intervention are agreed between all agencies.

⁹ <https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/642/64202.htm>

3. Child and adolescent mental health (CAMH) professionals provide a balance of direct and indirect services and are flexible about where children, young people and families are seen in order to improve access to high levels of CAMH expertise.
4. Children and young people are able to receive urgent mental health care when required, leading to a specialist mental health assessment where necessary within 24 hours or the next working day.
5. Child and adolescent mental health services are able to meet the needs of all young people including those aged sixteen and seventeen.
6. All children and young people with both a learning disability and a mental health disorder have access to appropriate child and adolescent mental health services.
7. The needs of children and young people with complex, severe and persistent behavioural and mental health needs are met through a multi-agency approach. Contingency arrangements are agreed at senior officer levels between health, social services and education to meet the needs and manage the risks associated with this particular group.
8. Arrangements are in place to ensure that specialist multi-disciplinary teams are of sufficient size and have an appropriate skill-mix, training and support to function effectively.
9. Children and young people who require admission to hospital for mental health care have access to appropriate care in an environment suited to their age and development.
10. When children and young people are discharged from in-patient services into the community and when young people are transferred from child to adult services, their continuity of care is ensured by use of the 'care programme approach'

In relation to developing high quality multi-disciplinary CAMHS teams (tier 3 services) the standard says:

9.1 A critical mass of staffing is required for services to be safe, timely and effective and able to respond to a wide range of demands which include the provision of: specialist and multi-disciplinary assessment and treatment services; teaching, specialist consultation and liaison services; research and audit; and support, training, consultation and face-to-face work within primary care settings. (p.28)

More recently the CQC review of CAMHS identified aspects of good and outstanding services from which others could learn.

What good and outstanding practice can we learn from?¹⁰

Common factors in the highest quality specialist services included:

Involving children, young people, families and carers through such activities as participating in ward rounds and other activities to help shape the way services are delivered; involving children and young people in staff recruitment activities; offering children and their families regular opportunities to provide feedback and a role in creating supporting materials for service users; and involving children and their families in multidisciplinary team (MDT) meetings.

¹⁰ This summary is taken from a briefing by NHS Providers: <https://nhsproviders.org/media/3825/nhsprovider-cqc-camhs-thematic-review-phase-1-report-26-10-17.pdf>

Collaboration between teams and professionals in services is done well in many providers, with the best services holding regular MDT meetings to share experiences and reflect and learn from incidents.

Collaboration between different organisations and services is particularly common between specialist inpatient and community based services, and where it works well across local systems it is often aligned to a collaborative group such as a local quality improvement network. Bringing representatives together for care planning also improves quality. Co-locating services in one place has aided good working relationships in many places. Strong links and joint working between schools and mental health services are an important feature of good or outstanding practices.

Innovative ways of providing person-centred care included flexible approaches to facilitate remote appointments, family-friendly arrangements for accommodation, and taking services to locations more convenient to service users such as at home or school, and innovative therapeutic approaches

Improving access to services for crisis care involved better provision in acute settings, proactive care planning and signposting for rapid support when approaching crisis point and providing copies to families, and some extended hours of operation to reduce waiting times. Good services kept children and their families informed about waiting times, monitored their wellbeing and supported schools- and community-based support while waiting for specialist care.

Education and training for staff, children and young people and their families made a significant difference to care quality and recovery, with some services offering topic-based workshops for families and service users, and provided mental health education and training in schools to staff and pupils to support children who did not meet threshold for specialist services. Children were also sometimes involved in helping to train teachers and schools staff in mental health skills.

Why Danger Signs?

If the above describe what a high-quality service looks like for children and young people with mental health difficulties, then what are the danger signs that may indicate a service is heading towards providing ineffective services? This report describes the results of a major survey of ACP members with experience of the NHS, and case studies of what went wrong in two specific services, in order to address these questions. It highlights some of the worrying changes in CAMHS as specialist services disappear and it becomes increasingly hard to provide effective care and treatment for children and young people (CYP).

There has been a lot of focus recently on the funding of CAMHS and the extent to which a lack of resources is the primary problem in delivering effective services. The case studies and survey show that, whilst clearly a factor, funding is only part of a more problematic movement away from specialist services. Given the dual pressures of increased demand and chronic underfunding, a move towards commissioning of services which claim to be able to offer a larger number of treatments at lower cost can seem to make sense. Our concern is that these services offer a limited range of assessment and treatment options, more often geared towards the treatment of mild to moderate difficulties, and are less cost-effective than it might appear. It seems that there are less visible costs of hidden waiting times, and resources wasted on managing risk and high levels of re-referrals, rather than offering effective assessment and treatment. Similarly, there is a concern that the plans in the Five Year Forward View for Mental Health for a significant expansion in the workforce (at least 1,700 more therapists by 2020/21) could lead to a focus on increasing the number of practitioners when what is needed is a range

of experience and expertise, in order to deliver a range of treatment options to children and young people. Our concern is that, without recognition of these more structural and systemic issues, any new monies for CAMHS would replicate the simplistic, quick fix, target driven management of services that, we argue, are driving the 'Silent Catastrophe' of CAMHS.

From the case studies and survey results taken together it is possible to identify a number of changes taking place in services that are linked with ineffective care for children and young people:

The Top 10 Danger Signs

1. Specialist services (at Tier 3) disappear and are replaced by interventions that would previously have been offered in primary care/Tier 2, leading to rising levels of suicide, self-referral to A&E departments, and pressure on in-patient units
2. Profession-specific roles and disciplines are dismantled and there is a loss of senior clinical leadership
3. Pressure on lower banded¹¹ staff to perform specialist demands whilst skilled professionals not working to maximum competency
4. Assessment and treatment focuses on symptoms, not the whole child or young person in context; in-depth case assessment and formulation are missing
5. Thresholds are increased to manage demand, leaving children and young people to get worse before being seen, and to an increasing mismatch between need and treatment offered
6. Unrealistic and under-funded service models due to competitive tendering
7. Loss of multi-disciplinary team working leaving services fragmented and staff isolated
8. Failing the next generation of practitioners through lack of effective supervision and opportunities for career progression which in turn threatens the future supply of high quality candidates for mental health professions as the field becomes less attractive
9. High staff turnover, poor morale and poor working conditions
10. Specialist treatments for the most vulnerable children offered by child psychotherapists and others survive despite, not because, of service design

The identified Danger Signs are demonstrated to be occurring in services across the country through the survey results which validate the evidence from the case studies.

Responding to the Danger Signs

The aim of this report is not simply to provide evidence of serious difficulties in many services and the factors behind them, important though that is, but to offer ways of working towards better services that meet the needs of all children and young people. We have highlighted what a high-quality service looks like, based on existing standards, and also gathered data from respondents to our survey who described the excellent aspects of their own service. From their responses we have drawn up a list of the top 10 ways in which services can respond to the danger signs. These are proposed as a starting point for discussion about how to respond to the danger signs and moving towards high quality services. Putting these elements of service design in place would be an important step in addressing the silent catastrophe.

¹¹ NHS staff (other than doctors) are paid on the Agenda for Change scale which runs from Band 1 to Band 9 with Band 8 subdivided into A-D. For reference, disciplines such as child psychotherapy and clinical psychology normally train on Band 6 before moving onto Band 7 upon qualification.

We asked those members who feel they work in excellent services what makes them so.

1. Specialist services for children and young people supported by effective early intervention in the community, including from birth to age 25
2. Profession-specific roles and clinical leadership
3. Skilled professionals able to work to their competency and support lower banded staff
4. In-depth assessment and formulation that considers the whole child or young person in context
5. Referral criteria that recognise the complexity of emotional, behavioural and social presentations of mental illness
6. Service models co-constructed with local agencies and service users and based on a realistic assessment of the burden of mental illness and sufficient funding
7. Strong multi-disciplinary team working with effective leadership
8. Provision of effective, discipline-specific supervision, training and opportunities for career progression
9. Focus on staff wellbeing and working conditions
10. Specialist treatments for the most vulnerable children central to the service design alongside effective early intervention

About the 2018 survey

The purpose of the survey was to ask child and adolescent psychotherapists who are members of the ACP about their experience of working in the NHS and allied public mental health services. This included current NHS staff, including those currently in training, and those who have previously worked in the NHS and left in the last 5 years. The survey was open for members to complete from 24th April to 10th May 2018. We received 416 responses in total. The ACP has 650 practising members on its register so this represents a very high proportion of those who have direct experience of the NHS.

Key findings from the survey

The survey contains some important and powerful findings:

- 61% said that the main NHS service they work in is/was facing downsizing.
- 72% said that the threshold for access to services has increased in the past 5 years.
- 33% described services as mostly inadequate or completely inadequate.
- 64% reported negative changes in the number of practitioner posts, 62% in sessions per client, 65% frequency of sessions and 48% in the quality of management.
- 38% felt there had been a large negative change in staff morale, in addition to 35% who had seen a moderate negative change.
- Of those respondents no longer working in the NHS, 62% left in the last five years. Their reasons for no longer working in the NHS included: "I felt burned out" (19%) and "I felt the service was unsafe" (18%).
- 93% saw no evidence of claimed investment and expansion in services.

About the case studies

In addition to the survey we spoke in detail to members who had particular experience of working in services that had suffered serious difficulties due to service redesign and changes to the way services are delivered. The case studies highlighted some worrying developments that we identified as the 'Danger Signs' of CAMHS in trouble, and which we used as the basis for some of the questions in the survey. The large amount of data from the survey supports

and expands upon what we heard from members about specific services. The case studies are provided in this report alongside the survey findings. They have been made anonymous and details have been changed so that neither the NHS trust nor the practitioner are identifiable.

About psychoanalytic child and adolescent psychotherapy

ACP child and adolescent psychotherapy (CAPt) is a core NHS profession with rigorously regulated standards and training, approved by the Department of Health and recognised as an important component of comprehensive Child and Adolescent Mental Health Services (CAMHS). Child and Adolescent Psychotherapists work in community services, hospitals, early years centres, schools, social services and the youth justice system. They may be employed by statutory agencies or work in the voluntary and independent sectors. Psychoanalytic child and adolescent psychotherapy is internationally recognised and as strongly evidenced¹² as many of the more common treatment models people may be more familiar with.

Child and Adolescent Psychotherapists are dedicated to understanding the complex emotional lives of infants, children, young people, families and carers in depth. This is a psychoanalytic approach which seeks to look beneath the surface of problematic emotions, behaviours or relationships and to help children and adolescents, and their families, to understand themselves and their difficulties. Child and Adolescent Psychotherapist are trained to carefully observe a child or young person and respond to what they might be communicating through their behaviour and play. Their distinctive NHS training enables them to develop and sustain relationships with children and young people whose difficulties may be long standing and severe and whose levels of disturbance may make it hard for them to benefit from the care and opportunities offered them.

Child and Adolescent Psychotherapists may see children and young people individually or with other family members often working with children and young people where other treatments have not been effective. They also apply their framework of thinking to work with parents, families and carers and to training and supporting other professionals who work with children, young people and families to encourage a deeper understanding of the child's perspective.

About the ACP

The Association of Child Psychotherapy (ACP) is the main professional body for psychoanalytic Child and Adolescent Psychotherapists in the UK. It is an accredited register of the Professional Standards Authority (PSA) and is responsible for regulating the training and practice standards of child and adolescent psychotherapy across the public and private sectors. It was established in 1949 and has nearly 900 members, including trainees, working in the UK and abroad. Child and Adolescent Psychotherapists who have qualified at one of the ACP recognised training schools are eligible for full membership of the ACP, which enables them to work with children, parents and families in a range of settings.

¹² Nick Midgley, Sally O'Keeffe, Lorna French & Eilis Kennedy (2017) Psychodynamic psychotherapy for children and adolescents: an updated narrative review of the evidence base, *Journal of Child Psychotherapy*, 43:3, 307-329, DOI: 10.1080/0075417X.2017.1323945

Call for Action

This report provides robust and powerful evidence which one respondent called the 'silent catastrophe' of CAMHS. Service redesigns to meet financial pressures and simultaneous demands for increased access to services can lead to the loss of the high-quality, specialist and multi-disciplinary services that are so essential for children, young people, and their families and carers who most need the right service, in the right place, at the right time. The catastrophe is that many years of investment and hard work in developing good services, expertise, knowledge, professionalism and training can be wiped out in a very short time. It is also a catastrophe for children and young people whose lives are blighted by the lack of effective treatment at the right time.

The view of the Association of Child Psychotherapists is that the time has come for a major renewal of mental health care and treatment for children and young people. This must include *both* early intervention in the community *and* access to highly trained clinicians, working in multi-disciplinary teams, who have the skills and experience to properly assess need and to understand and formulate how to respond to the complexity of emotional, behavioural and developmental difficulties that many children, young people and families are experiencing in 2018. This report is put forward to inform a new debate about what high quality, safe and effective services look like, and how we can deliver them.

Authors

This survey and report were produced by the Treat Them Right campaign team (Isobel Pick, Nick Waggett and Claudia Moselhi) who are very grateful for the members of the ACP who gave their time and knowledge in providing such detailed and important data.

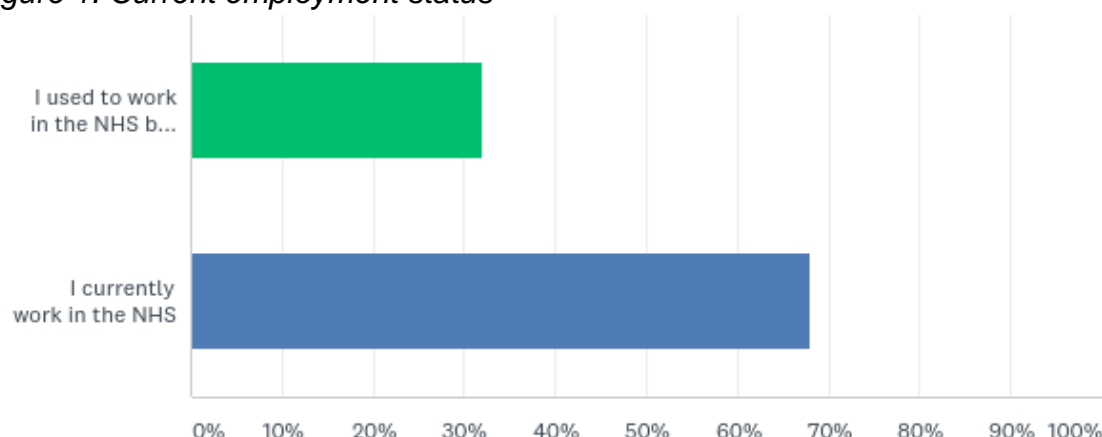
If you would like to discuss this report and its findings please contact: Dr Nick Waggett, ACP chief executive at nick.waggett@childpsychotherapy.org.uk or 020 7922 7751

RESULTS FROM THE SURVEY OF ACP MEMBERS ABOUT NHS CAMHS 2018

1. Information about the respondents

416 ACP members completed the survey in part or in full. Of the 416 total respondents, 68% (282) currently work in the NHS and 32% (133) used to work in the NHS but don't anymore. Respondents' history in the NHS goes as far back as 1960 with between 2% and 5% starting work each year from 2000 to 2017.

Figure 1: Current employment status

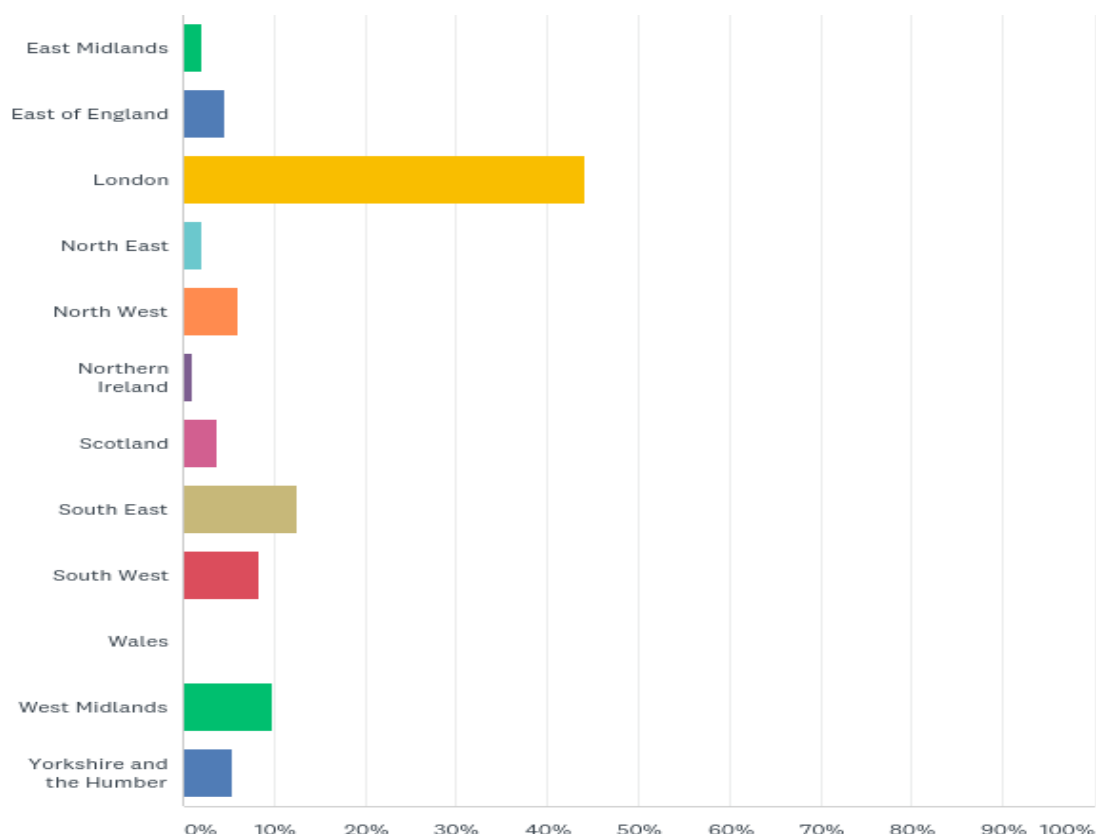


Of those who no longer work in the NHS, 62% left in the last five years. Their reasons for no longer working in the NHS include: "I felt burned out" (19%) and "I felt the service was unsafe" (18%).

A large number of chose 'other'. A review of their reasons shows that many were due to dissatisfaction with the service being provided and the working conditions for staff. Worryingly, several indicated that when their four-year NHS training was completed they were unable to find work as a child psychotherapist in the NHS. Answers included:

- Frequent change of managers. More staff employed that were not mental health trained
- Paperwork and working systems meant I had to work significant extra hours which impacted on family time
- My training finished after four years and my trust was not able to offer me a post at a qualified position as there were budget cuts.
- The service I worked in was redesigned and initially a Band 7 role was proposed rather than my own banding (top of 8b)
- Bullying; end of contract
- Ethically I could not support the service redesign
- Terrible working conditions, unsupported, no space for child psychotherapy in the team

Figure 2: Location of respondents

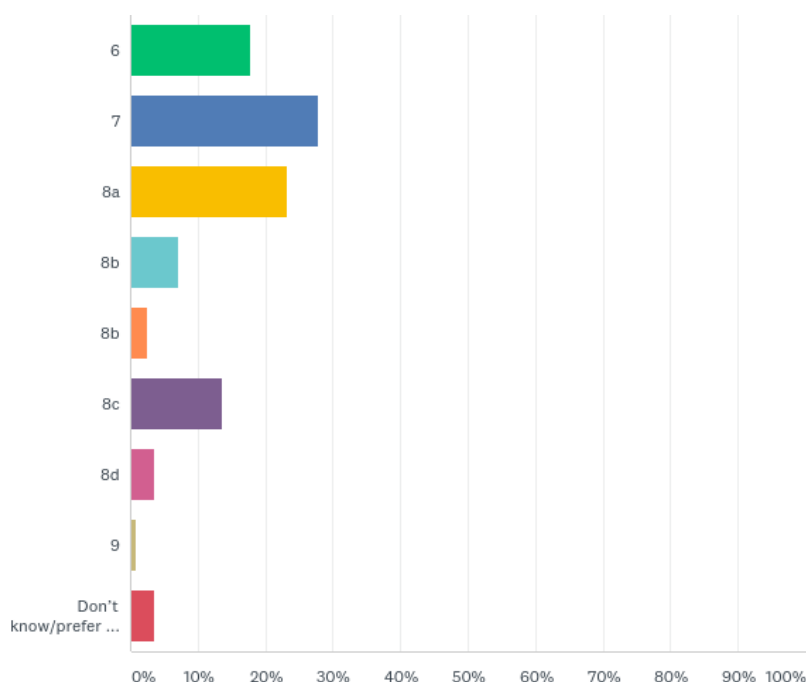


The ACP and its accredited training schools have made significant progress in recent years in expanding access to CAPt across the country, however, outside of London many services (perhaps 50%) do not employ a child psychotherapist. The survey therefore only reflects those services that our members have knowledge of and we have no data on those areas that have never included child psychotherapy in their provision.

Table 1: Type of service or setting in which respondent's work or worked

86%	Work, or used to work, in Tier 3 community CAMHS.
	<i>Other services represented include:</i>
12%	Looked After Children/Adoption and Fostering
5%	Inpatient CAMHS
3%-	Education settings
> 2%	Gender Identity; Forensic Service; Autistic Spectrum Disorder (ASD) Service; Children's Centre; Perinatal Mental Illness; Physical health/paediatric liaison; Parent-Infant Health Service; Perinatal Mental Illness; Learning Disability Service; Child or Adolescent Residential Care
97%	Are/were employed by an NHS Trust.

Figure 3: NHS Pay Bands of Respondents

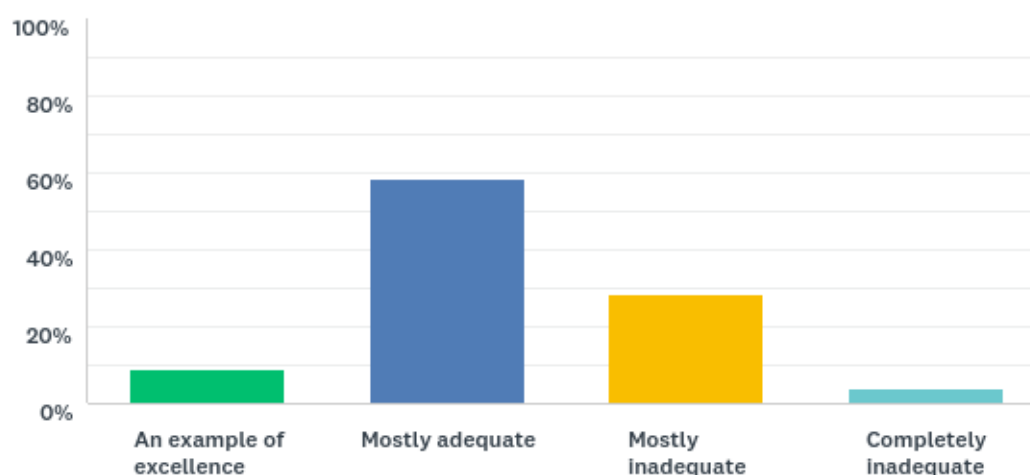


51% of responders are/were on Band 7 or 8a. Many of the Band 6 responses will be from trainees as this is the nationally agreed banding, though some qualified child psychotherapists may be work at this grade in, for example, mental health practitioner roles.

2. Data about the services respondents' work/ed in.

We asked members about how adequate the service they work/ed in was in meeting the needs of children and young people. The majority (58%) of respondents described the main service in which they work/ed in as mostly adequate (meeting the needs of most of the CYP it serves) and 9% described it as an example of excellence, meeting the needs of all CYP it serves. However, a concerning proportion (33%) described the service as either mostly inadequate (in some areas but not all) or completely inadequate (not meeting the needs of most of the CYP it serves).

Figure 4: How would you describe your service?



What makes services excellent

72 people provided additional information about what makes their service excellent. Comments included:

- Financially well managed, meaning there is a viable commitment to true multi-disciplinary team incorporating all professional disciplines. This means that NICE guidelines can be met but CYP needs are paramount
- Good team work, staff retention, good leadership. Service which is focused on needs of children and families and not narrow definitions of mental illness. The service is able to work with children and young people without rigid time limits, based on need. The clinicians are adaptable.

Multi disciplinary team putting child and family at the centre of our thinking.

- A community team, providing CAMHS support in every local school, and with no/very low referral thresholds; good multi-disciplinary team in which CAPt and other disciplines are respected.
- The team that I work in is still able to offer CAMHS services to wide range of young people (preventative work in schools, urgent risk assessment, short term work and longer term work).
- The service I work in is progressive in its use of expertise and resources both to provide a specialist service and also to skill up the wider workforce to work with parents, infants, and children under 5.
- Low waiting lists, mix of professions, clinician feedback listened to, responsive managers, no time limit to some therapies

Strong multi-disciplinary team, clear leadership, collaborative working, a learning environment, well focused on needs of users

What makes services inadequate

75 people provided additional information to describe why they felt their service was inadequate. Comments included:

The service doesn't care about a revolving door for patients. It focuses predominantly on short term work, getting patients off the waiting list and then discharged.

- Short term work emphasis when cases were very complex. Down-grading of posts so team had less qualified mental health staff. Team asked to do more with less resources. Managers were unaware of the clinical needs of families.
- Lack of staff. Lack of specialists. No time for proper assessments and treatment of CYP. Short term interventions by inexperienced staff, who were feeling overwhelmed.

The service maintains a façade of providing psychological therapy but in reality it is unable to provide anything much more than risk assessment and medication.

- Overstretched, overworked, stress, pressure, long waiting lists, overload of paperwork, overloads of other referrals, limited social care provision, if at all, limited preventative services, limited time to complete the necessary assessments, reports etc.
- Once the service was taken over by a new trust the service was redesigned and did not meet the needs of a large section of the population who had significant mental health needs.

Unsafe to practice, unreachable targets. Staff not supported and not contained. The service employing not qualified staff

Adequacy of specific aspects of services

We asked respondents about adequacy of specific aspects of their service to meet client needs. Key findings were that 60% thought the number of practitioner posts were inadequate. 63% that waiting times were inadequate. 64% felt staff morale was inadequate.

Table 2: How adequate are specific aspects of the service

	Completely inadequate	Mostly inadequate	Mostly adequate	Completely adequate
Number of practitioner posts	16.67%	43.33%	37.67%	2.33%
Number of sessions per client	6.08%	41.89%	47.30%	4.73%
Frequency of sessions offered	5.41%	38.18%	52.36%	4.05%
Range/choice of treatments available	4.42%	29.25%	60.20%	6.12%
Clinical experience of those providing psychological therapy	1.34%	18.39%	61.87%	18.39%
Level of qualifications of those providing psychological therapies	1.68%	18.12%	56.71%	23.49%
Waiting times for treatment	26.17%	36.58%	30.87%	6.38%
Time for supervision and reflective practice	13.00%	33.33%	45.67%	8.00%
Quality of management of the service	14.53%	33.78%	44.59%	7.09%
Quality of supervision	3.06%	17.01%	53.06%	26.87%
Staff morale	23.41%	40.47%	32.11%	4.01%

Respondents added a number of additional comments to this question including:

- Staff not valued. Families needs not thought about sufficiently in service due to so many pressures and due to cuts in funding to the services and to other public services. Stress amongst staff and psychiatrists carrying clinical responsibility in the service was very high with lots of staff on sick leave due to stress. Specialist posts cut and so many complex children were not given a service.

Our trust has promised twice as much to the commissioner as we can deliver as a team.

- Very limited joined up working, children and young people put on waiting lists for further assessments and diagnosis but not sufficient treatment
- Experienced people leave as feeling used up and burnt out

A complete collapse of a MDT approach, No longer a specialist service.

- The lack of support from the CCG has been quietly crippling
- Tragic to witness the demise of a once flourishing and truly multidisciplinary specialist CAMHS
- Staff in tears in meetings, management patronising and out of touch

Changes in the adequacy of aspect of service in the last 5 years

We then asked whether there had been any changes to these aspects of services in the last 5 years. Key findings were that 64% said there had been a negative change in the number of practitioner posts, 62% in the number of sessions per client, 65% in the frequency of sessions offered, and 48% in the quality of management of the service. Perhaps most worryingly, 38% felt there had been a large negative change in staff morale, in addition to 35% who had seen a moderate negative change.

Table 3: How has the adequacy of services changed in the last 5 years

	Large negative change	Moderate negative change	No change in the last 5 years	Moderate positive change	Large positive change	Don't know
Number of practitioner posts	29.49%	34.58%	7.80%	10.51%	4.07%	13.56%
Number of sessions per client	20.55%	41.78%	15.07%	3.77%	0.34%	18.49%
Frequency of sessions offered	14.63%	39.80%	24.49%	3.06%	0.34%	17.69%
Range/choice of treatments available	12.16%	28.72%	22.97%	17.91%	1.35%	16.89%
Clinical experience of those providing psychological therapy	13.80%	34.34%	27.27%	5.39%	0.67%	18.52%
Level of qualifications of those providing psychological therapies	10.85%	35.93%	26.78%	5.42%	1.69%	19.32%
Waiting times for treatment	31.63%	28.57%	14.97%	7.82%	1.36%	15.65%
Time for supervision and reflective practice	14.58%	38.31%	22.71%	6.10%	1.69%	16.61%
Quality of management of the service	20.34%	27.80%	25.42%	8.14%	2.03%	16.27%
Quality of supervision	5.08%	18.31%	45.08%	8.14%	3.05%	20.34%
Staff morale	38.10%	34.69%	9.18%	4.42%	0.34%	13.27%

Respondents added a number of additional comments to this question including:

- It is depressing to feel patients could be better healed if they were provided with sufficient length and frequency of work as per our training
- Service reorganisation involved substantial 'pruning' of posts alongside regrading down for all psychological therapy staff and a failure to ensure basic requirements were met, even down to furniture as initially there were no chairs in some areas

The service felt unsafe. There was an increase in suicide amongst young people.

- Space for reflective and safe practice isn't valued and staff are under a great deal of pressure to undertake impossible roles with continuous demands placed upon them, even in terms of managing risk.
- Cuts have resulted in higher work loads and long hours as staff continue to try to protect the vulnerable young people from the impact of thoughtless change and disinvestment.

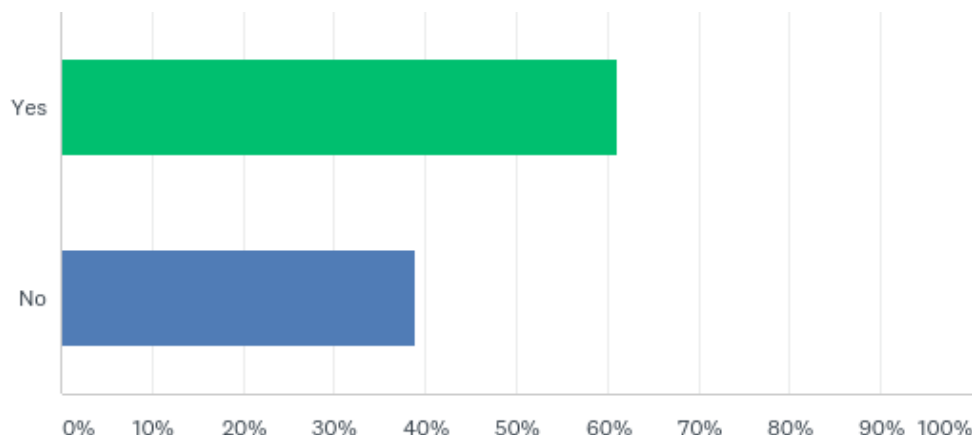
Those staff that have left have been replaced with less experienced and lower-banded staff, negatively impacting the service for CYP with more severe needs.

- Top-down, closed shop imposition of non-clinical priorities on clinical practice

Downsizing of services (reduction in staff)

61% of people who answered this question (177/290) said that the main NHS service they work in is/was facing downsizing as defined as a reduction in staff.

Figure 5: Is/was the main NHS service you work in facing downsizing (reduction in staff)?



32% said the downsizing was happening now, 36% said it had happened in the last 5 years.

Down-banding of child psychotherapy posts

In addition to being cut, many child psychotherapy posts have been down-banded, with 20% indicating a decrease from Band 8 to Band 7. Only 23% said that no downgrading had happened or was planned.

Additional detail provided in relation to this question included:

- Four Child Psychotherapists were made redundant
- Hardly any designated psychotherapy roles. When people leave specialist posts they are replaced with generic jobs and are often down banded when re advertised
- Current band 7 posts are stuck in that band whilst doing the job of band 8. No meaningful pay progression or recognition of more senior professional tasks.
- The service has made 3 Consultant Psychotherapists (band 8c) redundant.

Consultant Psychotherapists not replaced, Band 7s not offered any hope of promotion

- There are no opportunities for career progression which means that colleagues with significant experience remain on Band 7 contracts or may choose to leave the service
- Transformation 5 years ago led to many CAPt posts being downgraded or cut.
- No psychotherapy posts since reorganisation. Some employed as primary mental health workers, band 7.

Hard to fill posts

There is no doubt that there is a recruitment and retention crisis in many CAMHS. This table identifies that there is a particular problem with finding child and adolescent psychiatrists but also difficulty in filling posts in a third of services for child psychotherapists at bands 7 and 8, family therapists and clinical psychologists. The data indicate that the perception of some services as not providing a good working environment is a contributory factor. A shortage in some areas of suitably trained professionals is also a factor.

Table 4: Hard to fill posts

	Yes	No
Child psychotherapy Band 6	6.06%	93.94%
Child psychotherapy Band 7	33.19%	66.81%
Child psychotherapy Band 8	31.79%	68.21%
Child psychotherapy Band 9	11.82%	88.18%
Psychiatry	54.23%	45.77%
Family therapy	38.46%	61.54%
Clinical psychology	32.29%	67.71%
Other	42.20%	57.80%

Additional detail provided in relation to this question included:

- Child psychotherapy has been almost entirely gotten rid of
- Over reliance upon locum workers

All posts hard to fill in a crumbling service.

- All posts in all disciplines hard to fill in our service currently
- Both our consultant psychiatrists are due to leave in the next month. Other team members have recently left and I have just handed in my notice. Ours is not a team that people are keen to work in and turnover is high.
- Psychiatry team either left or were on sick leave due to stress following service redesign, several locum psychiatrists were employed. In my opinion, levels of risk rose, and continuity of care was compromised.
- Many posts disappeared, others were downgraded and trainee posts ended as there were no longer any premises to do child psychotherapy work

The reasons why people felt these posts were hard to fill included:

- Too much work and responsibility and not enough pay

Failing service, high staff turnover, poor working conditions, poor senior managerial attitude/approach.

- CAMHS has a poor local reputation as an employer.
- Jobs in teams which have vacancies are hard to fill because reputation of service means that people know the jobs are impossible to do.

Service has poor reputation for safety for patients and clinicians.

- Expected to carry huge caseloads and risk; so stress levels are high, and sickness levels even higher.
- Because our service has such a bad reputation for over-working staff, staff sickness and a high staff turn over.
- There is no interest in Child Psychotherapy

Asked what was being done to resolve the recruiting problems, the respondents said:

- Getting in large numbers of band 5 clinicians and making band 7s supervise them...unsure of how sustainable this will be
- More agency staff alongside efforts to address enduring basic problems in service provision
- Before I left I had made many attempts to raise concerns at senior level. The consultant Child Psychotherapist in a neighbouring service (same trust) did a great deal to raise this.

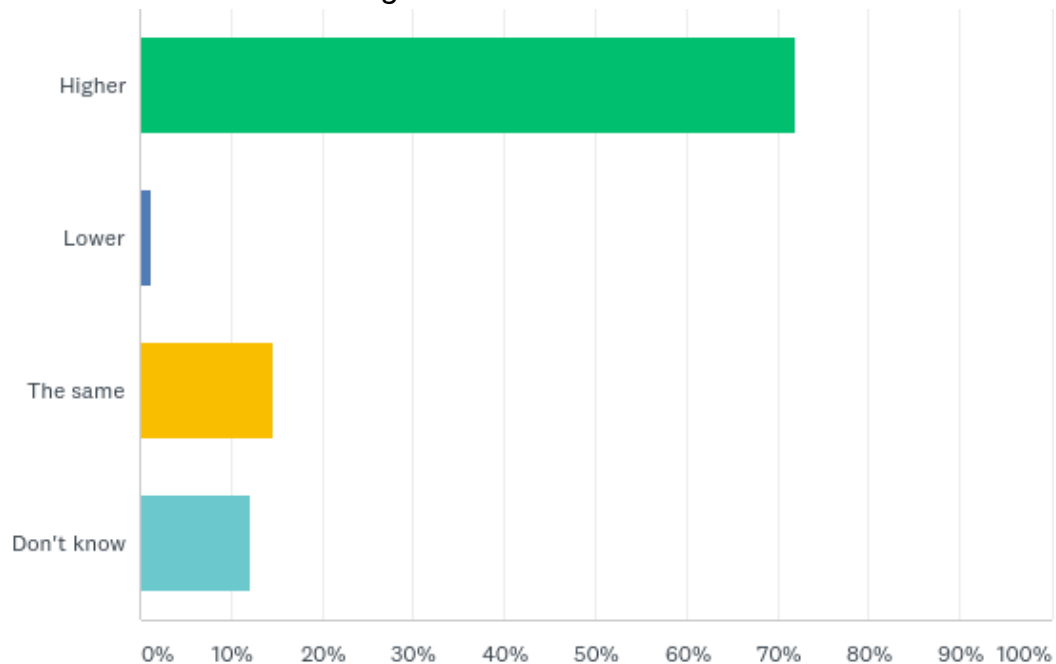
Nothing. More senior managers seem to ignore fast staff turnover and ridiculously high staff sickness levels.

- Therapists are challenging senior management about the need to make posts more manageable, but not much else, other than continuous workforce development conversations
- Psychotherapy fighting hard to recruit and retain only qualified psychotherapists to prevent dilution of clinical skill
- Nothing. Existing staff are continued to be pressured to take on more work, and more people are planning to leave (including myself).

3. Thresholds to access services

We were particularly interested in gathering more data about the widespread perception that thresholds for accessing services were too high and that they had recently increased. We asked whether access to NHS services depends on the severity of a client's presenting issue and whether these thresholds to entry have changed in the past 5 years? The view of 72% of members is clearly that they have increased:

Figure 6: Thresholds for receiving services



200 respondents wanted to provide additional information in relation to this question. What they told us about the evidence that thresholds are increasing included:

- Cases are based on level of risk and are predominantly about self harm or suicide attempts. My service 'doesn't do' attachment and behaviour issues.

Guidelines for acceptance of referrals have changed. Only severe cases accepted. No opportunity for preventative work.

- Young people having to present at A&E to access services. What would previously have been accepted in was signposted to early intervention services who in my view were not trained or supported enough to respond to often highly complex cases with considerable risks.
- Patients are unlikely to be seen unless they are in crisis (ie acutely suicidal)

More cases having to be re-referred several times and reaching a crisis point before being accepted.

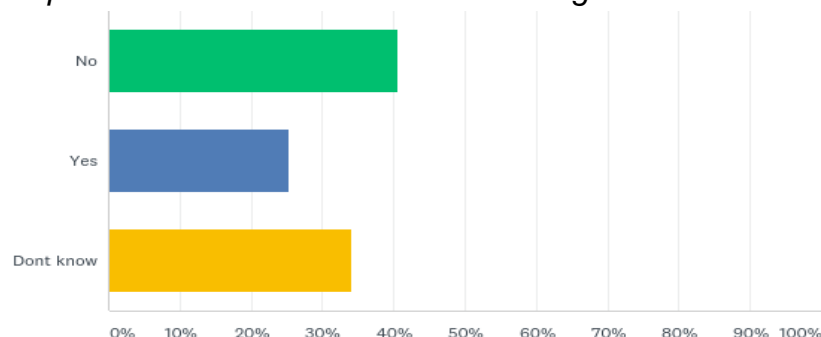
- Children at assessment are being turned away as 'don't meet threshold for treatment' even though there is clearly a need for help and clinicians agree previously would have been offered treatment.
- Many referrals are rejected until they display more severe symptoms

The severity (and complexity) of young people's presentations, and the number of years they have been waiting. Worryingly, very high levels of risk are minimised and dismissed. Sexual abuse no longer considered a reason for referral.

- Thresholds are increasingly driven by immediate risk to life. Inadequate resources making it hard to provide service for children in need of mental health support but not currently suicidal or other risk. Young children are especially missing out despite repeated government papers highlighting the need for early intervention in mental health
- No longer any self referrals permitted, early interventions much more difficult to offer. Quite often requirement that previous treatments failed before psychotherapy can be offered
- The cases we see are much more complex, have higher risks and higher complexity of social care needs. They often reach us at crisis point or in great distress as they have not received enough support elsewhere or have had to wait for a long time for a referral
- High level of complexity and risk and social care issues, frustration from schools etc having to manage low level mental health themselves

In addition, 41% said that specific measures, such as psychiatric measures, were used for establishing thresholds.

Figure 7: Specific measures used for establishing thresholds



Further detail included:

There is gate keeping based on psychiatric view, and anyone with psychiatric symptoms is most likely to be seen. However, presentations need to be extreme, and not related to 'social problems'. Children with high levels of social problems tend to be rejected as seen as social care problem. This is discrimination and inequitable.

- Supposed to have a psychiatric diagnosis to receive treatment.
- SDQ and RCADS¹³ used to inform clinical judgement.
- Need for medical diagnosis to get service or to fit in specific category of need
- The focus is on diagnosed mental illness and eating disorders

¹³ SDQ = Strengths and Difficulties Questionnaire. RCADS = Revised Children's Anxiety and Depression Scale

Asked for their view on why thresholds had increased, we were told:

- Excessive demand, rising referral rates not accompanied by rise in capacity.

Higher demand and fewer staff to treat this; also cuts in funding support for Tier 2 charitable services and education pastoral support have had an impact on the pressures on CAMHS - necessitating higher thresholds.

- Cuts to supporting services has increased referrals as unsupported children, young people & families reach crisis point.
- Lower capacity for the service to meet increasing demand, less experienced staff resulting in less productive interventions, universal services and voluntary services depleted

Level of crisis seems to be going up and the service is responding by only treating the crisis rather than prioritising early intervention.

- Just last week a senior colleague (non psychotherapy) suggested I 'assess the risk and get rid' when thinking about what to offer a difficult patient and their family. There is a very definite move towards blaming the patients for having the wrong kind of difficulties i.e. ones that don't respond to brief intervention.

Pressure in Tier 4 comes from Tier 3 services being over-stretched - Tier 3 is now unable to provide long-term and intense treatment to the most risky children and young people, consequently cases that would have been managed in the community are now being referred.

4. The Danger Signs

In our 'Treat Them Right' campaign, we are trying to identify and highlight danger signs that indicate that a CAMH service is failing or starting to fail to meet the needs of the children and young people (CYP) it serves, in particular the most vulnerable CYP who need the treatment that child and adolescent psychotherapists can offer. From the detailed case studies we have undertaken we identified a number of initial factors and asked people whether they would agree that they are common danger signs.

Table 5: Danger signs of CAMHS in trouble

	Yes	No
Chronic under-funding and under-staffing	96.60%	3.40%
Dismantling of 'Tier 2' services with consequent pressure on 'Tier 3'	93.79%	6.21%
Dismantling of profession-specific roles and disciplines, such as clinical psychology, family therapy and child and adolescent psychotherapy	90.97%	9.03%
Hollowing out of senior roles at 8a/b/c which were previously occupied by people with specific clinical qualifications	92.68%	7.32%
Consequential pressure on lower banded staff to perform specialist roles	95.17%	4.83%
Different 'pathways' for CYP are set up but what is offered in each is effectively the same	76.38%	23.62%
Proper case assessment, formulation and MDT thinking is missing	77.89%	22.11%

Thresholds are increased to manage demand	94.46%	5.54%
Self-esteem has been eroded and staff turnover is very high	89.90%	10.10%
Trust appears to be unaccountable for failures in service provision	81.65%	18.35%
Increased prescribing of medication in place of therapy	69.71%	30.29%
Lack of suitable space to work therapeutically with children and young people	78.01%	21.99%
Over-reliance on hot-desking	80.50%	19.50%

Additional comments included:

Clinical staff were less able to voice concerns about clinical governance. Staff were told to not be negative if they voiced concerns.

- These changes are having a significant impact on staff well-being and mental health
- We compete for rooms and hot desk in a way that undermines cohesion and promotes isolation.
- An attack on teams and thinking with MDT colleagues
- All absolutely true, and made me and my colleagues leave in a period of one year of the transformation. A team that previously worked well, covered all core disciplines, was solid was dismantled by the new organisation.
- The local authority have set up CAMHS in Schools, at the cost of the NHS service, clinical thinking is being side-lined
- The local Tier 2 services that we would have been able to sign post to have all closed their waiting lists.
- Attempt to impose 24/7 working on staff without adequate increase in resources

Medication increases are the biggest sign in my service.

- I have regularly experienced all of the above in our service (which is rated 'outstanding' by the Care Quality Commission).

We then asked what other danger signs these frontline practitioners would identify:

- Lack of recognition of 17 - 23yr old provision

Not recognising the complexity of cases and intensity of treatment needed.

- Risk. Lack of access. Lack of specialism within the service. Short term work is ineffective for complex cases, it can increase risk as families are so demoralised by having only 7 sessions. Clinicians are 'burnt out' by the emphasis on short term work.
- High presentations of self harm, high levels of child protection with inadequate social care involvement

Revolving door cases, that keep coming back and back.

- Children with mental health problems that are limiting their development are not seen as being at risk. Only self harming children and those under threat of abuse are deemed to be at risk. Those who may become psychopaths or depressed teenagers are not being treated early enough because they do not yet pose a risk.
- Staff mental health- sickness levels were high in my trust, bullying culture towards staff who disclosed they were struggling
- Basically asking junior people to deal with serious cases without adequate supervision
- Increase in frequency of near misses. Children expressing suicidal intent not followed up due to both inexperience and being overwhelmed. Staff sickness. Increased use of Locums.

All staff over-working significantly to meet demands on the service which can't be sustained.

- There is an epidemic of self harm & though small in numbers the rate of suicide is frightening
- Too much emphasis on administration too little time spent on clinical formulation and understanding the experience of the service users.

Dangerous working conditions for staff. Too stretched, too stressed, very low morale for extremely difficult work.

- So many demands are asked for data & on screen work which takes clinicians away from work with patients.
- Number of managers in comparison to clinicians
- Staff stress and the deterioration of multi-disciplinary teams, children and families are not being understood and their needs are overlooked. Tier 2 and 3 are not working together, and still adult mental health has poor clinical liaison with CAMHS.

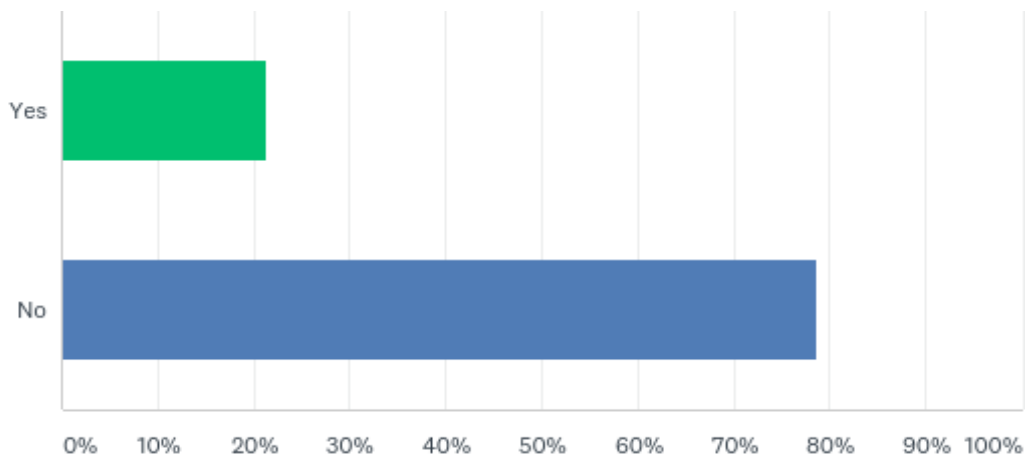
No in depth work with children who have been traumatised or abused, no early intervention with infants and under-fives.

- Erosion of supervision. Need to promote leadership skills within core professions to address complexity and not tick box models of supervision. These have been a retrograde step.
- Children under 12 years of age rarely getting accepted into service
- Lack of understanding of early intervention

5. Four-week waiting time standard

The government are proposing to introduce a four-week waiting time standard for CAMHS. We asked whether respondents think this will improve the quality of services provided to children and young people. 79% thought introducing a four-week waiting time standard would not improve the quality of services provided to children and young people.

Figure 8: Will a four-week waiting time standard improve the quality of service



The particular aspects of their service that members wanted us to know about included:

- Waiting time standard will only push waiting time into a more hidden wait, ie after being accepted into CAMHS, you will then have to wait for follow-up appointment.

Inexperienced staff will be doing triage and won't have skills for proper assessments. Some dangerously ill young people will get lost.

- I find it hard to see how it can be helpful to assess more people more quickly if then there is no provision of treatment but a long waiting-list.

I am currently working in a service that mostly achieves a 4 week waiting standard. All this means is that staff resources are used to offer an initial assessment. Then there is a very long wait for treatment.

- Child psychotherapy has been dramatically denuded. Nice guidelines are used to prioritise psychological therapies such as CBT. We are actively encouraged to close cases quickly even though we know they will re-refer.
- Increased inappropriate referrals to our hospital service because cases are not being seen in CAMHS due to much higher thresholds

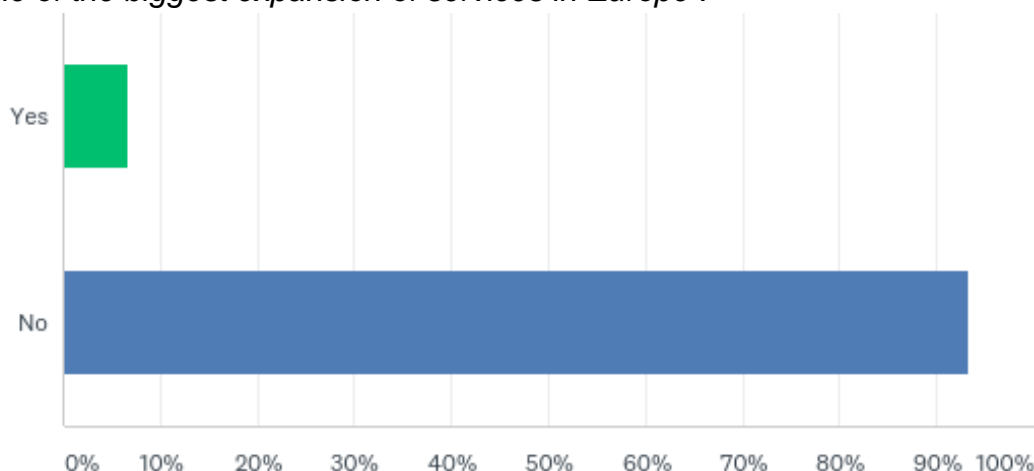
Staff work extremely hard with very challenging patients; the continual under-funding, uncertainty, and lack of post numbers, puts ever increasing pressure on them which makes it impossible to work as effectively as they would like to.

- Under resourcing of tier 2 and tier 3 services have now resulted in an increase presenting of young people in A & E in order for them to be seen
- The needs of under 5s and their families cannot be addressed with the lack of investment and resources in CAMHS currently
- The 'transition' of CAMHS patients to AMHS at 18. There are virtually no services for children post 18 & they do not fit the criteria for our current adult mental health service.

6. Rhetoric and reality

The government are investing additional money into CAMHS and claim they are overseeing 'one of the biggest expansion of services in Europe'. We asked whether members on the frontline were seeing evidence of this investment and expansion in the service they work in.

Figure 9: 'one of the biggest expansion of services in Europe'?



7. Final comments

Finally, we asked respondents if there was anything else they wanted to say:

- I'm pleased that these questions are being asked and hope the findings make a difference

Not putting money and resources will only lead to a worst outcome for society as a whole as these children and adolescents are the adults of the future.

- Working as a child psychotherapist in the health service there is an inability to provide the public with adequate and effective mental health support . We need to be able to support families and young people to become confident good enough parents in caring communities and therefore prevent many of the triggers to long term mental health problems.
- I continue to work hours more than I am contracted. Usually doing paperwork, outcome measures and so on. Not always easy to take the time back. I often worry about patients when I am not at work. Concerned for my own health in the long-term, and wonder if in a few years I will be in the NHS, or be working privately, or out of the profession all together. Which is hard to think about, given my original commitment to wanting to make Child and Adolescent Psychotherapy available to all children, young people and families who need it.

Perhaps MPs of all parties and even the PM could come and spend some time at our clinic and see how we work each day, and the emotional pain and distress we are faced with every single day.

- There does not seem to be any hope that working in CAMHS is ever going to improve again. It has become soul-destroying. All this intensive training and my skills are going to waste.
- I see no investment whatsoever. The level of psychological disturbance though is ever greater. Dark, dark times for child and adolescent mental health...
- I don't feel that I can have a weekend break, or any break, as I am constantly worrying about the amount of paperwork that I haven't completed, which then erodes in my time off.
- I am glad that I am nearing the end of my career.

I resigned because I felt I could no longer do my job properly both as clinical lead for a large trust and as a clinician. We are leaching good practitioners from the NHS.

- The main concern is that of the very vulnerable children and young people that are referred to our service, who are not receiving the level of support they need. They are seen quicker but not matched with the most appropriate treatment and for the length needed. With staff morale so low and staff feeling very stretched, mistakes can be made and the most important aspects of our work taken for granted and over looked.

I am concerned that the CAMHS services in which there are no child psychotherapists will not be included in this survey. These services that are likely to be some of the ones struggling the most won't be included in these results.

CASE STUDIES OF CAMHS IN TROUBLE

We spoke to members who had particular experience of working in services that had suffered serious difficulties due to service redesign. This highlighted some of the worrying developments that we have identified as the 'Danger Signs' of CAMHS in trouble. The survey data validates the experience of these changes being part of wider developments and problems happening in many areas. They also validate the findings of the Care Quality Commission (CQC) described earlier. The case studies provide a more detailed understanding of what may lie behind the difficulties in those services found to be inadequate or requiring improvement. As noted in the introduction, this could be read as a criticism of management or other professionals involved in CAMHS: on the contrary, both management and clinicians of all disciplines are faced with the problem of struggling with the demands of an under-resourced and over-burdened system, which in many cases does not provide the effective support needed to manage what are often impossible demands. The case studies have been made anonymous and details have been changed so that neither the NHS trust nor the practitioner are identifiable.

Case Study 1

The focus of this case study is on how pressure from commissioners to increase access can lead to detrimental impacts on the quality of services provided, especially for those with severe and complex needs who require specialist, multi-disciplinary and, possibly, ongoing treatment and support.

1/ Access to 'low level interventions' opened up, to the detriment of those with the most severe and complex needs

The processes identified began with commissioners requiring wider access to services for more people, including self-referrals. NHS community (Tier 3) CAMHS were historically underfunded and understaffed so the criteria for accessing services (thresholds) had kept getting tighter and the door was closed to many. This led to frustration as services were not accessible to GPs, schools and social services, or to self-referrals. Local authority and third sector (Tier 2) alternatives were amongst the first to be lost to cuts to budgets so no longer provided a 'buffer', and Tier 3 referrals consequently rose further. CAMHS were therefore redesigned to meet the pressure of GPs, schools etc. not being able to access services. This was seen as a form of 'early intervention' but was in fact the provision of shorter interventions appropriate for those children and young people (CYP) who were well enough to make use of them, i.e. still functioning, with relationships and resources. These CYP are 'easier' to respond to as they can ask for help and make themselves noticed. The changes led to a flood of patients and this in turn impacted on the provision of genuine early interventions for CYP with complex and severe difficulties e.g. severe attachment problems or childhood trauma. Services effectively became Tier 2 providers of interventions for low level disturbance, rather than effective early intervention for a range of difficulties, including more severe and enduring disturbance. For example, a group for CYP with mild anxiety was started but it was found the anxiety was not 'mild' so access was tightened up. The group was made to fit the competencies of the staff and the limitations of 'model' it was run on, rather than the needs of the CYP. The service has to aim to widen access but only for a narrow range of CYP who, for example, do not exhibit co-morbidity.

2/ Specialist services (at Tier 3) are misunderstood and disappearing

Social services and NHS budgets are simultaneously under pressure so the 'integration' of health and social care has unintended consequences including the loss of specialist services at Tier 3. As local authority funded Tier 2 services were closed the staff previously in social care shifted into health to fill the increasing number of Band 4/5/6 roles (see point 4 below). Their training equips them for Tier 2 work and in Tier 3 they are often out of their depth. The previous differentiation between tiers was helpful in defining roles and so current suggestions that they are outmoded can be seen as a further loss of differentiation between specialist and universal roles/services. Different 'pathways' for CYP are set up but what is offered in each is effectively the same. These are generic pathways and are *not* the specialist teams trained to work with specific conditions that exist in some areas. In each care pathway there will be moderate to severe patients who require a full assessment, formulation and sophisticated thinking. This is not available as it is not what the staff are trained for and is perhaps seen as unnecessary if there are no specialist treatments to which referrals can be made. The CYP with more complex and severe needs are in 'stasis' without effective treatment being provided and are likely to 'bounce around' the system receiving serial short-term interventions, inappropriate to their level of need, until they reach a crisis that requires in-patient admission. The loss of Tier 3 is seen in increased pressure on Tier 4 and evidenced in the extent to which children and young people with poor mental health harm themselves, use A&E and other services inappropriately, become NEET or are caught in the youth justice system, and often continue to suffer into adulthood from conditions that should have been met with an effective treatment at the appropriate time¹⁴.

3/ Dismantling of profession-specific roles and disciplines and loss of senior clinical leadership

A key transformation has been the dismantling of profession-specific roles and disciplines, such as clinical psychology, family therapy and child and adolescent psychotherapy, and of departments with lead professionals. The medical profession has also been disabled due to vacancies and the use of bank/agency staff. The identity of disciplines as groups with shared skills and experience disappears and this impacts on professional development, career progression within a profession and the demarcation between roles and disciplines. The result is that job-roles have generic titles such as psychological therapist and anyone can apply for any job. Where clinicians cannot receive supervision from a senior person in their own discipline they may not be able to meet the CPD requirements of their professional body. This has significant implications for the training of new professionals and the supervision and support of the current workforce.

Foundation Trusts had been given more authority to decide locally on service configuration and staffing. The pressure of opening the doors (see above) meant that more staff had to be employed with the same or less budget. It was inevitable that there would be a downward pressure on banding. There has been a 'hollowing out' of senior roles at 8a/b/c which were previously occupied by people with specific qualifications. Consultant positions have effectively been abolished and new senior positions are open to professionals with a variety of less rigorous and comprehensive training and with less clinical experience. Generic

¹⁴ The recent Guardian investigation on preventable deaths linked to mental health services, including those for children and young people, is powerful evidence of the systemic failures we are trying to raise awareness of. <https://www.theguardian.com/society/2018/mar/05/hundreds-of-mental-health-patients-dying-after-nhs-care-failures>

management competencies become favoured over specialist clinical and professional competencies.

The pressures of increased demand and underfunding mean that managers have an imperative to save money. This has led Trusts to get rid of buildings in the name of 'agile working', innovation and reaching the community but this destroys the base for multi-disciplinary team working. Seriously ill CYP often don't want to be, and perhaps shouldn't be, seen in schools and community settings. Seeing an ill young person in a different location for each appointment is like moving a patient with cancer to a different bed each night. Sometimes, services are provided in a way that minimises costs but means they are very likely to be ineffective. For example, while NICE may recommend 25 sessions only 8 are provided and this is not challenged. There has been a shift away from the clinical voice and authority of medics and clinicians towards business managers who are tasked with making complex decisions in impossible circumstances. Services are often not costed properly as they do not reflect the real demand in the community, but contracts have then to be fulfilled.

4/ Consequential pressure on lower banded staff to perform specialist demands, skilled professionals not working to maximum competency and staff turnover is high

The changes to the workforce structure affect not only those in senior roles as lower banded staff (4/5/6) feel the gap left in the senior grades. They recognise that their training equips them for the type of work that was previously seen in Tier 2 work and that they don't have the experience to work with the complexity and severity of patients seen in Tier 3, especially without adequate management and supervision from a senior clinician in an appropriate discipline. Bands 7 and above have become primarily managerial roles, even if the role specifies a clinical background. Staff turnover is now very high. CAMHS is no longer a coherent group of well trained staff. The number of CAPts has been significantly reduced and there have been similar reductions in clinical psychology and family therapy.

CAMHS has become a service provided cheaply with the same name but not the same content. The clinicians we spoke to have worked for many years in CAMHS and now feel they have no place to work safely and effectively. Skilled professionals are not able to work to their maximum competency whilst staff with briefer trainings feel they are having to manage patients beyond their competence. People are not wanted for the skills they have. Self-esteem has been eroded and the work is denigrating.

5/ In-depth case assessment and knowledge is missing and thresholds are increased to manage demand

The assessments that are undertaken are simply to sign-post CYP into the generic, often symptom-based, pathways. There is no space in this for in-depth assessment, formulation and multi-disciplinary team (MDT) thinking about contributory factors whether they be organic, environmental or inter-generational. For example, there is no understanding that an assessment might need to take place over several sessions in order to understand what is needed in a sophisticated way. There is in particular a lack of thinking about, and work with, parents, carers and families. The CYP's 'risk' is managed using traffic-lighting and lots of resources are taken up doing this. There is a view that anyone can do these risk assessments if they have done the half day risk training. The problem with there being no effective treatment for these CYP, apart from the obvious impact on them and their families, is that they continue to circulate within the system until they become seriously ill or commit suicide. All resources are therefore consumed in managing this 'at risk' population and there is no capacity for new

referrals. This also has a serious impact on the resources and well-being of parents and carers and on other agencies, such as schools, that do not have the skills and resources to support CYP with complex needs.

Because resources are consumed in managing those CYP showing the most immediate risk there is no capacity for new referrals and as a result the thresholds for admission to CAMHS start to increase again. This is demonstrated in examples of Trusts imposing strict new threshold criteria for new referrals to CAMHS while they scale back to deal with the current high risk and urgent cases. The problems of an inadequate service model have come full circle and changes intended to improve access to NHS treatment have effectively resulted in the opposite happening. The service redesign has led to the loss of specialist staff and a multi-disciplinary team that is able to meet a range of needs, including providing effective treatment for those children and young people with complex and chronic mental health difficulties.

Case Study 2

The focus of this case study is on the way clinical expertise can become marginalised when excess pressures on the service hold sway.

Part A: Service Management and Delivery Problems

1/ Loss of multi-disciplinary team working leaving services fragmented and staff isolated

A significant change in this service has been a shift away from groups of clinicians holding the thinking and concerns about children and young people to fragmented, individual working. This is unhelpful because in work with CYP and their families where the difficulties are co-morbid, severe and enduring, the situation can be too complex for one person to hold all aspects of the situation. Cases involving deprivation, abuse and trauma need, sometimes, two or three people working on them in CAMHS alone, often also liaising with staff in other agencies. The idea of multi-disciplinary working in this way has been undermined by service re-design. An example of fragmented practice is that if a CAPt needs a Family Therapist to work with the family of a patient they have to ask permission from someone with no first-hand knowledge of the need to co-work cases. This is seen as 'resource management' but also marginalises clinical expertise and judgement. The pressures on managers mean there is little scope for interest in the particular need for this kind of working in CAMHS. The demands the system is operating under become apparent in the extent to which parts of the service can end in conflict with each other: when senior clinicians draw attention to the way that changes increase clinical risk they are at times painted as 'well paid trouble makers'. People who have argued against this have left, feeling no one is listening.

The problems in fact start outside the service with the pressures that commissioners are under. There are instances of CCG managers taking decisions, over the heads of both lead clinicians and managers in the Trust, for example, intervening in the management of the waiting list.

2/ Loss of senior clinical leadership, replaced by operational management

The changes began with the transfer of CAMHS to a Foundation Trust and what was described as the 'transformation' of services. The Trust expanded quickly with the addition of more CAMH services. Then budget cuts began, carried out in a climate described as autocratic.. Very senior people were suspended, without discussion, including the clinical leaders for the service. New people were transferred from other services into general management roles: the lead manager role for CAMHS was taken by someone with no CAMHS experience.

3/ Loss of specialism and expertise

Senior staff are not able to work to their competencies to meet the needs of CYP referred to the service. For example, the Trust has stopped all work with under-5s. A senior CAPt has long-standing supervision relationships with health visitors dealing with some very severe needs. When they have done all they can and need additional support they try to refer to CAMHS but are told that this isn't necessary. The children need specialist intervention, are often in care, and exhibiting very difficult behaviour. The understanding of child development and mental health in the system has deteriorated.

The service has got new funding for eating disorders (ED). A senior CAPt is an expert on ED and often takes referrals when patients have finished briefer treatments and need more help. A Family Therapist asked her to take a case on but the decision is made by operations management who refused the referral as it was not understood as part of standard clinical practice. There is a mismatch between the complexity of need and the view of mental health which is possible within a system under great pressure, and as a result need is not matched to the competency of clinicians.

4/ Pressure on lower banded staff to perform specialist demands

There is an idea in the system that all CAMHS work can be done by people with brief training. Staff are employed on low pay bands which exclude the higher factors for Agenda for Change, such as knowledge and skills, and freedom to act. The importance of having some senior clinicians with roles that include clinical leadership has been lost. Originally there was one manager with several senior (8c/d) clinicians; now there are lots of operational and team managers, mainly on band 7, some with 'lead role' as part of their job description.

An example: a teenager, very anxious (thinks there is something wrong with their heart and that they will die in their sleep), history of loss, mum also anxious. GP refers to CAMHS who send a clinician with a tier 2 level qualification person to the house. Mum reports they were nice but not capable. The professional used the 'three houses' tool and suggested they take the young person for a milkshake to talk. This approach would not be able to engage with the potential seriousness of this situation, including the level of risk.

5/ Proper case assessment and knowledge is missing; bureaucratic systems increase

There are now so many crisis presentations to the service that the crisis team can't cope, people are leaving the team, and core staff are moved in to contribute to assessments. There are not the resources to offer appropriate treatment. For example, a senior CAPt, very experienced with suicidal adolescents, saw a girl and was very concerned about her: she was suicidal and hopeless, and there was the possibility of undiagnosed ASD. Her mother was checking windows at home because she thought the girl was likely to jump out. In the assessment meeting with the CAPt the girl settled a bit and expressed hope that something could change via talking to someone. The CAPt recommended that this patient be prioritised to receive treatment. A form had to be completed for prioritisation, which was rejected because it was decided that a safety plan was in place 'because mother was checking the windows'. When the CAPt questioned this decision she was reprimanded. Suicide rates in this area are high compared to national averages and increasing. Concerns about this have been dismissed 'because it is happening everywhere'. The service is not resourced or designed in a way that enables it to offer treatment even in potentially serious and risky situations.

The increase in bureaucratic processes can be understood as perhaps the only way service managers are able to have a sense of 'managing' the risk and complexity of need. Clinician time is then taken over with bureaucracy and entering data on computer systems. For example, five different assessment forms have to be completed for each child, which takes a half day, and staff are monitored every 3 months to ensure they are updating these. Managers in this kind of system can end up seeing the child as the 'easy part' of the job, and that 'the real difficulty is keeping the paperwork up to date'.

Part B: Workforce Problems

6/ Failing the next generation of practitioners

The service is now mainly composed of new, young Mental Health Practitioners (MHPs) on band 6 who are hoping to have a career in CAMHS. Their only supervision is from a team manager with no CAMHS clinical experience, and it is unclear how they are then supposed to learn and develop. There is increasing severity of clinical need but a mismatch between that and what is provided in assessment and treatment. The CAPts in the team are valued by the MHPs because they offer clinical support. MHPs also want to refer patients, such as teenagers in kinship care with a history of trauma and attachment difficulties, to CAPts for longer, weekly and more consistent work but there are no resources for this.

The service was a good place to train previously but it may not be possible to take any future trainees. The senior post in the trust needed for appropriate supervision of trainees was not filled and has now been withdrawn. For managers, under the pressures of high demand for services and limited resources, it is easy to see band 6s doing treatments of 12 sessions maximum as the solution. This is based on a misconception that the IAPT model can be applied to all work. The problem is that anyone who is well enough to improve significantly in 12 weeks is unlikely to be ill enough to meet the criteria for admission; there is a big mismatch between what is needed and what is provided.

7/ High staff turnover and poor working conditions

Clinicians on Band 8 are retiring or leaving. They are not being replaced, or the roles are changed to Band 7. There are also problems with working conditions which place both clinicians and administrative staff under huge strain, so people are leaving and the service is not able to recruit. There is no career progression. Two psychiatrists have left in the last 2 months because of the risk they were holding. Sickness levels are high.

A significant issue was the imposition of a 24/7 model of service provision without paying for 24/7 staffing, so that existing staff had to cover nights. There was no scope to take account of the impact on staff or on their patients, e.g. the strain of seeing a patient with long-term complex difficulties the morning after having to attend A&E during the night.

The pressures the system is under to provide services for which it is not adequately resourced are clear to see.

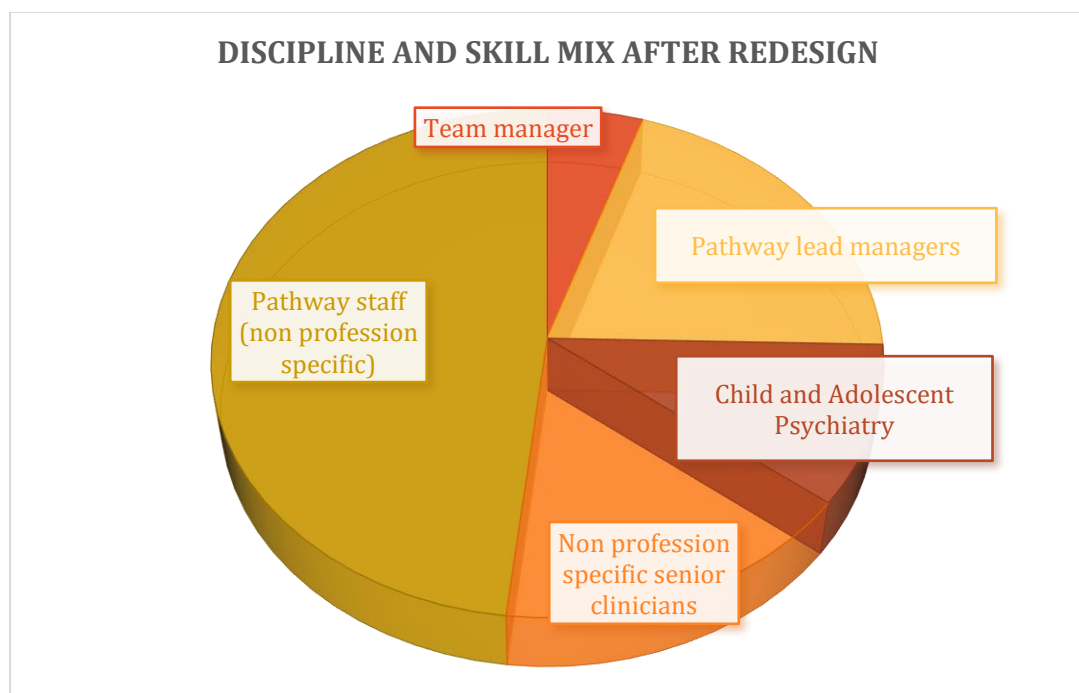
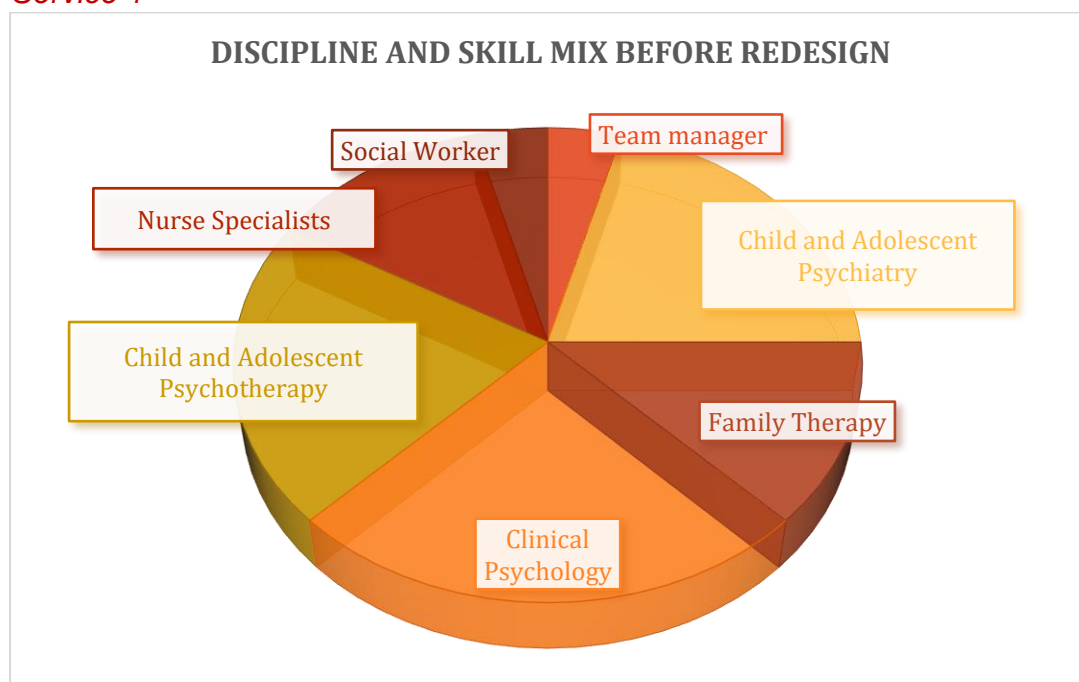
CHANGES IN STAFFING AND SKILL MIX IN CAMHS

We gathered information from two services that had undergone significant transformation to understand in more detail how the changes had impacted on the mix of disciplines and skills, and also on seniority.

Discipline and Skill Mix

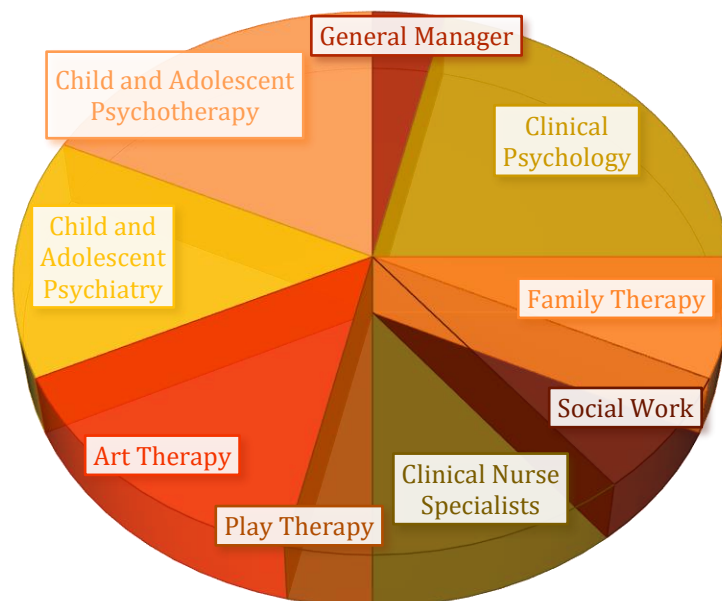
These charts provide a graphic representation of a shift from multi-disciplinary, cross-profession working to generic job roles with the loss of practitioners with focussed trainings. They also show an increase in operational management over clinical leadership.

Service 1

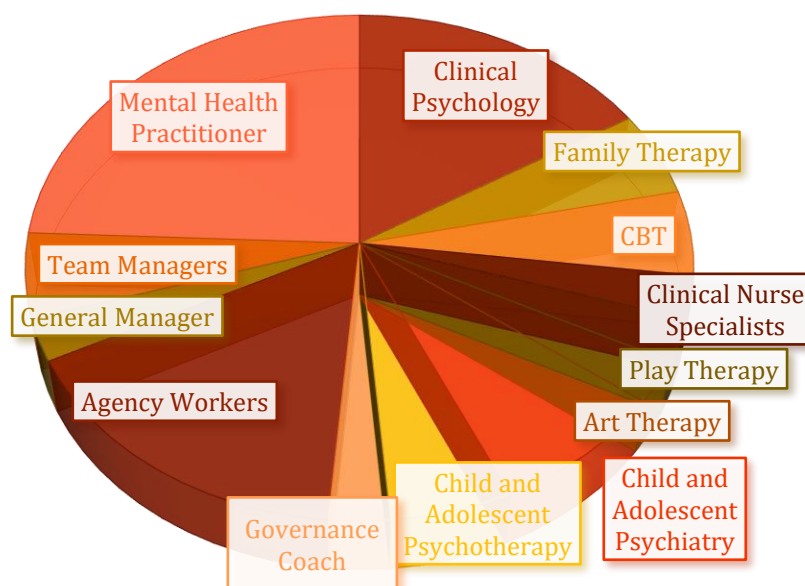


Service 2

DISCIPLINE AND SKILL MIX BEFORE REDESIGN



DISCIPLINE AND SKILL MIX AFTER REDESIGN

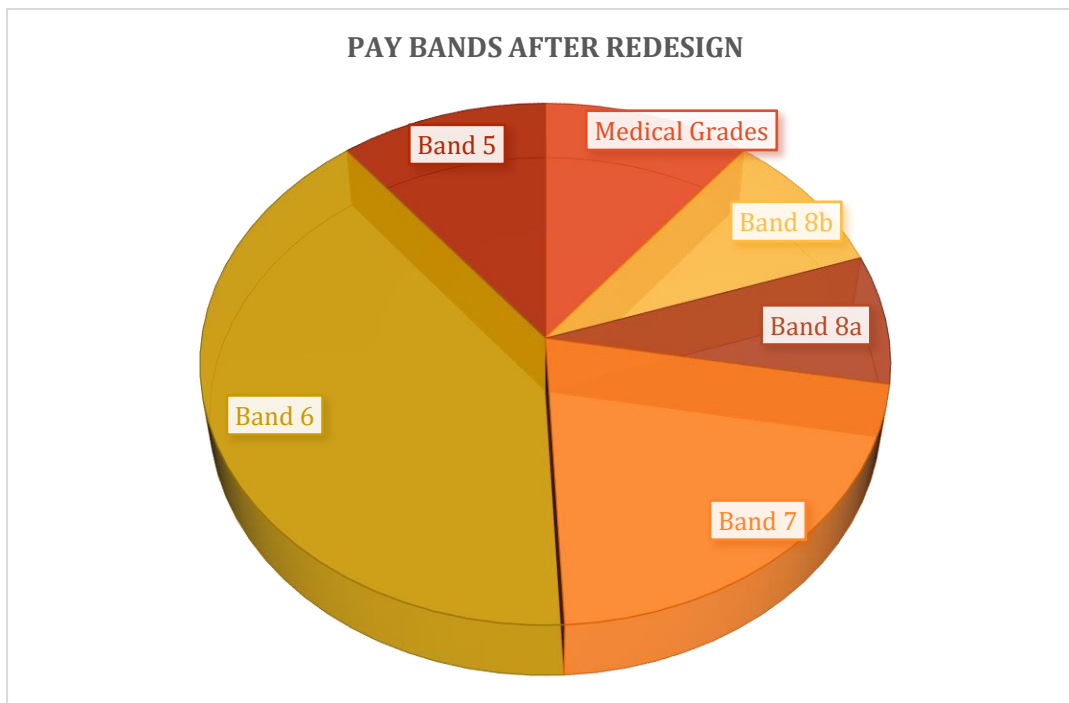
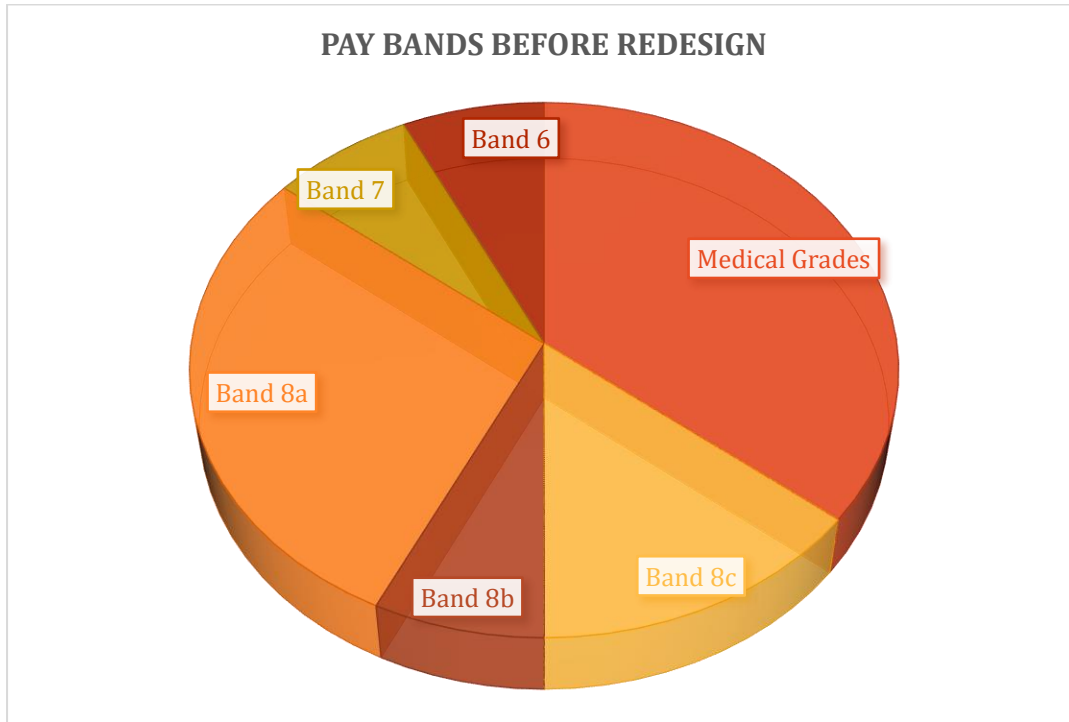


In service 2 after redesign, half the staff are generic mental health practitioners, managers or agency workers.

Pay Bands and Seniority

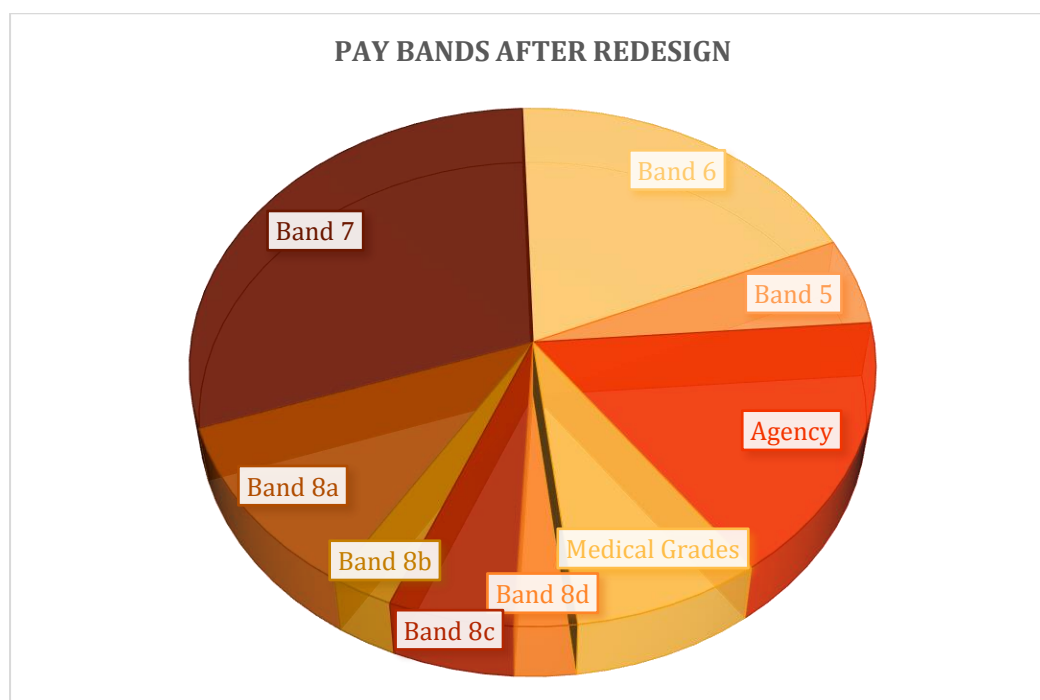
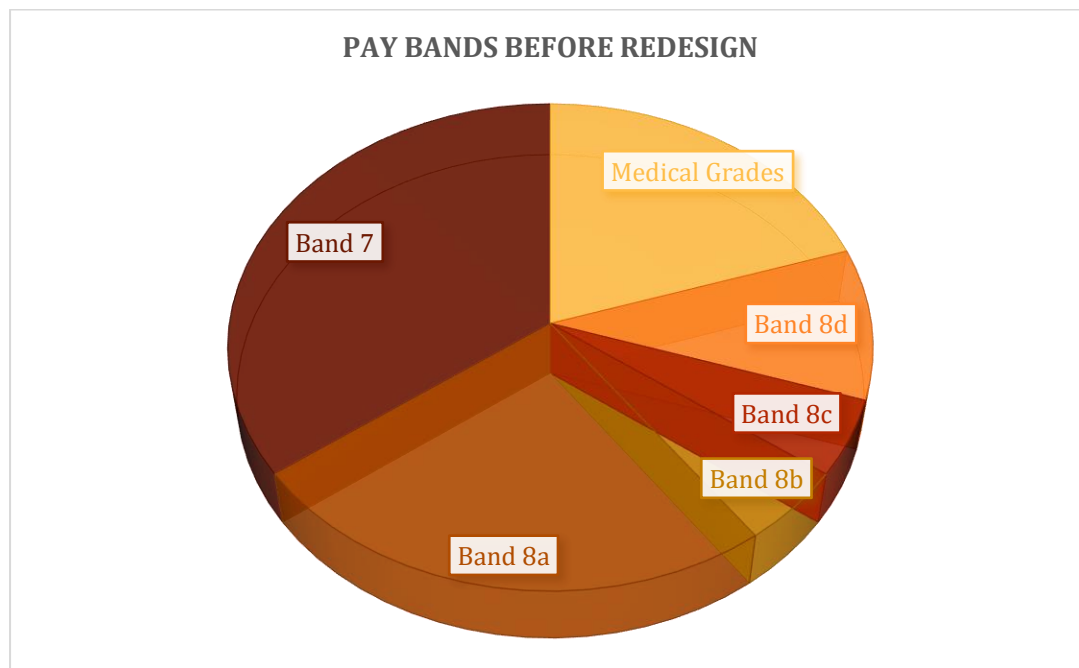
These charts demonstrate a significant movement towards lower bandings with the commensurate loss of clinical leadership.

Service 1



After redesign, the majority of staff in this service are Band 5 or 6.

Service 2



The capacity for leadership, supervision, consultation and training that is appropriately clinically informed is significantly reduced when the majority of clinical staff are in lower banded roles and senior posts are restricted to service management.

CONCLUSION AND CALL FOR ACTION

This report draws on data from a significant proportion of frontline child psychotherapists working in, or with experience of, NHS child and adolescent mental health services. It provides robust and powerful evidence of the danger signs of CAMHS in trouble. The survey and case studies show that service redesigns to meet financial pressures and simultaneous demands for increased access to services can lead to the loss of the high-quality, specialist and multi-disciplinary services that are so essential for children, young people and their families and carers who most need the right service, in the right place, at the right time. They highlight that national and local drivers towards a 'silent catastrophe' are present and that the danger signs of this are emerging around the country. They echo the concerns of the Care Quality Commission and the Children's Commissioner about children and young people's inability to access mental health care and that they experience a postcode lottery of fragmented support.

The report also suggests that there may be scope to do better even with existing levels of resourcing. Service re-designs which respond to the dual pressures of high demand and under-funding can in fact be ineffective in cost terms as well as in outcomes for children and young people. The survey results and case studies highlight hidden waiting times, and services wasting resources on managing risk and high levels of re-referrals, rather than offering effective treatment.

The view of the Association of Child Psychotherapists is that the time has come for a major renewal of mental health care and treatment for children and young people. The current crisis requires a whole system response including both public health and treatment components. Action to broaden the scope and capacity for CAMHS is vital, including services in schools, colleges and other community settings. Specialist clinic-based provision is also required, with well-supported clinicians working at different levels of experience and expertise, in multi-disciplinary and reflective teams. These different elements will only be effective if they are part of a comprehensive, properly funded and well-designed system.

A new approach is needed that recognises the importance of professional expertise and what it takes to sustain the care and support that our young people require. We need to rethink *what* services for children and young people with serious and complex mental health difficulties are provided, *how* they are provided and by *whom*. This must include access to highly trained clinicians, working in multi-disciplinary teams, who have the skills and experience to properly assess need and to understand and formulate how to respond to the complexity of emotional, behavioural and developmental difficulties that children, young people and families are experiencing in 2018. This will require national leadership and a coming together of all those who share our concerns in a new drive to define and build what high-quality services should look like.

We hope that this report serves to shift the current debates about mental health services for children and young people from a recognition that there *is* a crisis to an understanding of the factors and forces that lie behind it. We want to instigate a better-informed debate about what needs to be done to address the widely recognised problems. We want to get to a position nationally where children, young people, families and carers are guaranteed the high quality, safe and effective services that they need and deserve.

PUBLICATION INFORMATION

‘Silent Catastrophe’: Responding to the Danger Signs of Children and Young People’s Mental Health Services in Trouble

A Report from the Association of Child Psychotherapists on a Survey and Case Studies about NHS Child and Adolescent Mental Health Services

June 2018

The survey and report were produced by the Treat Them Right campaign team:

- Isobel Pick, Chair of the ACP
- Nick Waggett, Chief Executive
- Claudia Moselhi, Communications Lead

The team are very grateful for the members of the ACP who gave their time and knowledge in providing such detailed and important data.

Contact

If you would like to discuss this report and its findings please contact: Dr Nick Waggett, ACP chief executive at nick.waggett@childpsychotherapy.org.uk or 020 7922 7751

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Embargoed until: 00.01 Monday 25th June 2018

‘Silent Catastrophe’

Further evidence of NHS CAMHS failing children and young people with most severe needs

Today, the Association of Child Psychotherapists (ACP), has launched a report, ‘*Silent Catastrophe*’, which provides new evidence of the inadequacy of NHS mental health services for children and young people (CAMHS) and shows that this is due not only to chronic underfunding but also to the way in which some services are being restructured.

Based on a poll of 416 child and adolescent psychotherapists working within the NHS, the report records that specialist services are disappearing and it is becoming increasingly hard to provide effective care and treatment for children and young people, especially those with the most severe and long-standing needs. The survey of frontline NHS CAMHS staff shows a deterioration of specialist services:

- 61% said that the main NHS service they work in was facing downsizing
- 72% said that the threshold for access to services has increased in the past 5 years
- 33% described services as mostly inadequate or completely inadequate
- 73% had witnessed a down-banding of specialist clinical posts
- 64% reported negative changes in the number of practitioner posts, 62% in sessions per client and 65% in the frequency of sessions
- 73% felt there had been a negative change in staff morale

Just this year, the Care Quality Commission (CQC) rated 39% (26 services) of specialist CAMHS as requiring improvement. In the ACP’s report, 33% of respondents described services as mostly inadequate or completely inadequate in meeting the needs of most children and young people. Whilst the ACP supports the government’s proposals to extend mental health services into schools, they highlight that this will only be effective if it is part of a comprehensive, properly funded and well-designed system. When asked if they could see evidence of the government’s claim of making ‘one of the biggest expansion of services in Europe’, 93% of respondents saw no evidence of this.

The ACP has identified a number of initial factors of common danger signs of CAMHS in trouble. The top 10 danger signs are:

1. Specialist services disappear and are replaced by interventions that would previously have been offered in primary care, leading to rising levels of suicide, self-referral to A&E departments, and pressure on in-patient units.
2. Profession-specific roles and disciplines are dismantled and there is a loss of senior clinical leadership.
3. Pressure on lower banded staff to perform specialist demands whilst skilled professionals not working to maximum competency.
4. Assessment and treatment focuses on symptoms, not the whole child or young person in context; in-depth case assessment and formulation are missing.
5. Thresholds are increased to manage demand, leaving children and young people to get worse before being seen, and to an increasing mismatch between need and treatment offered.

6. Unrealistic and under-funded service models due to competitive tendering.
7. Loss of multi-disciplinary team working leaving services fragmented and staff isolated.
8. Failing the next generation of practitioners through lack of effective supervision and opportunities for career progression which in turn threatens the future supply of high quality candidates for mental health professions as the field becomes less attractive.
9. High staff turnover, poor morale and poor working conditions.
10. Specialist treatments for the most vulnerable children offered by child psychotherapists and others survive despite, not because, of service design.

The purpose of identifying these danger signs is to inform a debate about what needs to be done to address the danger signs and thus enable delivery of high quality, safe and effective services in all areas. The reports outlines what a high-quality service looks like and also suggests that there may be scope to do better even with existing levels of resourcing as service re-designs can be ineffective in cost terms as well as in outcomes for children and young people.

Dr Jon Goldin, Vice Chair of Child & Adolescent Psychiatry Faculty at Royal College of Psychiatrists, said:

"We welcome this report and the new information it provides about current problems in the provision of mental health services for children and young people in some parts of the country. It highlights that many children and young people, especially those with severe and enduring needs, are not receiving the specialist care and treatment they require. A well-led multi-disciplinary team of experienced clinicians is crucial to the delivery of high quality services and the report shows that this is lacking in many areas. We support the call by the Association of Child Psychotherapists for a review of how specialist services are provided to ensure they meet the needs of all children and young people."

Dr Marc Bush, Head of Policy, from mental health charity YoungMinds, said:

"Every day we get calls to our Helpline from parents whose children have been waiting months for an appointment with CAMHS, or who have been turned down because the thresholds for treatment are so high. The system is overstretched and disjointed, with a devastating impact on thousands of families across the country. This report rightly draws attention to the need for increased, long-term funding for children's mental health services across the board, as well as greater recognition of the crucial role that specialists play. For early intervention to be effective, front-line staff who work with children need to be able to access advice and guidance from highly-skilled professionals who understand the social, emotional, and psychological needs of children as they develop."

Dr Nick Waggett, Chief Executive of the Association of Child Psychotherapists, said:

"The ACP's report shows that in many areas specialist CAMHS services are being downgraded, with a loss of much needed clinical expertise and leadership. We know that a lack of resources is one factor but our report raises concerns about recent service transformations and re-designs. These can lead to inefficiencies that mean that resources, especially the skilled workforce, are not used effectively and children and young people are not offered the effective and timely assessment and treatment they require."

A child psychotherapist (who wishes not to be named), said:

"I am considering leaving the NHS as I am worried it is no longer safe to practise. It is tragic to witness the demise of a once flourishing and truly multidisciplinary specialist CAMHS. My skills are going to waste. Once the service was taken over by a new trust, the service was

redesigned and now does not meet the needs of a large section of the population who have significant mental health needs. There is no time for proper assessments and treatment.”

ENDS

Notes to editors:

For more information and access to the full report and interviews, please contact:

claudia@clopr.co.uk; 07521975756

About the ACP:

The Association of Child and Adolescent Psychotherapists (ACP) is the main professional body for psychoanalytic child and adolescent psychotherapists in the UK and is a accredited register of the Professional Standards Authority (PSA). It was established in 1949 and has over 900 members working in the UK and abroad. Psychoanalytic psychotherapy is internationally recognised and as strongly evidenced as many of the more common treatment models people may be more familiar with. ACP registered child psychotherapists have completed an NHS child mental health based training which lasts for at least four years and are therefore experienced and able to work with some of the most severe and enduring difficulties and disorders. ACP members work with children, adolescents, parents and families, individually or in groups.
<http://www.childpsychotherapy.org.uk>