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Scoping report

**The relationship between
specialist child and adolescent
mental health services
(CAMHS) and school- and
community-based counselling
for children and young people**

Sheila Spong, Rachel Waters, Claire Dowd
and Charlie Jackson – June 2013



Executive summary

Overview

This scoping study was commissioned by the British Association of Counselling and Psychotherapy (BACP) to inform the development of the Counselling MindEd e-learning resources (CounsellingMinded.com) for counsellors working with children and young people. It describes the relationship, in England, between specialist CAMHS and school- and community-based counselling services for children, as reported by counsellors and specialist CAMHS staff. Respondents were asked about their experiences of the relationship between these two types of service, what they saw as good and not-so-good practice, and their suggestions for how the two types of service could work together better. This study indicates that relationships between specialist CAMHS and school- and community-based counselling services were reported as highly variable in quality and form. The provision of a seamless service to children and young people could be strengthened by agencies being well-informed about one another, with clear protocols for inter-agency communication, referral and consultation. The existence of this is currently reported as uneven, with effective, respectful and constructive inter-agency liaison reported in some areas; whilst lack of understanding, confusion, frustration, limited interaction and little mutual respect are also frequently reported.

Methods

The report is informed by the following:

- A brief review of the available literature.
- A convenience sample of 14 interviews with members of staff of specialist CAMHS from a range of professional disciplines and geographical areas.
- A purposive sample of 15 interviews with counsellors, psychotherapists and managers in school- and community-based counselling services in a range of geographical areas.
- Four supplementary scoping conversations with individuals identified as having particular relevant knowledge and expertise of counselling services for children and young people but who were not part of the main sample.
- An e-survey of 134 counsellors/psychotherapists of children and young people in school and community settings.

Key findings

There is little literature on the relationship between specialist CAMHS and school- and community-based counselling services for children and young people. However, this study supports previous research in noting that systems for developing sound working relationships between specialist CAMHS and school- and community-based counselling are reported to be highly variable in both structure and effect.

The responses in this study indicate that the relationship between specialist CAMHS and school- and community-based counselling services varies on a number of dimensions including the extent of mutual knowledge, understanding and respect, levels of interaction, the extent of co-working with individual clients, and shared vision of service development. Where the relationship between counselling services and specialist CAMHS is well-developed, it can be regarded as symbiotic, as the two types of agency work closely together with mutual respect, creating a shared approach to meeting the needs of young people with mental health problems.

At the other extreme, in some areas there is considerable distance between counselling provision and specialist CAMHS reported. Counsellors described feeling disempowered, seeing specialist CAMHS as defining the terms of the relationship, and being critical of what specialist CAMHS provides. Specialist CAMHS staff described questioning the expertise and qualifications of counsellors, or seeing the role of counselling as very separate from that of specialist CAMHS. It is notable that many of the counsellors who were invited to take part in this study were appreciative of the opportunity to comment on the relationship between counselling and specialist CAMHS as this was an area of concern to them.

Another scenario is that in some areas little availability of school- or community-based counselling for children and young people was reported, and here specialist CAMHS may put Tier 2 services in place and/or provide a specialist CAMHS presence and mental health screening processes in schools.

Analysis of the interviews and e-survey indicate the following main themes:

- The structures and funding of both specialist CAMHS and school- and community-based counselling services for children and young people are reported to be in a period of rapid change. For many services there is considerable uncertainty about the future.

- Staff of both specialist CAMHS and counselling services largely agree on what are the criteria for appropriate referrals to each service. However, in some instances both parties expressed concerns that lack of resources in CAMHS meant that counselling services were ‘holding’ clients whose level of need, risk or problem severity required more specialist support.
- For some clients with severe and/or enduring mental health problems, who would be eligible for specialist CAMHS, a counselling service may be seen by counsellors as offering a more accessible, flexible or acceptable intervention than that available from specialist CAMHS. This may be particularly important where the young person’s family are not able or willing to engage with specialist CAMHS, or the young person does not agree to parental involvement.
- Some counsellors described having little contact with, or knowledge of, specialist CAMHS.
- A good relationship between counselling services and specialist CAMHS is seen as being built on good knowledge and understanding of one another’s services, and clear systems of liaison and communication; but this does not always exist.
- Well understood referral systems and acceptance criteria were seen as being important in both directions.
- Where there are direct routes for counsellors to consult with or refer to specialist CAMHS these were generally valued by counsellors and by specialist CAMHS, but they were not reported to be universally available. Some counsellors described not being able to refer to specialist CAMHS and some report that consultation arrangements were not at an appropriate level.
- An effective working relationship between agencies was perceived to be enhanced by good relationships between individuals.
- A good relationship was reported to be based on mutual professional respect and whilst respectful relationships were evident in some areas, this was not universal. Many counsellors did not feel professionally respected by specialist CAMHS, and many counsellors were critical of the policies and procedures of specialist CAMHS. In some cases, specialist CAMHS staff reported concerns about the training and qualifications of counsellors.
- Aspects of the policies and practice of specialist CAMHS were challenged by some counsellors. Challenges related particularly to the quality and continuity of the relationship developed between staff and the client, interventions that are not seen as young person-centred, cognitive-behavioural therapy (CBT) as the only form of therapeutic intervention offered, brief interventions, and the requirement to involve parents. Counsellors in some cases queried the rationale for these practices.
- Specialist CAMHS teams had differing policies about CAMHS staff and counsellors co-working with a young person where a counselling relationship had already been established before referral to specialist CAMHS. Where co-working did occur, it was generally seen as very helpful by both professionals.

- Differences in the way confidentiality was understood were reported by both counsellors and specialist CAMHS staff and this was seen to hamper effective liaison.
- Where services were seen as fragmented, the development of a strong and effective working relationship between specialist CAMHS and counselling services for children and young people was described as being more difficult to achieve.

Both counsellors and specialist CAMHS in many areas commented on the high workload of CAMHS staff, considerable waiting lists for young people with mental health difficulties to access specialist CAMHS support, and the pressure that this was placing on counselling services and CAMHS staff alike.

Key recommendations

This report recommends that:

- The Counselling MindEd e-learning materials include:
 - information on the importance of school- and community-based counselling services for children and young people forging and maintaining strong relationships with specialist CAMHS in their local area(s), including both relationships with key individuals and the development of sound systems and protocols for interagency communication.
 - information on how school- and community-based counsellors of children and young people can facilitate the development and maintenance of effective and mutually respectful working relationships with specialist CAMHS.
- Specialist CAMHS consider:
 - how to forge and maintain effective and mutually respectful working relationships with school- and community-based counselling services in order to provide the best possible service for children and young people drawing on all available resources
- National and local policy makers consider:
 - how to make more widespread the creation of systematic links between school- and community-based counselling and specialist CAMHS. This is of particular importance where counselling services are working with young people with increasingly severe and complex mental health difficulties and where these services may provide an important source of support for young people who are waiting to access specialist CAMHS.

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About the authors

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Charlie Jackson is Research Officer at BACP and has held this post since May 2013. Prior to this, she was Research Intern at BACP from August 2012 until April 2013. Charlie has a background in quantitative research and has previously worked with both adults and children with learning disabilities and mental health disorders.

Background

Services for children and young people with mental health and psychological wellbeing needs are located across a range of services provided by the statutory, voluntary and private sectors. In 2008 it was noted that the availability, delivery and structure of services was very variable [1], and differences occurred in response to both local conditions and historic factors. Since then, the delivery of CAMHS has been subject to new guidance and directives, including the Government response to the National CAMHS Review [2], the *No Health Without Mental Health* Strategy [3] and Implementation Framework [4], and the Children and Young People's Improving Access to Psychological Therapies (CYP IAPT) programme. CYP IAPT is a project to transform existing CAMHS by embedding evidence based practice, collaboration between therapists, children, young people and families or carers through regular feedback including session by session outcome monitoring and participation in service development. Key themes arising from this developing national framework are a focus on the development of 'comprehensive CAMHS' to include the full range of services delivering an integrated approach [3,4], and developing young person-centred services [5]. These developments can be expected to have a significant impact on the relationship between specialist CAMHS and school- and community-based counselling services.

Child and Adolescent Mental Health Services (CAMHS)

The terminology used to describe CAMHS services is not yet fully standardised in practice. The *CAMHS Review* [1] describes two main approaches to categorising CAMHS services: the four tier model, and the framework described in the *Every Child Matters* Report [6] which considers services to be 'universal' (for all children and young people), 'targeted' (for specific groups) and 'specialist' services for those children and young people with specialist needs. The *CAMHS Review* notes that: 'Both [approaches] are subject to local interpretation and differences in understanding' [1, p.17].

This report adopts the following usage: 'specialist CAMHS' (also abbreviated to CAMHS) are multidisciplinary teams with specialist training and/or experience in child and adolescent mental health care, providing services at Tiers 2, 3 and 4. 'Specialist services' work with children and young people with complex, severe and/or persistent needs. The role of specialist CAMHS also includes support to staff in universal services, such as consultation, training and support, mental health promotion and early intervention in community settings [7].

Counselling services for children and young people may be based in specialist CAMHS, or may be based in schools or in community settings. School- and community-based counselling services for children and young people may deliver services at Tiers 2 and/or 3, and may be seen as targeted or specialist services.

Literature review

There is little existing research available on the relationship between specialist CAMHS and school- and community-based counselling services [8]. The importance of effective collaboration and liaison between counsellors and statutory services has been noted previously [9–11] but there is less information available on how well this is achieved in practice. The studies below provide either direct or indirect evidence relating to this topic but due to limitations in the resources and time available an exhaustive search of the literature was not undertaken for this report. There may be more information available in 'grey' literature which we have not systematically searched.

In 2003, Pettit reported for the Department of Health on effective joint working between schools and CAMHS. He found that joint working was broadly effective, made services more accessible and less stigmatising, and led to more appropriate referrals to CAMHS. It could, however, be more time consuming, lead to some duplication of work, and there was a risk of CAMHS being swamped with referrals. Key issues were around information sharing, and in particular different approaches to confidentiality in the two professional cultures. Effective joint working required good communication and flexible working from staff who were confident in their own skills and able to pool skills with others [13]. It should be noted that this report pre-dates the recent strategic changes which followed the 2008 National CAMHS Review.

Youth Access reviewed the relationship between CAMHS and Youth Access member organisations, which provide 'under one roof' services to young people, including counselling [14]. This study found that of the 79 organisations that responded:

- the majority reported the relationship with CAMHS was solely around referral;
- 39% reported either no relationship or a limited relationship with CAMHS;
- 28% attended CAMHS planning meetings; and
- 22.8% received funding from CAMHS to provide Tier 2 and/or Tier 3 services.

Cromarty and Richards [11], in a small qualitative study, found that counsellors reported widely differing experiences of relationships with statutory CAMHS.

Pattison et al [10] and Pybis et al [18] make reference to the relationship between CAMHS and Welsh school-based counselling drawing on a survey of Welsh school-based counsellors and stakeholders in Welsh schools. Cooper reports that in this survey the relationship with CAMHS was 'generally perceived as a positive one' [8, p6] although there was considerable variation between those counsellors who reported high levels of collaboration with specialist CAMHS, and those who reported neither being involved in collaboration with, nor referring to, specialist CAMHS.

However, 92% of the counsellors in the study reported that they knew when it would be appropriate to refer a young person to specialist CAMHS, and 63% had been involved in either referring to, or receiving referrals from CAMHS. Cooper [8] goes on to note that the Welsh study indicates that different levels of such referrals are reported by different respondents: with counsellors reporting that 3% of clients were referred to specialist CAMHS, whilst the key stakeholders report a figure of 10% of clients being referred to specialist CAMHS.

Cooper also reported considerable variation in how satisfied school-based counsellors were with the strategies for co-ordinated care between schools-based counselling and specialist CAMHS. He recorded that in many areas there was scope for improving communication, particularly about referral pathways, referral criteria, confidentiality policies and information sharing: 'There is limited evidence of local protocols for ensuring integrated, seamless, and appropriately stepped pathways of care between school-based counselling and other CAMHS' [8, p16].

McKenzie et al. [14] recorded a case study of one school-based counselling service which is integrated into specialist CAMHS, with supervision, line management and consultation for the counsellor being provided by a consultant clinical psychologist; and with a clear protocol for direct referral from the counselling service to specialist CAMHS where required. This was seen as providing an effective approach to liaison.

Specialist CAMHS and other, non-counselling services

Reports about the relationships between specialist CAMHS and other services may be useful in understanding the relationship between specialist CAMHS and counselling services.

England et al. [15] report on difficulties in liaison between CAMHS and early intervention services for first episode of psychosis, noting that effective partnership was 'rare' (p1487), despite clear policy guidance to support this. This study suggests that effective partnership working was supported by joint learning and training, the presence of senior level champions, joint operational policies and protocols, and specific link workers.

Evidence from one recent study suggests that GPs do not always clearly understand the criteria for referral to specialist CAMHS and that GP referrals to specialist CAMHS are three times more likely to be rejected by specialist CAMHS than referrals from other sources (though it should be noted that voluntary sector counselling agencies were not categorised as referrers to specialist CAMHS in this study) [16].

Summary

In summary, there is limited information from the literature on the nature of the relationship between specialist CAMHS and school- and community-based counselling services, and there is mixed evidence about how effectively working together is achieved.

Method

This report is based on telephone interviews with specialist CAMHS staff from a range of professional disciplines, telephone interviews with counsellors/psychotherapists/counselling service managers from community and/or school settings, and an e-survey of respondents recruited from members of the BACP Children and Young People division.

Recruitment

Specialist CAMHS staff interviews

A convenience sample of specialist CAMHS staff was identified by approaching potential respondents from 14 geographical areas, identified through the professional contacts of the study team. Interviews were held with the first 10 who responded positively and who worked in a specialist CAMHS for children and/or young people. In addition, interview invitations were made to five counsellors who had responded to an email call for participants sent to members of the BACP Children and Young People division (see below), but who stated that they worked as counsellors or psychotherapists in specialist CAMHS rather than in school- or community-based settings. The first four of these who responded positively and who confirmed that they met the study criteria were included in the specialist CAMHS sample.

School- and community-based counsellors' interviews

Two types of interviews were undertaken with counsellors/psychotherapists in school and community settings. The main sample of interviews provided responses from informants working in a range of contexts and with a variety of levels of experience. These were supplemented with four additional interviews, included to ensure a breadth of coverage including the devolved nations, and cross-regional organisations in England.

The main sample consisted of 15 telephone interviews conducted with respondents contacted through the BACP Children and Young People division. An email was sent to all members of the division, inviting participation in the project. From those who responded, a purposive sample was selected to include a range of experiences including respondents from school-based counselling and from community-based counselling settings, and those who indicated they had particular knowledge or experience of the relationship with specialist CAMHS.

Individuals who responded to the email invitation but could not be interviewed due to the limitations of sample size were invited to complete an online survey on the topic (see below).

Four supplementary interviews were conducted with informants who were identified from the researcher's professional contacts within and outside the Counselling MindEd team. These participants were identified as having a broad knowledge of the relationship between specialist CAMHS and school- or community-based counselling services for children and young people, and were able to provide a comparison of this relationship in different geographical areas. Two of these informants were selected for their insight into the relationship between specialist CAMHS and counselling services for children and young people across England from roles which included a national remit. The other two supplementary interviews were held with service managers with experience of working with more than one specialist CAMHS team (or equivalent) in devolved nations (Wales and Northern Ireland).

E-survey of counsellors

A survey (see Appendix 1) was developed based on the initial analysis of the telephone interviews with counsellors. This was hosted on SurveyMonkey. Invitations to complete the survey were sent to all those who had responded positively to the initial email request for interview participants, but who were not interviewed. This amounted to 238 potential respondents.

Procedure

All the interviews were conducted by telephone. The basic interview format (Appendix 2) was standard for all interviewees, with minor adaptations made to tailor the questions to specialist CAMHS staff and counsellors, and to capture the experiences of those respondents who had knowledge of a range of geographical areas.

The majority of interviews were recorded and transcribed. Two specialist CAMHS interviews were not recorded due to equipment failure and so analysis was based on detailed notes taken at the time by the interviewer. All the interviews were analysed thematically by one researcher. Four of the counsellor interview transcripts were analysed separately in their entirety by a second researcher to confirm the themes. For the specialist CAMHS interviews, two questions in every interview were analysed separately by the second researcher.

The analysis of the counsellor interviews was completed first, and the analysis of the specialist CAMHS interviews worked from these categories, developing them and generating new themes as appropriate.

Notes of the supplementary interviews were made at the time by the interviewer, and these notes were sent to the interviewee to be checked for accuracy. The notes were reviewed systematically. A comparison was then made between the themes identified in the main sample, and the content of the supplementary interviews.



Frequency tables for the e-survey quantitative data were generated by SurveyMonkey. Responses to the qualitative questions were analysed using thematic analysis. Responses were coded for primary meaning and grouped into themes for each question in turn. The initial analysis was reviewed by a second analyst and subsequently grouped into super-ordinate themes across all questions.

A draft of the relevant findings was sent to those interview respondents who requested this before finalisation of the report, to check for accuracy and to confirm that anonymity was not compromised.

Ethical approval

Ethical approval was obtained from the University of Wales, Newport, Faculty of Education and Social Sciences. Written consent was obtained from each interviewee. Permission was sought from agency/team managers, directors of CAMHS or NHS Trusts as required.

Participants

Interview participants

The majority of respondents were female (counsellors 84.2%; specialist CAMHS 78.6%). 57.9% of counsellors described themselves as 'White British', as did 57.1% of specialist CAMHS respondents. Of the counsellors 10.5% described themselves as 'White other' and 5.3% as 'mixed Caribbean'. Of the specialist CAMHS respondents 14.3% described themselves as 'White other' (Appendix 3a, Tables 1 and 2).

Of the 14 members of specialist CAMHS teams who took part in this study, two identified as counsellors in Tier 2 provision. The other 12 respondents had a variety of original professional trainings (Appendix 3a, Table 3) and had roles in Tier 3 services at the time (Appendix 3a, Table 4). Tier 2 has been described as 'the first-line of specialist services' and as 'a level of service provided by specialist CAMHS professionals working on their own who relate to others through a network rather than through a team' [17]. Therefore in this report both Tier 2 and Tier 3 CAMHS staff are described as specialist CAMHS if they self-identified as such.

The range of experience (years working in services with children and young people in CAMHS or similar services) reported by the specialist CAMHS sample is shown in Appendix 3a, Table 5.

The specialist CAMHS sample worked in, or managed, a range of different types of CAMHS teams including adolescent, under-12s, looked after and adopted, and generic teams. Two respondents had cross-team roles (Appendix 3a, Table 6) and two managed more than one CAMHS team.

The school and community-based counsellors sample indicates a profile weighted towards substantial experience (Appendix 3a, Table 7), with the average years of experience reported being approximately 15¹. This seniority is also reflected in their professional roles (Appendix 3a, Table 8).

Across both main and supplementary respondents, 16 gave responses primarily related to one particular service or agency. Of these, two services were reported as being directly funded by CAMHS.² For the counselling sample, information was also collected on the type of counselling services that formed the basis for the information given by the respondent. Nine respondents were able to provide information on school-based counselling, five on community-based counselling, and five on both school- and community based counselling (Appendix 3a, Table 9).

Both specialist CAMHS and school- and community-based counsellor samples were selected to ensure a geographical spread across England (Appendix 3a, Table 10). Two respondents in the supplementary group were knowledgeable of counselling provision and CAMHS across the English regions. The other two were able to comment on their experience of counselling/CAMHS relationships in Wales and in Northern Ireland, respectively.

Survey participants

Survey responses were received from 134 counsellors who were contacted through the BACP Children and Young People division. This was a response rate of 56.3% of those invited to participate. A summary of demographic information of the respondents is reported here with full details given in Appendix 3.

Of the 134 respondents, 92.5% were female (Appendix 3b, Table 11). 59.6% stated that their highest counselling qualification was at postgraduate level, 29.9% at diploma level, and 6% at graduate level (Appendix 3b, Table 12). Respondents reported the modality of their training as follows: 47.8% integrative, 43.3% person-centred, 30.6% psychodynamic, 26.9% humanistic, and 20.9% CBT (Appendix 3b, Table 13).^{3,4}

¹ Respondents gave only approximations of their years of experience.

² The two informants whose work has a national remit relating to multiple services are not included in this figure, as data was not collected on the various services they work with.

³ Respondents could mark as many responses as applied and so figures do not add to 100%.

⁴ The choice of options means that there may be some double counting of person-centred counselling as this may also be reported as humanistic.

Of the respondents, 87.3% stated that they worked in England (Appendix 3b, Table 14). As the initial email request for participation specified those working in England, this bias is to be expected.

Of the respondents, 70.1% stated they worked within school-based counselling services and 22.4% in community- or third sector-based counselling services for children and young people; 27.6% reported working in private practice and 5.2% in specialist CAMHS, though it should be noted that this may be as well as – rather than instead of – working in a school or community-based (Appendix 3b, Table 15).

Of the respondents, 70.1% indicated their main work role was as a counsellor working with children and young people, 14.9% as a manager or team leader in a counselling service for children and young people and 6.8% as a psychotherapist, art psychotherapist or music therapist working with children and young people (Appendix 3b, Table 16). For both counsellors and psychotherapists, the modal time they had worked in this role was between five and ten years – 68% of counsellors had worked in the field of child and adolescent health for five years or more (Appendix 3b, Table 17).

Findings

Interviews with specialist CAMHS staff members

Types of interactions with school- and community-based counselling services

Specialist CAMHS staff were asked how their service related to school and/or-community based counselling services (Table 1).

Table 1: Types of interaction between specialist CAMHS services and school- or community-based counselling, reported by specialist CAMHS staff^{5,6}

Types of relationship	No. of respondents	% of respondents reporting this type of interaction
Specialist CAMHS recommends/makes referrals to counselling service	14	100%
Counselling service⁷ can contact specialist CAMHS for advice, support, consultation or occasional supervision	7	50%
Counsellors and specialist CAMHS staff may work with same client at the same time	5	35.8%
Counselling service and specialist CAMHS sit on multi-agency group	3	21.4%
Counselling service and specialist CAMHS sit on joint committees	3	21.4%
Direct contact with counsellors in schools	2	14.3%
Duty advice desk takes queries/consultation/referral requests	2	14.3%
Counselling service and specialist CAMHS meet or liaise on a regular basis (other than shown above)	2	14.3%
Counselling service and specialist CAMHS liaise about clients who are involved with both services	1	7.1%

All the specialist CAMHS staff reported at least some availability of community- or school-based counselling in their area though in some cases this was very limited, and all said that their service referred, at times, to a counselling service, or recommended that a young person self-refers. This might be instead of becoming engaged with specialist CAMHS, if the young person does not meet the criteria, or as part of a step down process following a specialist CAMHS intervention.

⁵ Respondents could report multiple types of interaction.

⁶ All figures are rounded to one decimal point in this and all tables

⁷ 'Counselling service' in tables refers to school- or community-based counselling services unless otherwise stated.

Seven specialist CAMHS respondents (50%) reported that counsellors in school- or community-based settings could contact specialist CAMHS staff for consultation about a particular client they were working with. This usually took place in one of three ways:

- Where the young person had been referred to the counselling service as a step down from their work with specialist CAMHS, a specified contact person may be given.
- As a query to a standard duty advice desk system, from which any professional or member of the public could ask for advice.
- Through personal contacts.

None of the specialist CAMHS staff reported the existence of a dedicated route specifically for counselling services to ask for advice or support; although that does not necessarily mean that none of these exists.

In this sample, none of the specialist CAMHS staff reported that members of their team worked within community-based counselling services. However, Tier 2 services, either in the community or in schools, are provided by five of the specialist CAMHS services, and some of these were identified as counselling provision.

Five (35.8%) of the specialist CAMHS staff reported that sometimes community- or school-based counsellors worked with a young person whilst they were also involved in specialist CAMHS, though two of these said this is infrequent. Where it happened, it would not normally involve both agencies providing a therapy-type relationship. One other respondent said that counselling was sometimes used to help support a client while they were on the waiting list for specialist CAMHS.

Regular liaison between counselling agencies and specialist CAMHS was not reported as being typical but where it did occur was identified as being useful. One specialist CAMHS staff member said: 'We have regular meetings. We're very aware of their limits and they're very aware of our waiting list, so we kind of try and help each other out.' Another person described how their specialist CAMHS invites counselling services into team meetings on occasion to share information, and another commented on how useful it had been to have voluntary sector representation on a steering committee.

Four specialist CAMHS staff (28.6%) discussed involvement in a variety of multidisciplinary case discussion fora including a Common Assessment Framework Arena or in multidisciplinary pastoral care meetings in schools, but the involvement of school- and/or community-based counsellors in these meetings seemed to vary between areas. It should be noted that, depending on their work, some of the respondents may not have full knowledge of this aspect of practice.

Referrals

Table 2: Referrals from counselling services to specialist CAMHS, as reported by specialist CAMHS staff

Referrals from counselling services to specialist CAMHS	No. of respondents	% of respondents reporting this
Counselling service makes referrals directly to specialist CAMHS	10	71.4%
Counselling service cannot refer directly to specialist CAMHS: referrals via GP or school nurse	2	14.3%
Community counselling services can refer to specialist CAMHS but do so rarely as encouraged to refer via GP; schools do not permit their counselling services to refer directly	1	7.1%
School and community counselling services can refer directly to specialist CAMHS but do not	1	7.1%
Total	14	100%

Ten (71.4%) of the specialist CAMHS staff interviewed said that counselling services made referrals directly to specialist CAMHS and an additional one said although such referrals were possible, counsellors were encouraged to refer via the client's GP (Table 2). In this case and one other, although counselling services can refer to specialist CAMHS, this was reported as not happening in practice. It may be that in these areas there are Tier 2 CAMHS that work at a similar level as community- or school-based counselling services do in other areas, and/or that there is limited availability of community- or school-based counselling. For example, one respondent described the local 'counselling service' as providing more of a drop-in, Tier 1 type service. Where counselling services could make direct referrals to specialist CAMHS, CAMHS staff most usually reported an open access referral policy where referrals came in through the duty advice desk or the single point of entry. Where counselling services were not able to make direct referrals, these were reported as needing to come via the young person's GP, or in the case of school-based counselling, via the school nurse.

A number of specialist CAMHS staff members expressed frustration and/or lack of understanding of why referrers (including counselling services and schools) did not give the level of detailed information which was needed for assessment for specialist CAMHS. For one member of staff this was particularly the case with referrals from schools: 'The question is, "Why do they not send us the information that we want?" and I think part of it is because it's often not

the school counsellor that makes the referral, they report back to the school and the school then make the referral.’ Others acknowledged that this may be a two-way process, with specialist CAMHS needing to make more effort to ensure that referring agencies thoroughly understood both the referral process and the criteria for admission to specialist CAMHS.

Referral from specialist CAMHS to counselling services in some areas was primarily indirect, through encouragement for young people to self-refer. However, in other areas systematic approaches to referring young people as part of a step down process, or if they do not meet the criteria for acceptance by specialist CAMHS, were reported.

The characteristics of appropriate referrals to specialist CAMHS and to counselling services, as described by specialist CAMHS staff, are shown in Table 3.

Table 3: Appropriate referral criteria to counselling and to specialist CAMHS identified by one or more members of specialist CAMHS

Specialist CAMHS should take referrals:	School- or community-based counselling should take referrals:
Moderate to severe mental health problems	Mild to moderate mental health problems
A clinical diagnosis	Emotional health and wellbeing problems
Where risk needs to be ‘held’	Those who are not at risk
When multidisciplinary skills are needed	Those whose lives are too chaotic to attend regular clinic appointments
Where social care elements are needed	When services only available in community agencies are needed (for example, drop-in)

Specialist CAMHS staff perceptions of comparative provisions of specialist CAMHS and counselling services

Specialist CAMHS perceived community- and school-based counselling as offering the following services above and beyond what is provided by specialist CAMHS:

- Accessible, informal and less intimidating services.
- Longer term work (possibly because the service is cheaper to provide).
- A consistent relationship with an individual counsellor.
- Flexible hours of service availability.
- A flexible response to clients who may find it difficult to sustain regular appointments.
- Counselling embedded in a wider range of support services such as drop-in.

- A non-medicalised and less stigmatising approach.
- Different types of intervention such as person-centred or less intensive psychodynamic work.
- Early intervention and access to a service for those who do not meet diagnostic criteria or the criteria for acceptance to specialist CAMHS.

Specialist CAMHS staff perceived their service as able to offer the following, above and beyond what is provided by community- and school-based counselling:

- Multi-disciplinary working, using a range of different interventions.
- Diagnosis.
- Medication.
- Specific interventions such as cognitive-behavioural therapy and/or family therapy.
- NICE compliant/ evidence based interventions.
- The ability to manage high-risk cases.
- The ability to work with complex, severe and enduring mental health problems.
- Consultation around mental health issues.
- Neuro-developmental assessments and support.
- More highly trained staff.
- A service that is monitored, evaluated and subject to governance procedures.

Characteristics of a good relationship between specialist CAMHS and school- and community-based counselling services for children and young people

From the perspective of specialist CAMHS staff, the primary elements in a good relationship between specialist CAMHS and counselling were found to be good communication and good individual relationships. There were also some comments on effective systems for working together, but there was relatively little mention of the issues of mutual valuing and respect which were significant to the counsellors in this study.

Systems. The systems described by specialist CAMHS staff as important to a good relationship with school- and community-based counselling services included specialist CAMHS staff visiting or working in schools, counselling agencies presenting at specialist CAMHS team meetings, joint training and attendance at shared case discussion meetings. One or more of these issues was mentioned by 43% of CAMHS staff. Good working relationships were not necessarily seen as meaning formal systems, but rather the ability to work together effectively. One specialist CAMHS staff member described how a counsellor would refer a young person to specialist CAMHS: ‘Usually what would happen, because there are good working relationships, is they talk to somebody senior or their supervisor or whatever, who would suggest that you maybe need to have a conversation with the [specialist CAMHS] team managers, ... and, it’s maybe that they do a referral across or they bring somebody or there’s a joint meeting.’

Communication. Dialogue, liaison, the ability to consult and determine the best options for a young person were the elements of a good relationship most commonly cited by specialist CAMHS staff. One specialist CAMHS staff member described this as ‘just trying to ... join up the gaps and hope that we’re all speaking the same language and you know, all working together in terms of information-sharing’. Another commented on how helpful it would be to communicate more regularly: ‘Rather than only talking in a crisis, which is what tends to happen... I can sort of envision, you know, maybe once a term gathering together counsellors and therapists from schools that, you know, in a space with a couple of people from my team to just, you know, bring a couple of cases and think together.’

Mutual valuing and respect. Four of the specialist CAMHS staff (28.6%) described a good relationship with counselling agencies as one which is mutually supportive and/or involving willingness to work together.

Individual relationships. The helpfulness of positive individual relationships was also reported by four specialist CAMHS staff members (28.6%). This was seen as facilitating discussion and consultation. As one specialist CAMHS staff member said: ‘I think people who do have contacts, would probably tend to use them, use those informal contacts rather than going through the formal system ... I think people are concerned, sometimes about whether this is big enough to bother us.’

Difficulties in the relationship

Systems and resources. Systems issues in relating to school- and community-based counselling services included the detrimental effect of competitive tendering on the ability of agencies to develop a coherent approach to service development. This was partly seen as occurring because long established inter-agency relationships disappear when agencies lose funding, but also partly because counselling agencies who are involved in competitive tendering are less likely to be able to discuss their work openly with one another.

In addition, in one area, a member of specialist CAMHS reported that their Health Trust discouraged openness about their service in conversation with other agencies: ‘I think that when you start moving in to secrecy and competitiveness and not wanting people to know about your waiting lists or about your this or about your that, it just completely erodes collaborative working, and it’s been really sad to see it happen.’

More frequently, lack of time, waiting lists, and pressure of work were cited as leading to difficulties in co-working: ‘There is a lack of sufficient resources for counsellors and specialist CAMHS to work together on a case – managerially, it would be seen as a waste of resources.’ One specialist CAMHS staff member commented about a specialist CAMHS advice line for other professionals: ‘I mean there’s no advert put in *Therapy Today* [the professional counselling journal], for example, so if you were in this area as a



counsellor with this particular age group you [knew you could] make use of this advice line, because I don't think the Trust could cope with the influx of phone calls.'

Communication. Some lack of knowledge of counselling services was reported by specialist CAMHS staff. More frequently mentioned, however, were problems caused by referrals that did not meet specialist CAMHS criteria or that did not give the information needed for specialist CAMHS to make a decision about the young person.

Perceived differences in confidentiality policies caused significant concern for three specialist CAMHS staff members, particularly the perception that counsellors are unwilling to share information about their clients: 'Now, my understanding often is, in counselling services, that probably, confidentiality is probably seen very differently, but I guess if you're not holding risk it is very different, isn't it?'

Differences between specialist CAMHS professions in ways of understanding children and young people's mental health issues were also mentioned by one specialist CAMHS staff member: 'I would say the ones who lean more towards long-term treatment cases seem to speak a language that's closer to the language that counsellors speak in schools, and they will have those relationships, whereas say, the consultant psychiatrist probably not so much.'

Mutual valuing and respect. Specialist CAMHS staff did not frequently report concerns about being valued or respected by counsellors although one person noted that, 'there's a way that we tend to manage our anxiety – because it's very anxiety-provoking – by identifying a baddie; I've been to lots and lots of child protection conferences, where CAMHS is the baddie'. Another member of a specialist CAMHS team commented that counselling services for children and young people sometimes have an unrealistic idea of what CAMHS can offer.

One person reflected: 'Some people in CAMHS might think they are a lot more superior and the intervention that they do is so much better but I think that this is a continuum, that the work that the voluntary sector does is invaluable ... and if it reaches a certain threshold, then it comes to us, but I think we respect each other's work and what we do.'

On the other hand, six respondents (42.8%) expressed concerns about the qualifications, experience or expertise of counsellors in community- and school-based counselling services: 'In my experience counsellors don't have sufficient training, usually, it's not part of their training, in terms of having an awareness of more complex mental health difficulties.' One counsellor within Tier 2 specialist CAMHS commented that some colleagues doubt the training of counsellors: 'Counselling agencies are not always looked upon favourably, there's still a perception that counsellors are "do-gooders" – this isn't my perception I hasten to add – that they're unqualified, unskilled do-gooders that haven't got a clue what they're doing – "tea and sympathy

brigade" I think somebody called them.' One member of specialist CAMHS staff also queried the ethics of working with people, such as many counselling trainees, who are not 'professional' and largely unpaid. These concerns were not universally reported. One member of the specialist CAMHS sample, for example, reported being impressed by the standard of training and practice of many counsellors, particularly more recently.

Other issues

Two specialist CAMHS staff members expressed concern about counsellors working with more complex mental health issues because they are not supported by a multidisciplinary or 24-hour team. One person expressed concerns that children seeing a counsellor may not be getting evidence-based treatments although she did also comment that it is important to have a range of interventions available to suit the needs and preferences of individual young people.

Current changes and challenges

The impact of current approaches to financing mental health services was mentioned by five (35.7%) specialist CAMHS staff, who noted their experience of the impact of payment by case and/or competitive tendering on inter-service liaison and coherent service planning. Two suggested that reductions in funding to counselling services had led to increases in referrals to specialist CAMHS. The absence of counselling services for children and young people was identified as a problem by three specialist CAMHS staff members: in one case a lack of services for the late adolescent/early adult age group, in another case, a lack of services for the 9 to 11 year old group and in a third case there was no general availability of counselling for children and young people of any age.

A potentially more positively viewed change was the possibility of including counselling services in the single point of entry system in some areas where this is not currently the case.

One specialist CAMHS staff member said that some counsellors for children and young people had an unrealistic idea of what specialist CAMHS could offer, and so gave families unrealistic expectations of the service they would receive. Another person described voluntary sector counselling services as 'getting put upon' because the statutory sector is unable to respond adequately to levels of need in their communities.

Proposed improvements to the working relationship between specialist CAMHS and school- and community-based counselling services for children and young people

The following items were identified by at least one member of specialist CAMHS as potentially improving this working relationship:

- Having more time.
- Counsellors engaging in consultation with specialist CAMHS.

- Counsellors asking for their clients to be assessed by telephone, before making a referral.
- Better communication.
- Specialist CAMHS being clearer about counsellors' qualifications, expertise and types of counselling offered.
- Counselling services and potential clients having a better understanding of specialist CAMHS.
- Engaging in open communication.
- Increased trust of one another.
- A shared understanding of confidentiality boundaries.
- A single point of entry that includes counselling services.
- Training for counsellors in how to write effective referrals to specialist CAMHS.
- Joint training or training for counsellors provided by specialist CAMHS.
- Regular meetings to talk about cases, such as a 'concerning cases meeting.'

Summary

Specialist CAMHS staff described differing relationships with counselling services in schools and in the community. Some CAMHS respondents expressed concerns about the competence, qualification and/or confidentiality boundaries operated by some counselling services. Others have good experiences of working with counsellors, who they saw as experienced and well qualified.

The referral policies described varied between specialist CAMHS. Referrals from counsellors were most often reported as being managed through a standard open access system. Where this does not exist, counsellors generally needed to refer via a health professional, or occasionally through individual contacts. Respondents did not report specific referral routes for referrals from counselling agencies but some specialist CAMHS staff reported that counsellors were encouraged to consult with CAMHS team managers about potential referrals.

Policies seemed to vary about whether or not specialist CAMHS and counsellors could co-work with a client (i.e. both working with a particular young person at the same time). In some areas co-working was seen as a waste of resources, whilst in other areas, specialist CAMHS would support a counsellor who was working with a client with serious mental health problems or who was seen as high risk. Sometimes a school- or community-based counsellor delivered the one-to-one therapeutic intervention while specialist CAMHS offered other types of support.

From the perspective of specialist CAMHS staff, the following were likely to be associated with a good working relationship with school- and community-based counselling services:

- Systems for counsellors to consult with specialist CAMHS about potential referrals.
- Regular presence of specialist CAMHS in schools.
- Dialogue.
- Mutual support.
- Good individual relationships.

Difficulties in the relationship between specialist CAMHS and counsellors were seen by some CAMHS staff as being related to the following:

- Resource constraints and high workloads.
- Distrust of other agencies, exacerbated by the competitive tendering process.
- Lack of knowledge of the other service.
- Unrealistic ideas held by some counsellors of what specialist CAMHS could offer.
- Counsellors not being sufficiently trained in complex mental health issues.
- Counsellors' confidentiality policies preventing effective liaison.

Specialist CAMHS staff variously suggested that the following would improve relationships with counselling services:

- Better information about each other's services and qualifications.
- Increased trust in one another.
- Counsellors (and other referrers) giving specialist CAMHS the information required for a referral.
- Increased use of consultation.
- Regular meetings, such as a 'concerning cases meeting'.
- Shared training.
- A single point of entry to include counselling, to ensure the best use of resources to meet young peoples' needs.

In some areas there was evidence of strong and effective relationships between specialist CAMHS and counselling services for children and young people, although there were concerns from some specialist CAMHS staff about the burden placed on voluntary sector provision due to workload pressures and long waiting times in CAMHS. In some areas there is very little counselling provision in schools and here specialist CAMHS may, in some cases, have a more systematic presence in schools. Some reference was made to specialist CAMHS admission criteria varying according to the availability of counselling services.

In summary, the relationship between specialist and CAMHS and school- and community-based counselling services was described as very varied in the structure, systems and frequency of working together. In some areas counselling services were seen by specialist CAMHS as important partners in the delivery of a rounded service to children and young people with mental health difficulties, and in other areas counselling services were seen as offering a useful service, but one not central to specialist CAMHS' core task of working with young people with severe and enduring mental health problems.

Interviews with school- and community-based counsellors

Types of interaction reported

The picture of how counselling services and specialist CAMHS interact, as viewed by counsellors, was complex

and heterogeneous. Whilst some counsellors had little knowledge of, or connection with, specialist CAMHS, other agencies had strong and multi-faceted relationships with specialist CAMHS, and a few counselling agencies were funded by or semi-embedded in specialist CAMHS. This was particularly apparent from the interviews with respondents who had knowledge of a number of counselling/CAMHS relationships. The most frequent types of interactions with specialist CAMHS reported by the 15 main sample interviewees are shown in Table 4.

Table 4: Frequency of types of interaction between specialist CAMHS services and school- or community-based counselling, reported by counsellors

Types of relationship	No. of respondents reporting this type of interaction	%
Counselling service ⁸ makes referrals to specialist CAMHS	13	86.7%
Counsellors and CAMHS staff may work with same client at the same time	8	53.3%
Specialist CAMHS recommends/makes referrals to counselling service	6	40.0%
Counselling service and specialist CAMHS liaise about clients who are involved with both services	6	40.0%
Counselling service contacts specialist CAMHS for advice, support, consultation or occasional supervision	5	33.3%
CAMHS staff work within counselling agency on occasion/regularly	4	26.7%
Counselling service and specialist CAMHS meet or liaise on a regular basis	3	20.0%
Counselling service funded wholly/partly by CAMHS	2	13.3%
Counselling service and specialist CAMHS sit on joint committees	2	13.3%

Note: Figures relate to the main sample of 15 respondents, who work in England.

⁸ Respondents could mark as many responses as applied and so figures do not add to 100%.

Of the main sample of counsellors, a large majority (86.7%) described having referred clients to specialist CAMHS either directly or indirectly. The exceptions were both school counsellors, one of whom reported having very little knowledge of specialist CAMHS and not having made any referrals. The other counsellor, who had not made referrals herself to specialist CAMHS, advised other school staff on whether or not a referral was appropriate. A third school-based counsellor rarely made such referrals.

Three respondents (20%) reported that there was no route available for them to refer directly to specialist CAMHS; instead they ask the child's GP or parents to make the referral. Four counsellors reported having a direct referral route: 'We're lucky enough to have a direct referral in that we have a contact within CAMHS.' Nonetheless, this respondent also commented that her service made referrals to specialist CAMHS infrequently, and only where the client had serious problems: 'The only time I would say that we make a referral to CAMHS, is if we're, like, hugely concerned that the self-harm is out of control and it is driven by an underlying mental health issue.'

One third of the main sample and all four of the supplementary group reported that counsellors ask specialist CAMHS for advice, consultation or information. This might include asking for consultation or back-up where a young person is assessed as being at a higher risk than the counsellor would usually be expected to support. One respondent commented: 'You can also contact CAMHS if they have a specialist worker, in a particular field, for example, in like anorexia. In one particular school, a counsellor that I supervise, she's working with two children with anorexia, who have been referred to CAMHS, but through some specialist support and guidance the counsellor is working with the children because that's what the children want.'

Where counsellors reported that CAMHS staff occasionally meet with clients in the counselling venue, this was regarded as a useful arrangement. 'We've had ... a psychologist from CAMHS come in to offer a different kind of service to what we might offer, and they might come in to do an assessment, ... [with] maybe a young person who is having a first episode of psychosis.'

There were some very different experiences reported about specialist CAMHS and counselling services working with the same client. In some instances described, there had been an agreement between specialist CAMHS and the counselling service for the counsellor to work with one type of problem whilst the CAMHS staff worked in another way: for example, the counsellor working with bereavement issues in a person-centred way, and CAMHS staff working with anxiety or phobias using CBT. One counsellor reported: 'At the minute ... two of our youngsters are working with CAMHS, and I did have ... regular contact with the psychiatrist who was working with them who was great.' In other cases described, there was the opportunity

to liaise in order to decide on the appropriate intervention for a client, or the counsellor supported a young person as an interim measure: 'They could continue to see me, you know, after they've seen CAMHS because I think they'll have an assessment first, and then, possibly have to wait again. So, that's a really useful way for the school service can support the young person during the waiting period.'

This type of agreement for counsellors and specialist CAMHS staff to work in parallel, however, was not reported universally. Some counsellors stated that their counselling service would not continue to offer one-to-one counselling to a young person who was working with specialist CAMHS, but might offer another type of support such as group work or drop-in.

In other areas, counsellors reported having been asked not to continue working with clients who have been referred to, or accepted by, specialist CAMHS. For instance, two respondents said: 'I was phoned by [specialist CAMHS] and asked not to see a student because they were going to be dealing with it from here, which was somewhat undermining of my input,' and 'most [specialist CAMHS] teams will say, "Oh, no, the, the young person has to transfer to our therapist". Well, of course, the whole nature of therapy is that you don't want them to have to suddenly leave their therapist and have a new one, but because of the way the system works they don't want me to go on working with them.' One counsellor commented: 'I contacted the CAMHS team because we were aware that she [my client] had been seen by the CAMHS unit. They immediately said that we had to stop seeing the young girl, I said that I didn't think

that was in the best interest of the client.' An expectation for the counsellor to close the case when their client is referred to specialist CAMHS was experienced as particularly problematic if there was a delay between the referral and the client receiving a service from specialist CAMHS, as the young person might be left temporarily without a service.

Both school and community counsellors reported difficulties where there was little communication between specialist CAMHS and a counselling service that had worked with a child before the CAMHS intervention, and may work with them again afterwards. 'I often feel the school counsellor is disregarded in the process, as the child can go away for an intervention, [but when] they come back in the school there's no information transfer and we're meant to pick it up'.

Three respondents reported that their counselling service met or liaised regularly with specialist CAMHS, and another was trying to set up such a system. For example: 'I have probably had quite a long term relationship with family therapists in CAMHS ... so that means regular attendance at meetings, and just kind of general talking to other professionals around working with families.' Another interviewee said, 'We had started taking the initiative to set up meetings between counselling co-ordinators here and primary mental health workers, so to start exploring more their common issues, share practice and so on and get to know each other a bit better and how systems work.' One of these respondents said that the arrangements to meet regularly were unlikely to continue because his agency's funding was not being renewed. Where these arrangements



existed they were seen as very useful, but systematic liaison between specialist CAMHS and counselling was not reported to be the norm.

Counsellors' perceptions of comparative provisions of specialist CAMHS and counselling services

Counsellors perceived specialist CAMHS as offering the following services above and beyond what was provided by counselling services for children and young people:

- A referral point for problems beyond the remit of counselling services.
- Specialist back-up and expertise.
- Involvement of parents/ families.
- Medication.
- Family therapy or working with families.
- A medical/psychiatric model.
- Other services cited include:
 - Diagnosis and/or treatment.
 - More in-depth/ longer term work.
 - Support and consultation for counsellors.
 - CBT.
 - Psychiatric assessment.
 - Crisis intervention.

School-based counselling services also noted:

- Services during school holidays.
- Seeing the child outside of the school context where this is helpful.

Although these were the most frequently mentioned services provided by specialist CAMHS, counsellors did not report a completely consistent pattern of what was provided by either specialist CAMHS or by counselling services for children and young people. Some areas of overlap existed either in theory or in practice:

'[L]et's just say if a child was an early teenager and was psychotic, then actually, that is not a referral to the school counsellor, that's a referral to CAMHS. However, in practice, even with cases like that, they bounce back from CAMHS into school ... They bounce back because parents don't take them to CAMHS, and it's a two-strikes-and-you're-out sort of situation, so if they don't turn up for two appointments that's it, they're off the books.'

Counsellors' perceptions of what school- and community-based counselling services for children and young people can provide

Counsellors perceived counselling services for children and young people as offering the following services above and beyond what is provided by specialist CAMHS:

- Flexible hours.
- Accessible services:
 - Local services.
 - A more informal/relaxed approach.
 - Shorter waiting lists.

- Support for both teenagers and young adults within one service. This was seen to avoid both the potential for a hiatus in service provision for young people approaching the age of 18, and the need for transition at age 18.
- Longer term work.
- A service that is not recorded on NHS records.
- A service that does not require parental consent, involvement or presence. This was considered to be particularly important where a young person experiences severe difficulties in the relationship with her or his parents and/or where the parent is unwilling or unable to engage effectively with services.
- A service that is not perceived as stigmatising.
- A wide range of services, often under one roof.
- In addition, school-based counselling is seen as offering:
 - A service accessible to almost all children and young people.
 - A service that focuses on school as the relevant system.

Characteristics of a good relationship

Four main domains of a good relationship between specialist CAMHS and counselling for children and young people were identified: systems issues, good communications, valuing and respect, and individual relationships.

Systems issues. The most positive relationships between counselling services for children and young people and specialist CAMHS were associated with *involvement* in one another's services, rather than having a relationship that only consisted of *referrals* between the two services. Examples include the following:

- Arrangements for attending team meetings or case discussion meetings of the other service.
- Having psychiatrists and/or psychologists acting as consultants to counselling services.
- A counsellor having a link person in specialist CAMHS to contact directly for consultation or advice.
- Specialist CAMHS staff visiting a school or community counselling base to liaise with staff or see a young person.
- Specialist CAMHS staff regularly working out of the community-based counselling service.
- A culture and/or policy which allow for specialist CAMHS staff and staff of counselling services to work jointly with a client or alongside one another where this was agreed to be in the young person's interest.
- A member of specialist CAMHS acting as a 'back-up' to a counsellor to enable him or her to continue working with a client where this is considered to be in the young person's interest, but where the risk levels are such that management within specialist CAMHS is indicated.
- Making joint funding applications for future services (reported by one respondent).

Communications. The importance of good communication between specialist CAMHS and community- and school-based counselling services was emphasised by the counsellors. This includes the following:

- Clearly understood confidentiality/information sharing policies.
- Clearly understood referral criteria.
- Tracking and follow-through with referrals from counselling services to specialist CAMHS, i.e. for specialist CAMHS to inform the counselling service whether or not the young person has been offered a service, and when any specialist CAMHS intervention ends.
- Liaison about individual clients who are at risk,
- Regular opportunities for dialogue and discussion.

Mutual valuing and respect. Counselling respondents reported that a basic prerequisite for a sound working relationship with specialist CAMHS was the existence of mutual valuing and respect: 'We have had a lot of support from the child and adolescent psychiatrist in the local unit, who absolutely, totally supports school counselling, and that's been very helpful in the sense that he's filtered that down to his team.'

Two aspects of this foundation for working together were specialist CAMHS and community- or school-based counselling services valuing, understanding, respecting and trusting *the service* provided by the other, and staff in each of these services valuing and respecting the *skills and experience of staff* in the other service.

Personal relationships. A recurrent theme reported by counsellors was the importance of good relationships with specific individuals. This seemed to be particularly vital where the structural or formal relationship was not well developed. Good individual relationships were reported as most likely to occur when:

- Managers, team leaders and staff in specialist CAMHS value and are supportive of what counselling can offer.
- Individual staff members in counselling services and specialist CAMHS can be flexible in their approach.
- Good one-to-one relationships have been established between individuals in counselling services and in specialist CAMHS.

Difficulties in the relationship

Negative or unhelpful relationships, as described by the counselling respondents, can be divided into the same four domains as helpful relationships.

Systems issues. Disjointed or fragmented services, and a lack of established and appropriate systems for interaction were identified by the counselling respondents as associated with poorer relationships with specialist CAMHS.

Some problems were seen to be due to the absence of specific protocols, processes and mechanisms for reciprocal working that recognised and acknowledged the skills and work done by counselling services. Examples included the following:

- The use of standardised CAMHS referral and assessment pathways that did not take account of assessment or on-going work by a counselling service.
- Consultation pathways that did not take account of the experience and levels of knowledge of counselling service staff.
- Joint working or liaison relationships between different statutory agencies that did not include counselling services: 'I often feel the school counsellor is disregarded in the process'.

Effective joint working was reported as being made more difficult where the overall provision of services in a locality was disjointed, overlapping or fragmented, without clear pathways or connections. Where counselling provision was reported as fragmented (for example, where schools employ individual counsellors directly, or where there are multiple counselling organisations operating in an area), it was described as difficult to develop and maintain strong relationships with specialist CAMHS. Similarly, counsellors described additional difficulties in forming strong relationships with specialist CAMHS where their counselling organisation or school covered a geographical area served by two or more specialist CAMHS teams, especially if each CAMHS teams had different policies and protocols.

Limited communication. Some counselling respondents described experiencing difficulties in communicating with specialist CAMHS due to lack of time, lack of knowledge and differences in expectations. Pressure of work in both specialist CAMHS and counselling services was seen as making it difficult for staff to take the time needed for the development and continuation of dialogue: 'We try and have communication and meetings and things, but it's quite difficult... everyone's over-stretched, one way and another.' Where counselling services lacked information about referral criteria for specialist CAMHS, or where these criteria were fluid or undergoing changes, counselling services said that they found it difficult to refer appropriately. This is discussed in more detail under 'Referrals', below.

Difficulty in getting in contact with a particular member of specialist CAMHS to discuss a mutual client was also mentioned: 'We do a lot of "telephone tagging," trying to talk to practitioners because ... we're not directly available on the phone always, when they call in, and vice versa'.

Unclear or differing expectations around information sharing about clients was another issue which was seen as limiting communication, particularly as many counsellors would only share information with the client's consent unless there were real and pressing concerns. On the other hand, some counsellors also reported frustration at the confidentiality policies of specialist CAMHS, where this meant that a counsellor did not hear back from specialist CAMHS about a client they had referred for assessment.

Mutual valuing and respect. In many areas, counsellors reported a lack of mutual trust, respect and valuing between specialist CAMHS teams and counselling services. This included counsellors feeling that their work was unrecognised, misunderstood or undervalued, and feeling frustration and annoyance arising from their interactions with specialist CAMHS or with the service provided by CAMHS to young people.

Of the main sample, eight counsellors (53.3%) reported feeling that counselling and/or the work of their counselling services was undervalued or misunderstood by staff in specialist CAMHS. These respondents thought that specialist CAMHS staff did not understand the extent to which counsellors were trained and supervised: 'Very often, there is this lack of understanding, which could go in some way to explain the "pooh-poohing" by certain mental health professionals of counselling.' 'I wonder if school counsellors are considered a little bit light-weight'.

Some of these respondents thought that specialist CAMHS staff were not aware of the seriousness of the problems counsellors work with:

'Young people entering into our service have very high levels of need and it's not really appreciated by CAMHS or others, either ... People will say, "Well, you know, it's having a chat, you know, sit down, nice friendly chat," and so on, bit of relationship-building, get things off your chest, whereas it's actually it's, you know, it's a sophisticated method of supporting young people's psychological wellbeing, and we, we have young people coming into our service, who could easily be seen by specialist CAMHS.'

Some counsellors, particularly in schools, reported that their role in mental health and emotional wellbeing was not recognised: 'If you look in the documentation, the school nurse is always mentioned but never any school counsellors are mentioned; it's as if we don't exist.' Requirements that referrals are channelled through the school nurse or GP, and the absence of feedback to the school counsellor following a referral of his/her client to specialist CAMHS, led to counsellors feeling ignored and undervalued.

Four counsellors (26.6%) explicitly stated that they had felt patronised or put down by specialist CAMHS staff members. For example: 'There's almost this patronising view of you know, we can deal with, you know, a bit of befriending'. 'It [the approach specialist CAMHS took] felt disrespectful.' One school-based counsellor commented:

'I felt a bit like I was looked down on....I kind of felt, "well, actually, I'm on a pretty even footing with what sounded like a fairly young, newly-qualified, clinical psych." But I did not get any kind of respectful, you know, sharing of information or sort of you know, I wanted us to work professionally and ... really you know, that person was not interested.'

In addition to some counsellors describing feeling undervalued and misunderstood by specialist CAMHS, a proportion of counsellors reported feeling anger and frustration at aspects of the functioning of the CAMHS service. In particular, counsellors responded negatively to what they saw as high, varying, and unclear criteria for acceptance; long waiting times; the requirement for the involvement of parents regardless of the young person's wishes or the relationship with the parents; and services that were not 'young person centred' (see below).

However, despite these strong negative feelings being expressed by more than half of the main sample, they were by no means universal, as in some areas there was strong evidence of agencies working together respectfully, and in some areas the situation was more complex. One respondent reported getting mixed messages about how the counselling agency was perceived by the specialist CAMHS team. Some respondents noted that they felt respected and valued by one specialist CAMHS team though not by another. Others commented that joint working on committees or case groups had improved the mutual understanding and respect between specialist CAMHS and counselling.

One supplementary interviewee noted that: 'Before having even "talks about talks" about working more closely together, CAMHS and counselling services need to have a conversation about the professionalism of both services – a genuine, respectful, professional conversation to reduce the mistrust.'

Personal relationships. A lack of personal, one-to-one connections between counselling service staff and individual members of specialist CAMHS teams was seen as making communication more problematic. This was exacerbated by rapidly changing staff teams, which can make it difficult to develop consistent working relationships

Referrals. One area that was reported as causing difficulties and concerns for many (but not all) counselling services was managing referrals to and from specialist CAMHS. Some counsellors (13% of the main sample) had not ever referred to specialist CAMHS and had little idea of what the referral criteria might be. Some other counselling services referred to specialist CAMHS with some frequency but nonetheless found it difficult to assess whether or not a particular referral would be accepted. Differences between referral criteria and referral processes in different specialist CAMHS provision were seen as adding to this uncertainty. One respondent commented that the differentiation between referrals to the two types of service had changed: 'It's not so obvious these days, really, in terms of what kind of referral would be more appropriate for CAMHS and what kind of referral would be more appropriate for us.'

Thresholds for acceptance of clients by specialist CAMHS were seen by some counselling respondents as high and inflexible, leaving a gap between what counselling services believed they were able to effectively and appropriately provide, and acceptance by specialist CAMHS. Where the criteria for acceptance by specialist CAMHS were seen as becoming more rigorous in recent years, counselling agencies were described as experiencing increased pressure of referrals both in terms of numbers and the severity of problems experienced by young people. This was experienced as particularly difficult where funding for counselling services has been reduced.

Two other specific concerns about referrals were identified by some counselling respondents. Firstly, where a young person was referred to specialist CAMHS by a counselling service but was not offered a service, or did not take up the service offered by specialist CAMHS, they may end up with no service from either organisation. This problem was seen as being avoidable if specialist CAMHS were able to inform the counselling service of the progress of the referral.

Secondly, the operation of a single point of entry to CAMHS was seen as unhelpful if it prevented a swift and direct referral between counselling and an appropriate specialist CAMHS intervention. For example, this could occur where all referrals to specialist CAMHS went via Primary CAMHS first, even if the young person was already working with a Tier 2 or 3 type community-based counselling service.

Current changes and challenges

Counsellors and counselling agencies reported observing a rapidly changing environment both for themselves and for specialist CAMHS, leading to uncertainties and alterations in their relationship.

Important areas of change reported included the following:

- Increased pressure of referrals in specialist CAMHS leading to higher referral criteria.
- Higher numbers of referrals to counselling services.
- Counselling services managing more clients with more complex problems and higher levels of risk.
- Increased localism and variations between service structures in different geographical areas.
- Restructuring of services, in part through the current commissioning process, leading to uncertainty about future provision and lack of continuity.
- Changing referral processes, for example the single point of access to CAMHS and/or limitations on accepting referrals other than from GPs or certain other health professionals.
- Increasing difficulty in accessing specialist CAMHS staff for consultation.

One supplementary interviewee noted that the funding and organisation of all types of mental health services for children and young people was characterised by fragmentation and arbitrary differences between areas, and another counsellor commented: 'They don't all seem to operate according to the same rules'. This was seen as leading to considerable challenges in meeting the needs of children and young people in school- and community-based counselling settings.

Summary

Community-based counselling services generally reported having some knowledge of specialist CAMHS and referring clients to them when needed, although the criteria were not always clear to counsellors, and referrals were not always successful. Some school-based counsellors reported having little knowledge of CAMHS and described rarely, if ever, making or receiving referrals, but other school-based services described a more substantial relationship with specialist CAMHS. The relationship between specialist CAMHS and community- and school-based counselling was described as very variable, and there was considerable frustration or anger expressed by some counsellors at the limitations in what specialist CAMHS could provide. There was also acknowledgement of the workload pressures experienced by specialist CAMHS and constraints on resources available. Some counsellors commented that they were very pleased to have the opportunity to comment on what they experienced as the difficulties of working with specialist CAMHS.

From the perspective of providers of school- and community-based counselling for children and young people, the following were likely to be associated with a good working relationship with specialist CAMHS:

- Clear understanding of each other's services and working practices including:
 - referral criteria;
 - accountability;
 - range of services and staff;
 - levels of qualification of staff;
 - types of issues and severity of difficulties worked with;
 - confidentiality and information sharing policies; and
 - age ranges.
- Well-developed systems for working together such as:
 - specialist CAMHS staff working with clients within counselling organisations, for assessments or on-going work;
 - specialist CAMHS providing accessible systems of consultation for counsellors, appropriate to their knowledge, experience and work;
 - systems of referral between specialist CAMHS and counselling services that take account of the expertise of both organisations and provide an integrated system of care that also takes account of client choice;

- clear information sharing systems, within agreed boundaries of confidentiality, to ensure a joined-up service to children and young people referred between counselling and specialist CAMHS; and
 - joint working with individual clients when this provides the service that best meets the needs of a young person.
- Attitudes of mutual respect and valuing.
 - Acceptance of differences in working practices, models and discourses, as these enable alternative provision for different purposes, at different venues, for different children and young people.
 - Fostering strong relationships with key individuals.
 - The development of complementary services that work together seamlessly.
 - Development and maintenance of stable and on-going relationships despite changes in the funding and commissioning environment. This may be facilitated by one or more of the following:
 - Involvement in joint committees or panels;
 - attendance at one another's team meetings or at case management meetings;
 - joint training; and
 - clinical supervision provided by specialist CAMHS staff to counsellors.

The extent of mutual valuing, respect and the ability to work productively together was reported by counsellors

to vary substantially between CAMHS teams, for instance:

'[O]ur CAMHS team in [area] ... we sit on the same panels together, they've got a sense of us as an organisation working ethically and appropriately because we, we've been able to develop a mutual respect. My experience of the other three CAMHS that I have to deal with is because they don't know ours as an organisation, their sense is just to kind of, it sounds dreadful, just take clients away and just say, "No, we'll deal with this client, it's not for you", and they will say to a client, 'No, you can't go there anymore', which, for us, is quite frustrating.'

Counsellors in many areas reported fragmented services with poorly understood differences between localities, uncertainty about the future, and a lack of understanding between specialist CAMHS and counselling in the community and schools. In many areas, counsellors described a reliance on informal and personal relationships with individuals in specialist CAMHS, rather than structural and formal systems of working together with clear lines of communication. In some areas there was evidence of strong and effective relationships between specialist CAMHS and counselling services for children and young people, but in other areas it appeared that these would benefit from further development to maximise the benefits of working together, particularly in a time of financial stringency.



Survey of counsellors

Counsellors' responses to the quantitative questions of the e-survey are presented first, followed by a thematic analysis of the answers to the survey open questions. The e-survey is in Appendix 1.

Quantitative findings

Respondents were asked to select from options to indicate the nature of their work relationship with specialist CAMHS, their experience of and confidence about referral to specialist CAMHS, and referrals from specialist CAMHS to their service.

Work relationship with specialist CAMHS. The most frequent response (41.4%) to the question on the types of relationship with specialist CAMHS was 'my service works occasionally with specialist CAMHS but I do not have much contact with them myself'; 10.5% 'work regularly with specialist CAMHS' but at the other extreme, 8.3% state that 'neither I nor my service has contact with specialist CAMHS'. This indicates the very variable frequency of contact between counselling services for children and young people and specialist CAMHS (Figure 1).

Referral to specialist CAMHS. Respondents demonstrated a moderate degree of confidence in their knowledge about referral criteria for specialist CAMHS with 50% of responses either 'confident' or 'very confident' about this. However,

24.6% indicated that they lacked confidence in their knowledge of these referral criteria (Figure 2).

Direct referrals to specialist CAMHS from their counselling service was reported as possible by 61.8% of respondents, with 25.4% being unable to refer directly to specialist CAMHS (Figure 3).

The primary reasons given for referrals to specialist CAMHS from counselling services were the need for more specialist interventions, the identification of the client as 'at risk', the availability of family therapy and the availability of medication (Figure 4).

Referral to counselling services from specialist CAMHS. Of respondents, 57.7% reported that their service received referrals from specialist CAMHS either regularly or occasionally (Figure 5). These referrals were perceived as primarily occurring in order to receive one-to-one counselling (71.6% of respondents) with 48.1% reporting receiving referrals for quicker access or shorter waiting lists, and 40.7% so that longer term work could be provided (Figure 6).

Other types of interaction between counselling services and specialist CAMHS. Of responders, 36% stated that the counsellor's service currently only interacted with specialist CAMHS regarding referrals. The most frequent type of contact other than referrals occurred when

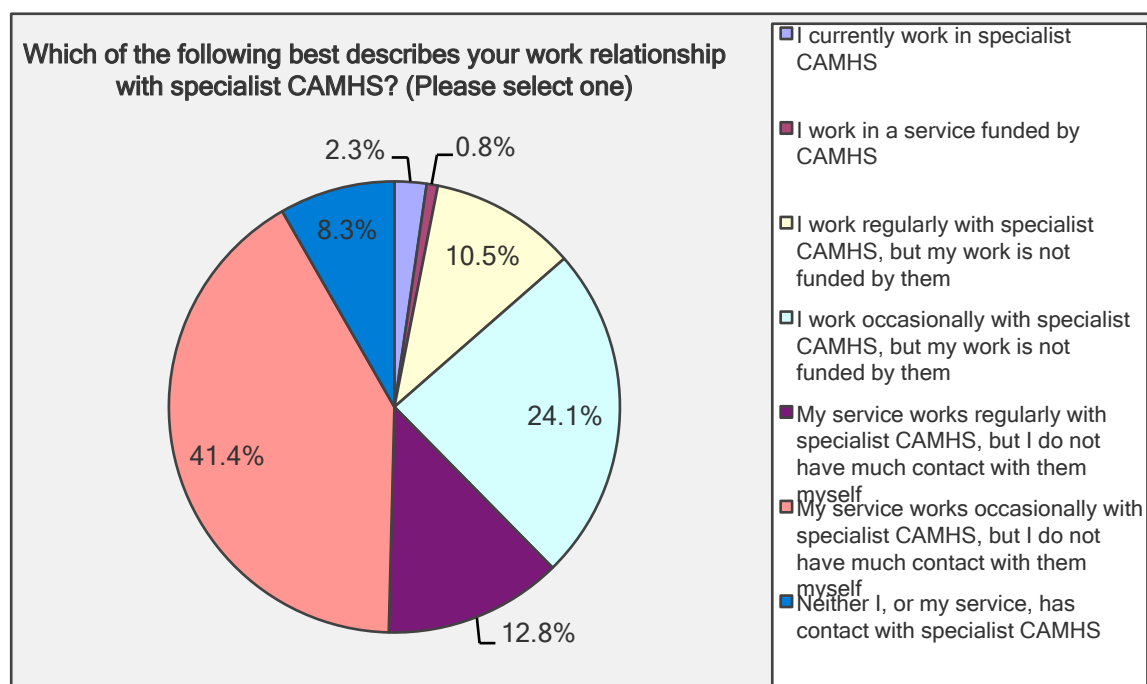


Figure 1: Work relationship with specialist CAMHS

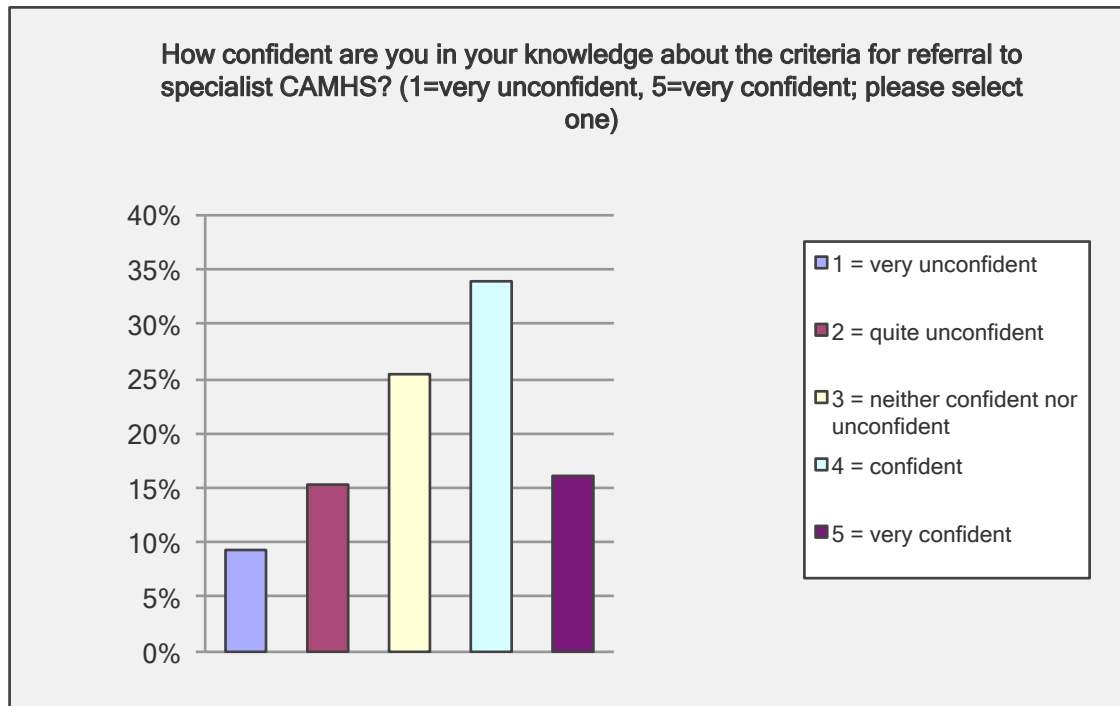


Figure 2: Counsellors' confidence in their knowledge of referral criteria to specialist CAMHS

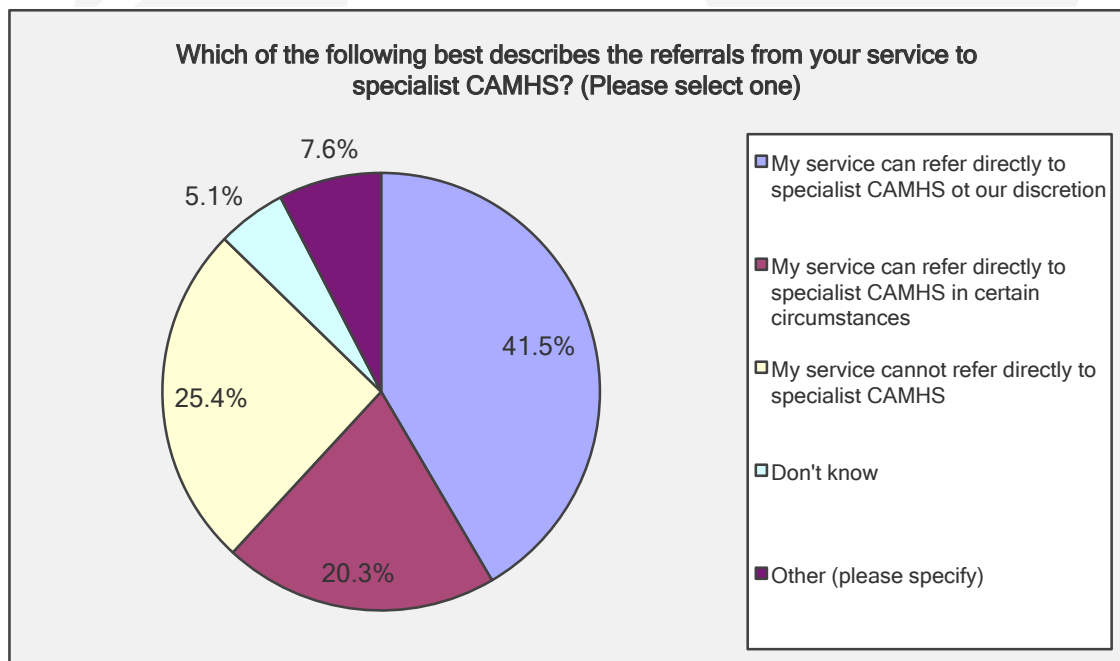


Figure 3: Referrals from counselling services to specialist CAMHS

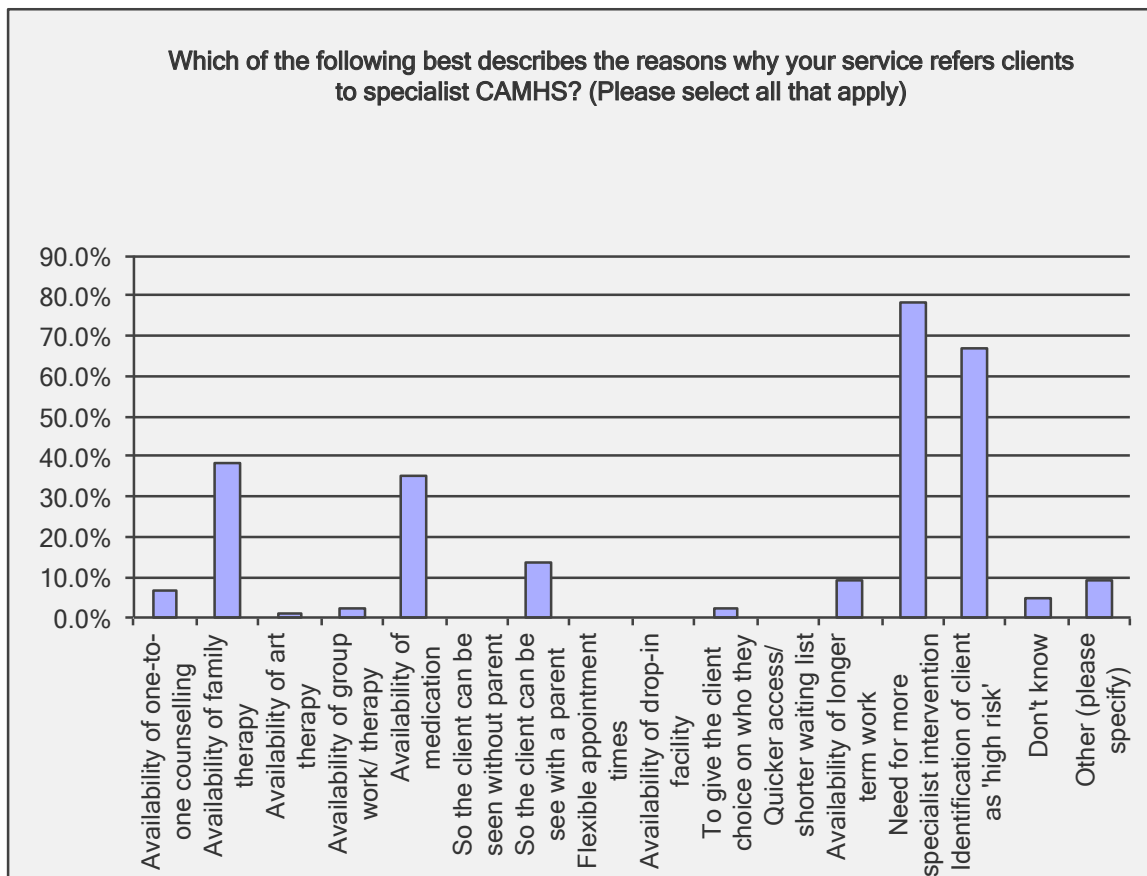


Figure 4: Reasons for counselling services referring to specialist CAMHS

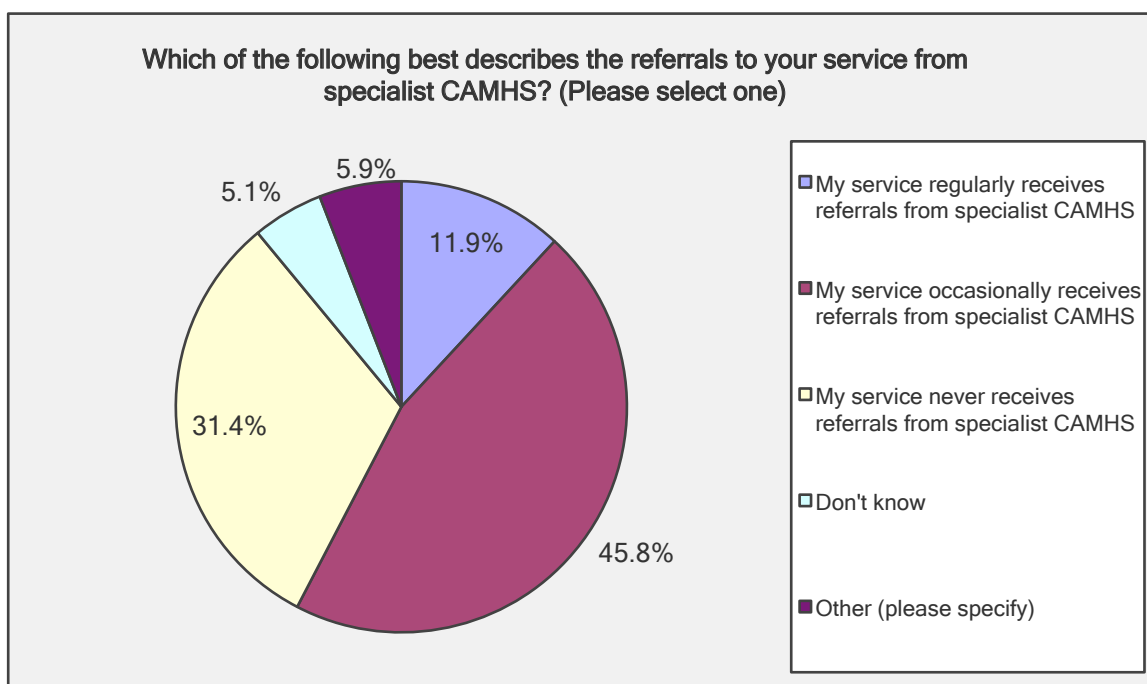


Figure 5: Frequency of referrals from specialist CAMHS to counselling services

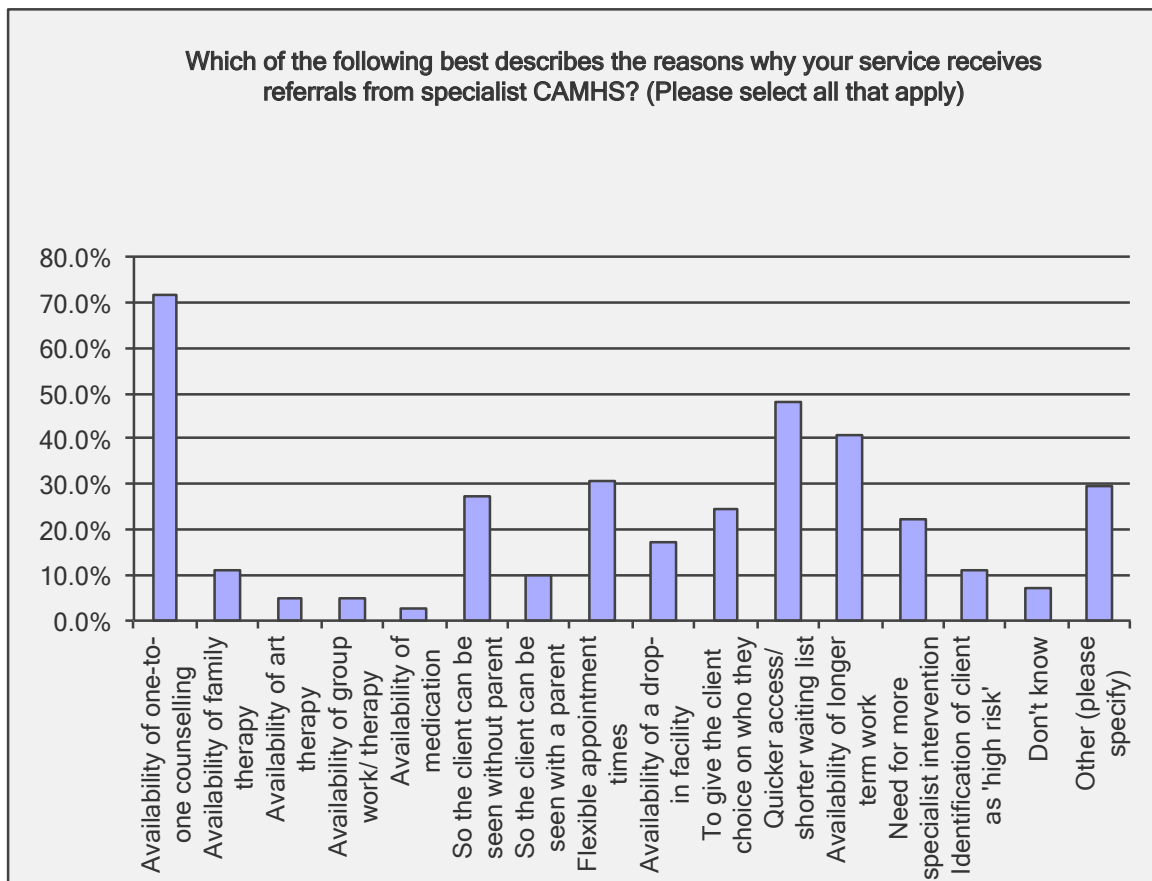


Figure 6: Reasons for specialist CAMHS referrals to counselling services

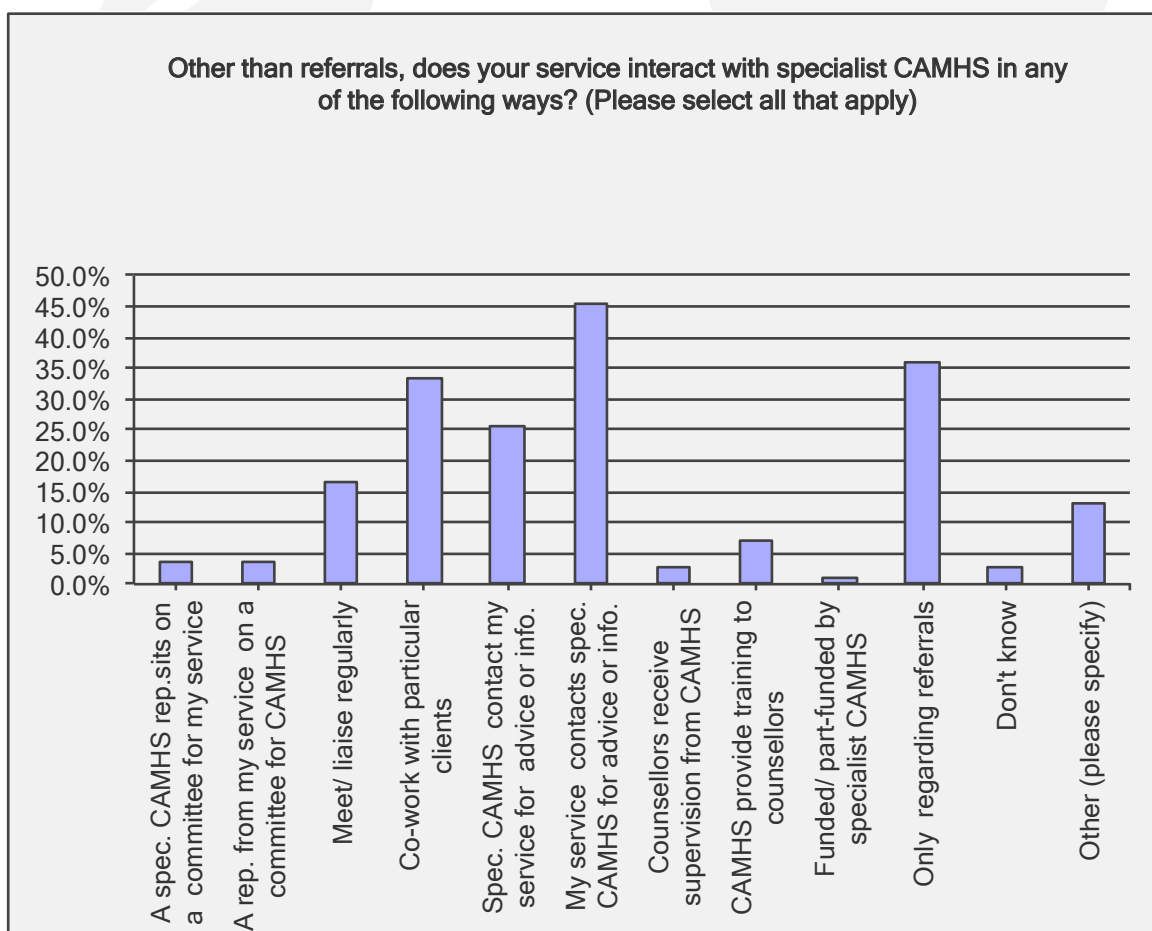


Figure 7: Other types of interaction between counselling services and specialist CAMHS

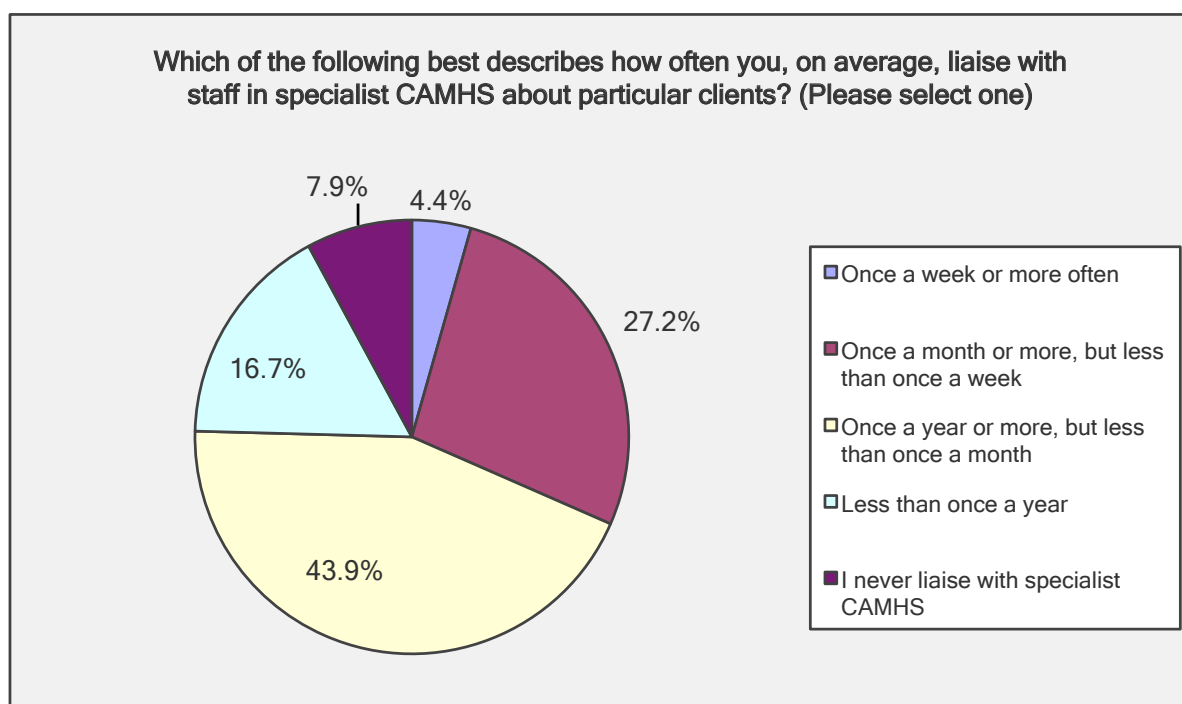


Figure 8: Frequency of liaison between counselling services and specialist CAMHS about particular clients

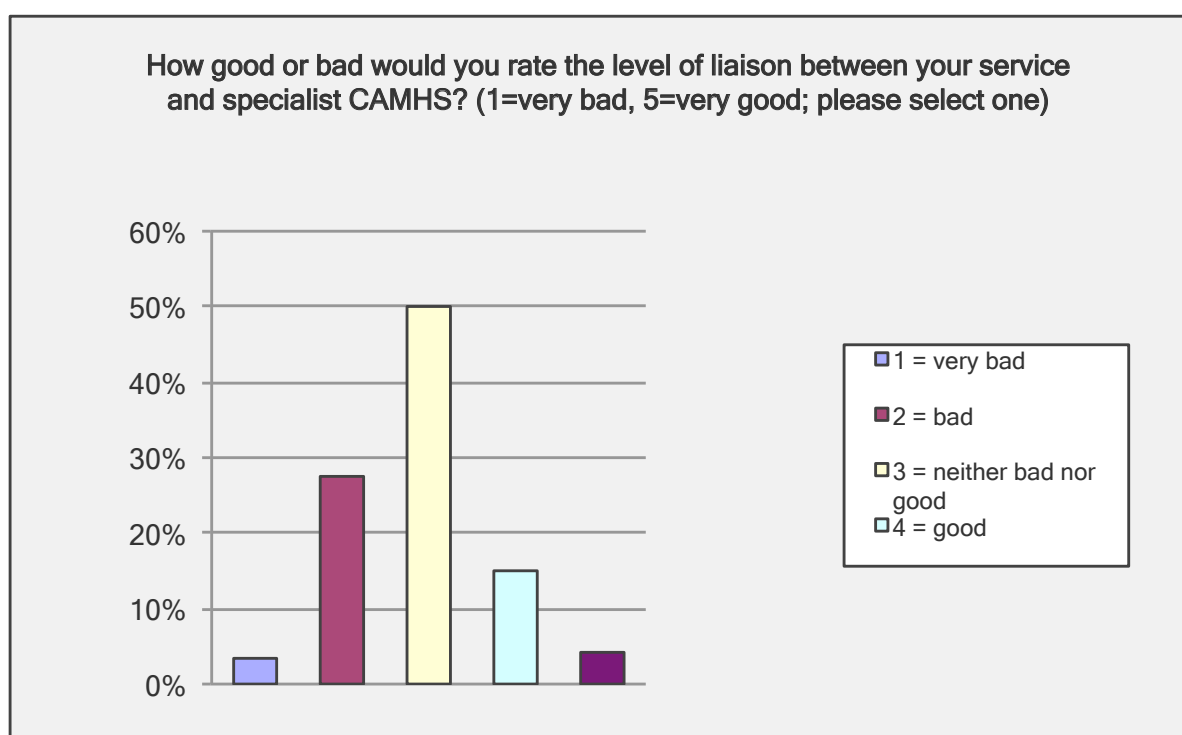


Figure 9: Counsellors' assessment of the quality of liaison with specialist CAMHS

counsellors contacted specialist CAMHS for consultation, advice and information (45.6%). Co-working by specialist CAMHS and counselling services with particular clients was also reported frequently (33.3%), though it should be noted that 'co-working' was not defined in the survey and could be understood in a variety of ways (Figure 7). It appeared to be relatively unusual for there to be formal management, committee or strategic links between counselling services and specialist CAMHS, but this may be an area of difference between community-based counselling services and school-based counselling services.

The frequency of liaison between counselling and specialist CAMHS about particular clients was reported as variable, with 31.6% of responses reporting liaising once a month or more often and 24.6% reporting liaising less than once a year or never (Figure 8).

Counsellors' assessment of the quality of liaison with specialist CAMHS. When asked 'how good or bad would you rate the level of liaison between your service and specialist CAMHS' the majority of respondents answered neutrally: 50% chose 'neither good nor bad'. The next highest response was 'bad' (27.5%); 19.2% rated the level of liaison either as 'good' or as 'very good' and of these, five respondents (4.2% of the total) rated the level of liaison as 'very good' (Figure 9).

Responses to open questions

The open questions on the e-survey asked counsellors the following:

- What do you see as the positive aspects of the relationship between your service and specialist CAMHS?
- What do you see as the negative aspects of the relationship between your service and specialist CAMHS?
- How do you think the relationship between your service and specialist CAMHS could be improved?
- What, if anything, would you/your service like to know about specialist CAMHS?
- What, if anything, do you think it would be useful for specialist CAMHS to know about counselling/psychotherapy for children and young people?

The themes developed from the answers are shown in Table 5. A table of the themes and sub-themes with further examples is in Appendix 5.

What do counsellors see as the positive aspects of the relationship between their service and specialist CAMHS?

Table 5: Counsellors' perceptions of the positive aspects of the relationship between specialist CAMHS in counselling¹⁰

Theme	Sub-theme	%
Service issues	CAMHS as an 'expert'/ specialist support service	40.9%
	Availability of CAMHS – locally/ during school holidays	5.4%
	CAMHS can prescribe medication	2.2%
Working towards a shared goal		32.3%
Good communication		24.7%
Referrals	Referrals to CAMHS	11.8%
	Referrals from CAMHS	4.3%
Mutual respect		8.6%
Training opportunities		2.2%

The most frequently cited positive aspects of the relationship between their services and specialist CAMHS was the availability of specialist CAMHS to provide expert or specialist support. Examples include: 'Anything out of my expertise can be re-assessed by somebody more qualified'; 'It provides a back-up for us – somewhere to refer more serious cases to or to get an assessment/second opinion'.

The potential for CAMHS to prescribe medication was mentioned, but not frequently (2.2%).

Counsellors being able to refer to CAMHS was cited more frequently than receiving referrals from CAMHS, possibly because of the importance of CAMHS as a specialist support service. Examples include: 'I have been able to refer in "at risk" clients and have had the referral accepted'; 'I know that the service is available locally'; and 'Can see clients during school holidays'.

Good communication and working towards a shared goal were both mentioned relatively frequently (24.7% and 32.3% respectively) as aspects of a positive relationship. For instance: 'Both attempting to find available solutions to young people's needs'; 'The opportunity to provide wrap around care for young people, to liaise to ensure young people get the service they need,'; and '... We are able to discuss concerns and receive a CAMHS assessment with an outreach psychiatric nurse. She is very supportive towards

¹⁰ Percentages total more than 100% as some responses may have expressed multiple themes. Percentages calculated as a proportion of the total number of appropriate responses given.

all school staff, and is a great point of contact. Also, I can ring the CAMHS team if I have particular concerns about a client. I have always felt listened to, taken seriously and supported when I have made such calls.'

The importance of being respected was mentioned by 8.6% of respondents: for instance, 'There is mutual respect, trust and willingness'; and 'They know about us, they trust us for counselling young people.'

What do counsellors see as the negative aspects of the relationship between their service and specialist CAMHS?

Table 6 summarises counsellors' views on the negative aspects of their relationship with specialist CAMHS.

Table 6: Counsellors' perceptions of the negative aspects of the relationship between specialist CAMHS and counselling

Theme	Sub-theme	% ¹¹
Communication issues	Lack of direct communication between the two services	31.1%
	Poor quality of communication between services	21.4%
	Poor communication between CAMHS and clients	3.9%
Service issues	Referral difficulties	17.5%
	Long waiting lists in CAMHS	17.5%
	High workload of CAMHS	8.7%
	High staff turnover rates in CAMHS	4.9%
	Perceived lack of adequate CAMHS input	3.9%
Client issues	Negative experiences of clients/families who have accessed CAMHS	10.7%
	Difficulties with family involvement	5.8%
	Confidentiality issues	4.9%
Therapist issues	Perceived lack of respect for counsellors	14.6%
	Counsellors not included in inter-agency work	1.9%
Financial issues	CAMHS underfunded	2.9%
	Lack of funding for C+P services	1.9%

¹¹ Percentages total more than 100% as some responses may have expressed multiple themes. Percentages calculated as a proportion of the total number of appropriate responses given.

The two most common themes in response to the question about negative aspects of the relationship between counsellors and specialist CAMHS were communication issues and service issues.

Communication issues relating to a lack of communication or poor communication between CAMHS and counselling services were frequently cited, for instance: 'Not being contacted by CAMHS when a client is referred to them, say by parents, even though the client tells them they are receiving weekly 1-1 counselling.'

In some cases, respondents identified a breakdown in communication: 'Inappropriate sharing of information, insecure boundaries, inappropriate, incorrect and unchecked quoting of school therapists to the parents thus negatively impacting and in some cases breaking down a previously strong therapeutic attachment. Because of this I now avoid contact with CAMHS...'

Difficulties with referrals and long waiting lists were the most frequently mentioned service issues, for instance, 'Sometimes we "hold" clients in desperate need of CAMHS support because the waiting lists are just too long'; and 'CAMHS criteria for acceptance of referrals (which in my area are exclusively through PCAMHS) are not in line with NICE guidelines.'

Much less frequently, but nonetheless emphatically, some counsellors (3.9%) reported concerns about the quality of service input from specialist CAMHS, for instance: 'When a client is referred on safeguarding issues, they assess and then hand back. There does not seem to be any specialist intervention work done, the case is just referred back.'

High staff turnover was also seen as problematic, as was the workload of specialist CAMHS teams. For instance: 'CAMHS workers seem to change regularly which affects depth of relationships and consistency'; and 'There are too many barriers to working effectively such as time constraints, overload and a very small team of staff.'

Client issues around confidentiality were linked to referral issues. For example, 'The fact that as school counsellors we...have to go through the school nurse, or the outreach psychiatric nurse. Sometimes this feels like sharing too much information with too many people for my clients'.

Other client issues were related to the requirement for specialist CAMHS to involve a young person's family. For instance: '[They] are not willing to visit a young person in school, when specifically asked by a young person if they would do so, in cases where young people do NOT want or are not able to talk freely in front of parents'; and 'They are very narrow in their attitude to dysfunctional families. If the family doesn't turn up twice, then the child is assumed not to be in need. The fact that dysfunctional families are so chaotic doesn't seem to register.'

A substantial proportion of counsellors (10.7%) referred to negative experiences that clients and their families had

of contact with specialist CAMHS: for instance: ‘Clients’ feedback has not always been positive, unapproachable staff, then disengagement likely’; and ‘Our client’s mum is very concerned and is unhappy with the service, as are we.’

Therapist issues refers to counsellors feeling that they were not respected (14.6%), or, less frequently, that they were excluded from inter-agency fora (1.9%). For instance: ‘They are precious about their work. Their attitude to others outside their circle is superior. My experience, except rarely, is that I am not a professional colleague.’ ‘The meetings are held with the teachers and parents and sometimes the agencies within the school, the counsellor, art therapist and music therapist are not involved so their individual input is not included.’

Financial issues for both specialist CAMHS teams and counselling services were mentioned by a small number of counsellors as constraints on the relationship between the two agencies. For instance: ‘CAMHS as a concept is great, however as they are underfunded, undermanned and overworked, their morale is low and this often shows in their communications.’

How do counsellors think the relationship between their service and specialist CAMHS could be improved?

Table 7 summarises counsellors’ views on how their relationship with specialist CAMHS could be improved.

Table 7: Counsellors’ perceptions of how the relationship between specialist CAMHS and counselling could be improved

Theme	Sub-theme	%
Improve communication		68.3%
Improve understanding of what each service provides	If CAMHS better-understood counselling services	18.8%
	For counselling services to understand CAMHS better	12.9%
Work more collaboratively		18.8%
For CAMHS to respect counselling services and staff		13.9%
Make CAMHS easier to access		10.9%
More funding	More funding for services/ training in general	6.9%
	For CAMHS to fund/part-fund counselling services/training	2.0%
Joint training		4.0%
For CAMHS to understand and support the need for counselling		4.0%

Two areas for improvement identified by counsellors in the survey were related to communication (68.3%) and collaboration (18.8%). In some responses these were general statements, in others there were specific pointers as to how the relationship could be improved:

‘Contact between CAMHS and the school service to be more co-ordinated with information on waiting times and students being shared.’

‘CAMHS need to have a streamlined way in which to respond to professionals, organise regular professionals’ meetings that include the school’s representatives such as SENCOs and safeguarding officers as well as counsellors. They also need to participate in schools and work within a school’s time framework between the hours of 9-3.30pm, and be willing and able to have important meetings in the school setting with professionals and families if they require it.’

‘A group of school-based counsellors in my area have formed a network group. We recognise ‘gaps’ in communication and working together between school-based counsellors and CAMHS in an effort to bridge this gap and for the ultimate benefit of our clients we have been proactive in approaching CAMHS in our area to discuss how we could work more collaboratively.’

The need for greater mutual understanding between the two types of service was also frequently stated. Some counsellors wanted to know more about specialist CAMHS. For instance: ‘A clearer understanding of distinction between Tier 2 and Tier 3’; ‘Frequent meetings to provide an understanding of the limitations of the service they are referring to and other community counselling services’; and ‘I think it could be dramatically improved if CAMHS staff had a greater understanding of the complexity of issues that counsellors/psychotherapists are trained to work with effectively.’

Linked to counsellors’ desire for more *understanding* of their work, were comments that that the relationship would be improved by specialist CAMHS having greater *respect* for what they do (13.9%), and greater understanding or support of the *need* for counselling and psychotherapy (4.0%). For instance: ‘If CAMHS accept counsellors as fellow professionals with knowledge and experience of the young people being referred’; and ‘joint working with complex clients who are not being seen by CAMHS due to long waiting list or who would prefer to be seen by a school counsellor.’

Practical issues mentioned by counsellors (10.9%) included making CAMHS easier to access through lower thresholds, accepting direct referrals from counsellors, having clearer referral criteria, and not always requiring parental involvement. For instance: ‘If a counsellor is referring a client on then there must be a serious issue and it should be dealt with quickly... by being able to refer directly.’

Joint training was mentioned as potentially improving the relationship by 4.0% of respondents. The need for more funding for CAMHS, or from CAMHS for counselling services was also reported.

Counsellors’ views on what they would like specialist CAMHS to know about them.

A summary of counsellors’ views on what they would like colleagues in specialist CAMHS to know about them is presented in Table 8.

Table 8: What counsellors think it would be useful for specialist CAMHS to know about counselling/ psychotherapy for children and young people

Theme	%
Counsellors are valuable professionals	22.0%
Understanding of school and community counselling services	16.5%
The importance of approaches besides CBT	15.4%
That counselling services are limited/ stretched too	13.2%
The importance of sensitivity, flexibility and accessibility in counselling and psychotherapy services for children and young people	11.0%
The importance of ‘continuity in care’ and the therapeutic relationship	11.0%
The problems of only being seen if with a parent	6.6%
Understanding of school systems	5.5%
The links that counselling services have in schools	4.4%
Awareness of school and community counselling services	4.4%

The most frequently mentioned theme in response to this question concerned a desire for recognition of the value of counsellors as professionals. For instance: ‘I think it would be very worthwhile for them to know that there is a good evidence base for the effectiveness of school counselling, and treat school counsellors as fellow professionals.’

Two closely linked themes were *awareness* (4.4%), and *understanding* (16.5%) of school- and community-based counselling services. Examples include: ‘I think that it is important that CAMHS know the school counsellors out in their community and what schools have/don’t have this support’; ‘More about what is offered in our service, what we can and cannot work with effectively’; and ‘The importance of the bond with school counsellors. Students have often been in and out the service and we know the bigger picture really well, and often have parents on board already.’

A third related theme was for specialist CAMHS to understand school systems (5.5%). For instance: ‘It is essential that CAMHS fully appreciate the different pastoral care structures within the different schools they have contact with.’

Another 13.2% of responses were related to the limitations and pressures experienced by counselling services, for example: ‘That we have limitations and long waiting lists too’; and ‘We can only do so much. If we refer to CAMHS it is because we feel the client is out of our remit and we hope they can get the specialist care that CAMHS are supposed to give.’

Four themes were concerned with the service offered by specialist CAMHS, and some of these responses offered either an implied or a direct criticism of CAMHS. 15.4% of participants emphasised the importance of approaches other than CBT, and many of these refer to a person-centred approach, for example, “CYP need to be listened to with empathy and valued and accepted for who they are. Person-centred, core conditions.”

The need for accessibility, sensitivity and flexibility in the provision of services was mentioned by 11.0% of respondents. For instance:

‘The struggle to attend [at] their [CAMHS]’ static location as the families that are referred are often in poverty. As my service goes into the school setting and community, we are more accessible.’

‘[M]any young people speak of feeling confused and let down by CAMHS practitioners. Appointments are often cancelled; they speak of feeling threatened by the multiple of people sitting in on sessions and bleak unfriendly rooms. Parents speak of feeling talked down to and confused by the jargon used.’

The requirement for the involvement of parents in a young person’s attendance at specialist CAMHS (6.6%) and the importance of continuity in therapeutic relationships with young people (11.0%) were other critical themes. Examples include: ‘To know that for many young people the experience of being seen with a parent can be both intrusive and disempowering’; and ‘The importance of continuity of/and the relationship to young people.’

What did counsellors want to know about specialist CAMHS?

Table 9 provides a summary of what counsellors wrote that they would like to know about specialist CAMHS.

Table 9: What counsellors thought it would be useful for them to know about specialist CAMHS

Theme	Sub-theme	%
Service details	General information about CAMHS	26%
	Interventions offered inc. medication	21.9%
	Referral criteria	15.1%
	Practitioners in CAMHS	9.6%
	How the appointment system works	8.2%
	Location specific problems/ issues	5.5%
	Assessment process	5.5%
	Why parental involvement is deemed necessary	2.7%
Contact details for local specialist CAMHS team		17.8%
How counselling services and CAMHS can work together/support each other		11%
Why some CAMHS clients report negative experiences		5.5%
Possibility of funding from CAMHS		2.7%

The majority of information that counsellors reported wanting to know about specialist CAMHS referred to practical aspects of the service, for instance: 'Better working knowledge of their processes and procedures'; 'More detailed referral info available to all therapists'; 'More about medication/clinical supervision re prescriptions'; 'How a client is assessed, what their package of care contains, how they assess when to discharge a client'; and 'What specialist services are available locally and regionally.'

However, some of these answers also seemed to contain an implicit request for specialist CAMHS to explain or justify their practices:

'The theoretical/clinical orientation of staff members. Different Consultant Psychiatrists will sometimes give different diagnosis and treatment plans for the same client.'

'How their appointment system works – they tend to offer appointments monthly rather than weekly – how does this benefit young people?'

'Why are they extremely reluctant to listen to adolescent young people and value their choices and opinions in regard to what they want to happen i.e. mainly to be heard in private usually without parents present.'

How counselling services and specialist CAMHS could work better together was mentioned by 11% of respondents, for instance, 'We are hearing negative stories, waiting times, reduction of qualified staff to cut costs etc etc. We would like contact and discussion as to how we can help.'

Some respondents to this question queried negative experiences they report hearing about from their clients (5.5%). For instance, 'Why clients who are referred to CAMHS so often feel that the support they are provided with is inadequate at best.'

In a few instances (2.7%), counsellors expressed wanting to know how to gain funding from specialist CAMHS, for instance: 'A plan and funding to enable liaison between workers to continue'; and 'More about the possibility of funding.'

Summary

The survey results indicated varying types of interaction reported between specialist CAMHS and counselling services, with 36% of counsellors reporting that their only contact with specialist CAMHS was through referrals. Other frequently-reported types of contact are consultation and co-working with specific clients.

Counsellors indicated a fair degree of confidence in their knowledge of referral criteria to specialist CAMHS, particularly bearing in mind that more than 25.4% of respondents said that their service could not refer directly to specialist CAMHS.

When asked to rate the quality of liaison with specialist CAMHS, answers ranged from 'very good' to 'very bad', with more at the 'bad' end of the spectrum, but by far the greatest number (50%) were neutral ('neither good nor bad').

The most frequently reported reasons for referral from counsellors to specialist CAMHS were to access more specialist intervention and to manage risk.

From the open questions, seven overarching themes appeared repeatedly. These are: counsellors wanting to know more about how specialist CAMHS operate; counsellors valuing specialist CAMHS; communications; the importance of mutual respect between services; differences in the perspectives of counselling services and specialist CAMHS; problems counsellors perceive in the availability and quality of specialist CAMHS provision; and resourcing counselling services and specialist CAMHS. Although these themes occur repeatedly, the experiences of specialist

CAMHS varied from very positive to very negative, and it should not be assumed that any given comment on the relationship between counselling services and specialist CAMHS is a reflection of a universal or even majority experience. What is apparent, however, is that a significant number of counsellors expressed strong negative feelings when describing their experiences with specialist CAMHS.

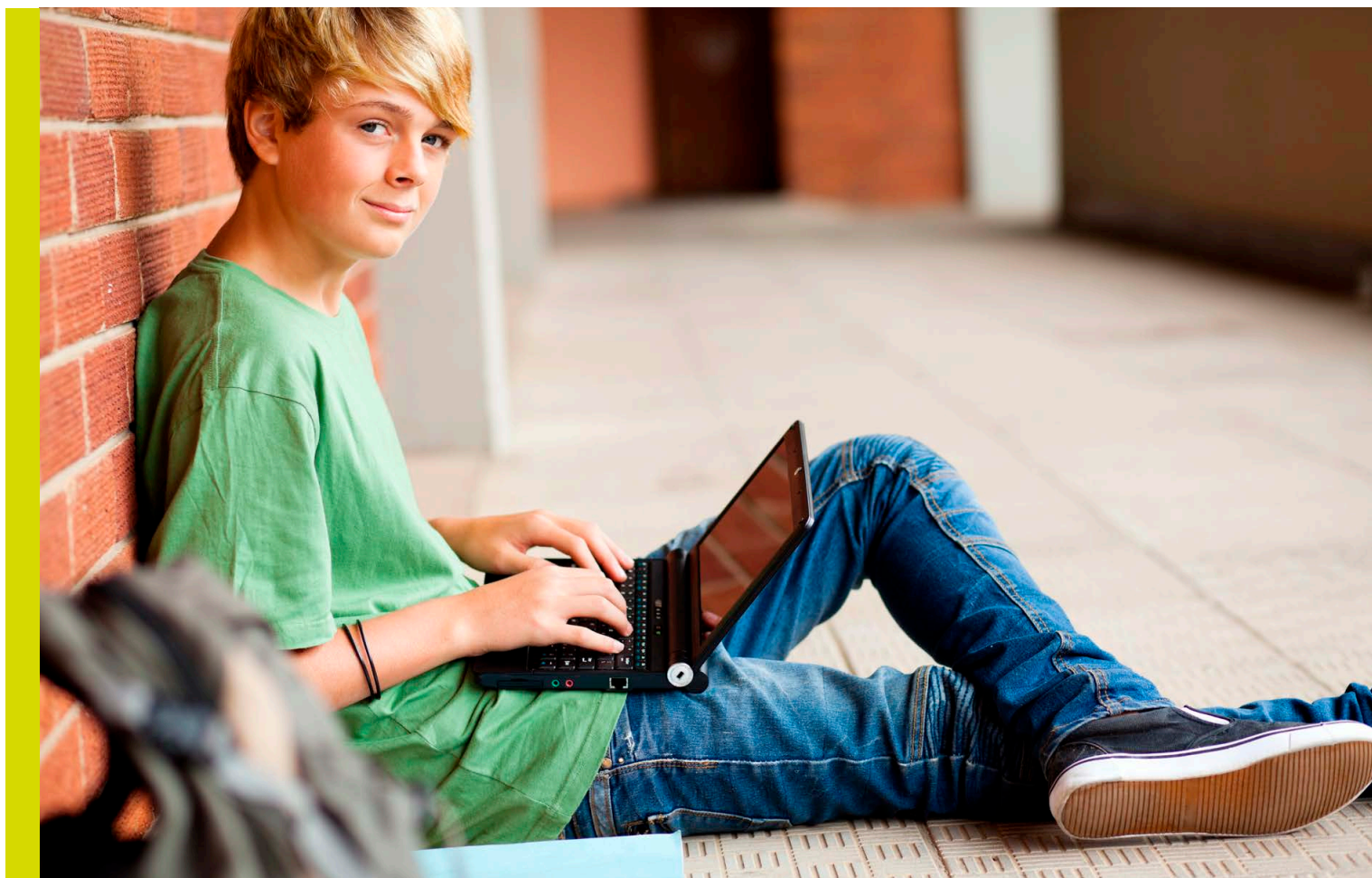
How specialist CAMHS operates. When asked directly, counsellors wrote that they wanted to know more about how specialist CAMHS operated. In most cases this referred to practical matters such as information on contact details, referral systems, appointment systems and other practical matters. A smaller number of counsellors wanted to know about the rationale behind some of the specialist CAMHS policies that counsellors saw as problematic, for example the requirement for parents to be involved when a young person engaged with specialist CAMHS.

Counsellors valuing specialist CAMHS. Counsellors particularly valued the following aspects of the relationship with specialist CAMHS: the availability of consultation, the ability to refer on when a client needs more help than the counsellor can provide, receiving referrals, being respected as a fellow professional, availability of the service locally or in school holidays and joint training.

Communications. The need for good communications between counselling services and specialist CAMHS

was repeatedly stated by survey respondents, and some counsellors reported helpful, clear lines of communication. However, the problem of limited communications was a recurrent theme that appeared in responses to all the open questions. Specialist CAMHS were perceived as not always having sufficient understanding of counselling, school systems, or counsellors' roles in schools. There was not always a direct route of communication between specialist CAMHS and counsellors, particularly school counsellors, even though the counsellor may be the member of staff with the most in-depth knowledge of the young person's mental health issues. In addition, the inclusion of counsellors in inter-agency meetings or other inter-agency work was not universal practice, though it was experienced positively when it occurs. Without such inclusion the counsellor could be frustrated that their perspective on the young person's case was not heard or valued, and concerned they were not being kept informed.

The importance of mutual respect between services. Some counsellors reported supportive and mutually respectful relationships with specialist CAMHS but more commonly respondents reported feeling that their skills, experience and/or qualifications were not respected by specialist CAMHS. Considerable anger and frustration was expressed in these responses. The importance of counselling being available as an alternative option for young people was sometimes seen to be under-rated by specialist CAMHS.



Differences in the perspectives of counselling services and specialist CAMHS. Specialist CAMHS and counsellors were perceived as having different perspectives on a number of issues including confidentiality, modality and flexibility of services. Some counsellors were concerned that specialist CAMHS only valued CBT, and that their services were not young person centred. It was not always clear from the responses whether the counsellors were referring to 'person-centred' as a counselling approach, or in a more general sense of responsiveness to the needs and preferences of the young person, but both an over-focus on CBT at the expense of other types of therapy, and a lack of flexibility to meet the young person's preferences were seen as problematic.

Problems counsellors perceive in the availability and quality of specialist CAMHS provision. Counsellors reported multiple concerns about what specialist CAMHS provided and how they provided it, including inadequate interventions, the requirement of parental involvement with Gillick/Fraser competent young people, negative experiences reported by young people, lack of continuity in client/staff relationships, a focus on CBT only and difficulties in making referrals. Some respondents expressed strong feelings about what they perceived as the failure of specialist CAMHS to develop good relationships with young people or to provide appropriate interventions. In some cases this was allied with an acknowledgement of the limitations of specialist CAMHS resources and the high workloads of specialist CAMHS staff. In other cases, counsellors stated that they did not understand the rationale for policies which they saw as unhelpful to young people.

Resourcing counselling services and specialist CAMHS. Insufficient resources for specialist CAMHS was an occasional theme. This was linked to the high workloads and long waiting lists observed in specialist CAMHS which were perceived as causing problems for both counsellors and their clients when more specialist support was needed. Insufficient resourcing for counselling services was particularly noted in relation to the existence of high admissions criteria for specialist CAMHS.

Summary and conclusion

The main finding from this study is the variability in reported perceptions of specialist CAMHS, counselling services and the relationships between these two types of service across the country. This means that it cannot be assumed that the perceptions reported here apply to every area and service.

The majority of staff in specialist CAMHS clearly differentiated between an appropriate referral to specialist CAMHS and one that is appropriate for counselling services in the community and/or schools, with a focus on risk, the need for multi-disciplinary input, a diagnosable condition, and severe and enduring mental health issues. Specialist CAMHS staff also identified neuro-developmental problems as within their remit. Counsellors also referred to these categories (apart from the neuro-developmental problems) but stated that they frequently worked with young people with moderate to severe mental issues or with significant risk, because of difficulties for young people in accessing or continuing with specialist CAMHS involvement. This is borne out by the empirical evidence [see 8].

The following points emerged, across the study, in relation to what makes a good relationship and conversely, a poor relationship:

- A good relationship between counselling services and specialist CAMHS was understood to be built on good knowledge and understanding of one another's services. At present this understanding is limited in some areas, and in particular, counsellors reported that they would welcome a greater understanding of the processes of specialist CAMHS.
- A good relationship between counselling services and specialist CAMHS was perceived to be built on clear systems for liaison and communication. The extent to which this occurs appears to be very variable.
- Clear referral systems, with acceptance criteria that are understood by referrers, were perceived as helpful in developing a good relationship.
- Appropriate referral systems were perceived as important. Counsellors considered it unhelpful to their clients if counsellors are unable to refer directly to specialist CAMHS. In some cases, young people were seen as needing to access specialist CAMHS through their GP rather than through their counsellor, despite evidence that GP referrals to specialist CAMHS frequently do not meet CAMHS referral criteria [16]. Counsellors also considered it unhelpful if all referrals are channelled through a common point of entry to a Tier 2 service, regardless of the level at which a counsellor has been working with the young person. One alternative suggested was the inclusion of counselling in a single point of entry.

- An effective system whereby counsellors can speedily consult with specialist CAMHS team managers or experienced specialist CAMHS staff was reported as being highly valued by both counsellors and specialist CAMHS staff. Consultation systems using the CAMHS duty advice desk can be helpful, but may provide an unsatisfactory level of support to experienced and well-qualified counsellors if the duty staff are relatively inexperienced.
- An effective working relationship between agencies was perceived to be enhanced by good relationships between individuals. This was seen as facilitating communication, consultation and the provision of a seamless service. Frequently changing staff was seen to inhibit the development of strong interpersonal relationships between agencies.
- A good relationship was seen to be based on mutual respect:
 - Many counsellors reported not feeling respected as professionals by specialist CAMHS.
 - Some specialist CAMHS staff reported having reservations about the training and expertise of some counsellors.
 - Some specialist CAMHS staff expressed great respect for counsellors and appreciated the work of their services.
 - Specialist CAMHS staff did not discuss feeling disrespected by counsellors although some of the criticism expressed by counsellors in this study was very challenging of specialist CAMHS practices and intentions.
- In some areas counsellors reported being asked to cease working with a young person once they have been referred to specialist CAMHS. Counsellors reported concerns that the loss of a longstanding therapeutic relationship can be extremely unhelpful to clients. In some instances, the closure of the counselling relationship was understood by counsellors to be required even while the young person is on the waiting list for an intervention from specialist CAMHS, leaving them without support.
- Differences in the way confidentiality is understood were reported by both counsellors and specialist CAMHS staff. It did not appear that confidentiality was consistently tighter or looser in one group or the other, though some specialist CAMHS found that school counsellors' strong version of confidentiality limited the possibilities of inter-agency working.
- Where services are reported as fragmented, the development of a strong and effective working relationship between specialist CAMHS and counselling services for children and young people was perceived as more difficult to achieve.

In addition, differences in practices, perceptions and tasks of specialist CAMHS and counselling services were identified and acknowledged. Addressing these may improve shared understanding and mutual respect and so enhance the ability to provide a seamless service.

Both specialist CAMHS staff and counsellors in some areas noted that counselling services do not only provide a service for mild to moderate problems, but in addition may offer early intervention and a more accessible service for some clients with severe problems or who are considered to be at risk. They also identified that counsellors sometimes act as a safety net for those young people specialist CAMHS cannot support due to limited resources, for example whilst they are on the waiting list.

This study has indicated that the relationship between specialist CAMHS and school- and community-based counselling services has been reported as variable on a number of dimensions including the extent of mutual knowledge, understanding and respect, levels of interaction, extent of co-working with individual clients, and shared vision of service development. Where the relationship between counselling services and specialist CAMHS was well-developed it could be seen as symbiotic, as the two types of agency worked closely together with mutual respect, using a shared approach to meet the needs of young people with mental health problems.

Aspects of the policies and practice of specialist CAMHS were challenged by some counsellors. These related particularly to the quality and continuity of the relationship developed between staff and the client, interventions that were not seen as young person centred, CBT as the only form of therapeutic intervention, brief interventions, and the requirement to involve parents. Counsellors in some cases queried the rationale for these practices.

The level of acceptance of specialist CAMHS and counsellors co-working with a particular client varied between areas, and demonstrated different perspectives on the skills and experience of counsellors and the preferences of clients:

- Some specialist CAMHS teams reported co-working with, and/or supporting a counsellor to continue to work with, a young person referred to specialist CAMHS if this was the young person's preference or if it seemed to be in their best interest, so long as both interventions do not involve therapy or a therapeutic relationship. Such co-working arrangements were described positively by both counsellors and CAMHS staff.

At the other extreme, in some areas there was considerable distance between counselling provision and specialist CAMHS. Counsellors described feeling disempowered, saw specialist CAMHS as defining the terms of the relationship, and were critical of what specialist CAMHS provides. Specialist CAMHS staff reported questioning the expertise and qualifications of counsellors, and/or seeing the role of counselling as very different to that of specialist CAMHS. It is notable that many of the counsellors who were invited to take part in this study were appreciative of the opportunity to comment on the relationship between counselling and specialist CAMHS as this is an area of concern to them.

In some areas a different scenario was reported in which there was little availability of school- or community-based counselling for children and young people. Here it was reported that specialist CAMHS sometimes put Tier 2 services in place and/or provide a specialist CAMHS presence and mental health screening process in schools.

In a number of areas, respondents commented that recent changes have led to a reduction in availability of counselling services, which has had a knock-on effect on referrals to specialist CAMHS, or vice versa. In addition, it was suggested that competitive tendering has made the process of negotiation and the development of coherent service provision more difficult.

Both counsellors and specialist CAMHS in many areas commented on the high workload of specialist CAMHS staff, the long waiting lists for young people with mental health difficulties to access specialist CAMHS support, and the pressure that this places on counselling services and CAMHS staff alike.

Recommendations

Recommendations for Counselling MindEd

It is recommended that Counselling MindEd sessions include the following:

- Information on the importance of school- and community-based counselling services forging and maintaining strong relationships with specialist CAMHS in their local area(s), including both systematic approaches to communications such as liaison committees and, where possible, relationships with key individuals.
- Information on the importance of school- and community-based counsellors making themselves familiar with the policies and procedures of specialist CAMHS, and in particular, the referral processes and acceptance criteria for specialist CAMHS. This knowledge needs to be refreshed periodically.
- The importance of school- and community-based counselling services regularly updating specialist CAMHS about the counselling service's priorities, policies, client profile and the levels of experience and qualifications of their staff.

- Advice on how to expedite referrals to specialist CAMHS. This includes providing the full information requested by specialist CAMHS in order for a referral to be accepted, and the advantages of consulting with specialist CAMHS team managers or duty advice desk staff where this is available.
- Suggestions of how counsellors and counselling services can work effectively with specialist CAMHS to develop an agreed policy on information sharing, paying attention to both the boundaries of counselling confidentiality, and the importance of counselling services and specialist CAMHS communicating with each other in the interests of the young person's wellbeing.
- Information on the roles, responsibilities and resource constraints of specialist CAMHS, and the ways in which these may result in different priorities and policies to those of counselling services.

Recommendations for specialist CAMHS

It is recommended that specialist CAMHS managers assess the relationship of their service with counselling services in schools and community contexts, and consider the following:

- Forging and maintaining strong relationships with school- and community-based counselling services where this does not already occur. This may include both systemic approaches to communications such as liaison panels or committees and, where possible, relationships with key individuals. Such relationships enable specialist CAMHS and counselling services to develop a sound mutual knowledge of the other's experience, qualifications, policies, procedures and client groups, and encourage confidence in the capacity of the other.
- How best to encourage an informed and mutually respectful relationship between specialist CAMHS and counselling services. In particular it may be useful to explain to counselling services the functioning of specialist CAMHS and the rationale for specialist CAMHS policies on issues such as parental involvement, the length of interventions, multi-disciplinary work and client non-attendance at appointments. Working to develop a shared model of inter-agency information sharing about specific clients may improve the ability of both agencies to respond to the needs of young people with complex problems.
- The ways in which the working relationship with school- and community-based counselling services can be improved, so that these services can be fully supportive of specialist CAMHS in providing a seamless service to children and young people. In particular counselling services can provide early intervention, step down from specialist CAMHS intervention, accessible support for young people who are unable or unwilling to engage in services with their parents, and services for those young people who prefer a more confidential or less medicalised service. In some instances specialist CAMHS may consider joint working or providing the counsellor with

advice, consultation and back-up if it is in the interests of a young person to remain working with a counsellor in a school or community service despite risk levels or problem severity that are sufficient to warrant a referral to specialist CAMHS.

- Ensuring that systems for school- and community-based counsellors to access support and consultation are appropriate to their levels of expertise, and ensuring that counsellors are aware of these routes.
- Ensuring that referral routes to Tier 3 services in specialist CAMHS take account of the previous type and level of support a young person has been receiving in a school- or community-based counselling service, to enable a timely and direct step up in provision from therapy with a counsellor or psychotherapist in these sectors.

Recommendations for national and local policy makers

- Consider how to make more widespread the good practice that is reported in some areas e.g. the creation of systematic links between school- and community-based counselling and specialist CAMHS.
- Note that in some areas, counselling services provide an important source of support for young people who are waiting to access specialist CAMHS.
- Note that counselling services in many areas are reported to be working with young people with increasingly severe and complex mental health difficulties.
- Note that competitive tendering between providers may diminish the cooperation and sharing of knowledge between organisations, and so hinder the provision of a seamless service for children and young people with mental health difficulties.

'It's about actually having open conversations, and that's often the way to start building some relationships.'

(Specialist CAMHS interviewee)

'Good practice is rooted in respect for the other professional.'

(Counsellor interviewee)

'More joined-up thinking, more joined-up work.'

(Counsellor interviewee)

'One of the things I wish we did better in this part of the world is, we would like to actually serve the population of kids around here, together. You have these skills to offer, we have these skills to offer, let's sit down and look at our referral list and look at what we can do here, but that's not the way it works.'

(Specialist CAMHS interviewee)

'I am aware that I have moaned quite considerably about CAMHS, and yet I want to repeat what I said earlier... there are some really, really good supportive people, who do work there. ... This is an opportunity, really to be heard, so I appreciate it,'

(Counsellor interviewee)

List of abbreviations

BACP	British Association for Counselling and Psychotherapy
CAMHS	Child and Adolescent Mental Health Service
CYP	Children and Young People
IAPT	Improving Access to Psychological Therapies

References

1. Department for Children, Schools and Families and Department of Health, *Children and Young People in Mind: the Final Report of the National CAMHS Review*, 2008. Department of Health: London.
2. Department for Children, Schools and Families and Department of Health, *Keeping Children and Young People in Mind: Full Government Response to the CAMHS Review*, 2010. Department for Children, Schools and Families / Department of Health: London.
3. Department of Health, *No Health without Mental Health: A Cross-Government Mental Health Strategy for People of All Ages*, 2012. Department of Health: London.
4. Department of Health, *No Health Without Mental Health: Implementation Framework*, 2012. Department of Health: London.
5. Department of Health – Children and Young People, *You're Welcome: Quality Criteria for Young People Friendly Health Services*, 2011. Department of Health: London.
6. Department for Education and Skills. *Every Child Matters*. (Cm 5860, 2003). HMSO: London.
7. National CAMHS Support Service, *CAMHS in Context: Helping You to Achieve Better Outcomes for Children and Young People*, 2010. OCB Publishing Ltd: Leicester. <http://www.wikicamhs.co.uk/home/induction/CD1/documents/Workbook.pdf>
8. Cooper, M., *School-Based Counselling In UK Secondary Schools: A Review and Critical Evaluation*, 2013. British Association of Counselling and Psychotherapy: Lutterworth.
9. Polat, F. and Jenkins, P., *Provision of counselling services in secondary schools: a survey of local education authorities in England and Wales*, Pastoral Care in Education, 2005. **23**: 17–24.
10. Pattison, S., Rowland, N. et al., *A research study into counselling services for children and young people in Wales*, 2007. British Association for Counselling and Psychotherapy: Lutterworth.
11. Cromarty, K. and Richards, K. *How do secondary school counsellors work with other professionals?* Counselling and Psychotherapy Research, 2009. **9**(3): 182–186.
12. Pettit, B., *Effective Joint Working Between Child and Adolescent Mental Health Services (CAMHS) and Schools*, Research Report N. 412, 2003. Department for Education and Skills: London.

13. Youth Access, *Access to Counselling: Key Findings*, 2005. Youth Access: London.
14. McKenzie, K., Murray, G. C. et al, *An evaluation of a school counselling service with direct links to child and adolescent mental health (CAMH) services*. British Journal of Guidance and Counselling, 2010. **39**(1): 67–82.
15. England, E. Lester, H. and Birchwood, M., *Collaborating to provide early-intervention services to persons in England with first-episode psychosis*, Psychiatric Services, 2009. **60**(11):1484–8.
16. Hinrichs, S., Owen, M. et al. *General practitioner experience and perception of Child and Adolescent Mental Health Services' (CAMHS) care pathways: a multimethod research study*. British Medical Journal, 2012. pen.2012:e001573doi:10.1136/bmjopen-2012-001573
17. Appleton, P. *Tier 2 CAMHS and its interface with primary care*. Advances in Psychiatric Treatment, 2000. **6**: 388–396
18. Pybis, J., Hill, A. et al., *A comparative analysis of the attitudes of key stakeholder groups to the Welsh Government's school-based counselling strategy*. British Journal of Guidance & Counselling, 2012. **40**(5): p. 485–498.

Bibliography

British Association of Counselling and Psychotherapy, *Counselling Children and Young People: A Systematic Scoping Review*, 2004. British Association for Counselling and Psychotherapy: Lutterworth.

Department for Education, *Me and My School: Findings from the National Evaluation of Targeted Mental Health in Schools 2008-2011*. Research Report DFE-RR177 2012. Department for Education: London.

Department of Health, *Improving Access to Child and Adolescent Mental Health Services: reducing waiting times policy and practice guide*, 2009. Department of Health/ Department for Children, Schools and Families: London.

Department of Health, *National Service Framework for Children, Young People and Maternity Services*, 2004. Department of Health: London.

Hill, A., Cooper, M., et al., *Evaluation of the Welsh School-based Counselling Strategy*, 2011. Welsh Government Social Research: Cardiff.

Welsh Assembly Government, *Everybody's Business: Improving Mental health Services in Wales: Child and Adolescent Mental Health Services (CAMHS) Strategy*, 2001. Welsh Assembly Government: Cardiff.

Appendices

Appendix 1: E-survey questions.

1. **Gender (please select one)**
 - Male
 - Female
2. **Highest level of counselling qualification (please select one)**
 - Diploma
 - Undergraduate degree
 - Postgraduate Diploma
 - Masters
 - Doctorate
 - Other (please specify)
3. **Which theoretical modality are you trained in? (Please select all that apply)**
 - CBT
 - Gestalt
 - Humanistic
 - Integrative
 - Person-centred
 - Psychodynamic
 - Other (please specify)
4. **Whereabouts in the UK do you work? (Please select one)**
 - England
 - Wales
 - Scotland
 - Northern Ireland
5. **Which of the following best describes your place of work? (Please select all that apply)**
 - School-based counselling service
 - Community/third-sector-based counselling service
 - Private practice
 - Specialist CAMHS
 - Other service that provides counselling/ psychotherapy to children and young people
 - Other (please specify)
6. **Which of the following best describes your work role? If you work in more than one role, please select the one that is most relevant.**
 - A counsellor working with children and young people
 - A psychotherapist/ art psychotherapist/ music therapist working with children and young people
 - A manager or team leader in a service offering counselling to children and young people
 - Supervisor
 - Trainer
 - Researcher
 - Other (please specify)
7. ***How long have you worked as a counsellor for children and young people? (Please select one)**
 - Less than 5 years
 - Between 5 and 10 years
 - Between 10 and 15 years
 - Between 15 and 20 years
 - More than 20 years
8. ***How long have you worked as a psychotherapist/ art psychotherapist/ music therapist with children and young people? (Please select one)**
 - Less than 5 years
 - Between 5 and 10 years
 - Between 10 and 15 years
 - Between 15 and 20 years
 - More than 20 years
9. ***How long have you worked as a manager or team leader in a service offering counselling to children and young? (Please select one)**
 - Less than 5 years
 - Between 5 and 10 years
 - Between 10 and 15 years
 - Between 15 and 20 years
 - More than 20 years
10. ***How long have you worked as a supervisor? (Please select one)**
 - Less than 5 years
 - Between 5 and 10 years
 - Between 10 and 15 years
 - Between 15 and 20 years
 - More than 20 years
11. ***How long have you worked as a trainer? (Please select one)**
 - Less than 5 years
 - Between 5 and 10 years
 - Between 10 and 15 years
 - Between 15 and 20 years
 - More than 20 years
12. ***How long have you worked as a researcher? (Please select one)**
 - Less than 5 years
 - Between 5 and 10 years
 - Between 10 and 15 years
 - Between 15 and 20 years
 - More than 20 years
13. **How long have you worked in your current role? (Please select one)**
 - Less than 5 years
 - Between 5 and 10 years
 - Between 10 and 15 years
 - Between 15 and 20 years
 - More than 20 years

14. How long have you worked within the field of child and adolescent mental health? (Please select one)
- Less than 5 years
 - Between 5 and 10 years
 - Between 10 and 15 years
 - Between 15 and 20 years
 - More than 20 years
15. Which of the following best describes your work relationship with specialist CAMHS? (Please select one)
- I work in specialist CAMHS
 - I work in a service funded by CAMHS
 - I work regularly with specialist CAMHS but my work is not funded by them
 - I work occasionally with specialist CAMHS but my work is not funded by them
 - My service works regularly with specialist CAMHS but I do not have much contact with them myself
 - My service works occasionally with specialist CAMHS but I do not have much contact with them myself
 - Neither I nor my service has contact with specialist CAMHS
16. How good or bad would you rate the level of liaison between your service and specialist CAMHS? (Please select one) (1=very bad, 2= bad, 3 = neither good nor bad, 4 = good, 5=very good.)
17. How confident are you in your knowledge about the referral criteria for specialist CAMHS? (Please select one.) (1=very unconfident, 2=quite unconfident, 3 = neither confident not unconfident, 4 =confident, 5= very confident.)
18. Which of the following best describes the referrals from your service to specialist CAMHS?
- My service can refer to specialist CAMHS at our discretion
 - My service can refer to specialist CAMHS in certain circumstances
 - My service cannot refer directly to specialist CAMHS
 - Don't know
 - Other (please specify)
19. Which of following best describes the reasons why your service refers to specialist CAMHS? (Please select all that apply)
- Availability of one-to-one counselling
 - Availability of family therapy
 - Availability of art therapy
 - Availability of group work/therapy
 - Availability of medication
 - So the client can be seen without parental knowledge /involvement
 - So the client can be seen with a parent
 - Flexible appointment times
 - Availability of drop-in facility
 - To give the client choice in who they see
 - Quicker access/ shorter waiting list
 - Availability of longer term work
 - Need for more specialist intervention
 - Identification of client as 'high risk'
 - Don't know
 - Other (please specify)
20. Which of following best describes the referrals to your service from specialist CAMHS? (Please select all that apply)
- My service regularly receives referrals from specialist CAMHS
 - My service occasionally receives referrals from specialist CAMHS
 - My service never receives referrals from specialist CAMHS
 - Don't know
 - Other (please specify)
21. Which of following best describes the reasons why your service receives referrals from specialist CAMHS? (Please select all that apply)
- Availability of one-to-one counselling
 - Availability of family therapy
 - Availability of art therapy
 - Availability of group work/therapy
 - Availability of medication
 - So the client can be seen without parental knowledge /involvement
 - So the client can be seen with a parent
 - Flexible appointment times
 - Availability of drop-in facility
 - To give the client choice in who they see
 - Quicker access/ sorter waiting list
 - Availability of longer term work
 - Need for more specialist intervention
 - Identification of client as 'high risk'
 - Don't know
 - Other (please specify)

22. Other than referrals, does your service interact with specialist CAMHS in any of the following ways?

(Please select all that apply)

- A specialist CAMHS representative sits on a management group/ committee for my service
- A representative from my service sits on a consultative or strategic group/panel/ committee for specialist CAMHS
- Members of specialist CAMHS and my service meet/liase regularly
- Members of staff from specialist CAMHS and my service co-work with particular clients
- Staff from specialist CAMHS sometimes contact my service for consultation, advice or information
- Staff from my service sometimes contact specialist CAMHS for consultation, advice or information
- Counsellors/ psychotherapists from my service receive supervision from specialist CAMHS
- CAMHS provide training to counsellors/ psychotherapist from my service
- My counselling service is funded/part-funded by specialist CAMHS
- No, my service only interacts with specialist CAMHS around referrals
- Don't know
- Other (please specify)

23. Which of the following best describes how often you, on average, liaise with staff of specialist CAMHS about particular clients? (Please select one)

- Once a week or more often
- Once a month or more, but less than once a week
- Once a year or more, but less than once a month
- Less than once a year
- I never liaise with specialist CAMHS

24. What do you see as the positive aspects of the relationship between your service and specialist CAMHS?

25. What do you see as the negative aspects of the relationship between your service and specialist CAMHS?

26. How do you think the relationship between your service and specialist CAMHS could be improved?

27. What, if anything, would you/ your service like to know about specialist CAMHS?

28. What, if anything, do you think it would be useful for specialist CAMHS to know about your service?

*Respondents were invited to answer only one of the questions marked with an asterix, according to how they described their work role.

Appendix 2: Interview format*

Background information

1. Could you tell me what your job/s or role/s is/are?
2. How long have you been working as a counsellor for children and young people?
3. What part of the country do you work in?
4. Have you had any contact with a specialist CAMHS team during your current (or recent) work as a counsellor/psychotherapist?

Knowledge and referrals

5. Are you familiar with the specialist Child and Adolescent Mental Health Services locally? What do you know about what they do and how they work? Do you or your service work with/refer to or relate in any other way to these with this/these services?
6. How would you describe the difference between what is an appropriate referral to specialist CAMHS and an appropriate referral to a counselling service?
7. What can specialist CAMHS provide that is helpful to the work of counsellors of children and young people? What can a counselling service for children and young people provide that specialist CAMHS cannot? In your experience, how does this work in practice?
8. Can you give me an example of when you have worked or would have liked to work in conjunction with a specialist CAMHS?

Good practice

9. In what ways does your counselling service/s work well with (the) specialist CAMHS team/s?
10. In what ways could this work be improved?
11. Can you give any examples of what you would see as good practice for the relationship between specialist CAMHS and counselling services for children and young people? (Without giving any identifying details of people or agencies.)
12. Can you give any examples of not such good practice in the relationship between CAMHS and counselling services for children and young people? (Without giving any identifying details of people or agencies.)
13. Is there anything else you'd like to tell us about the relationship between specialist CAMHS and counselling for children and young people?

*This is the interview format used with the main group of counsellors. Minor adaptations were made to make it applicable to the other groups of respondents.

Appendix 3a: Demographic data of interview participants¹²

Table 1: Gender of informants

Counsellors (school- or community-based)	Male	Female	Total
No.	3	16	19
%	15.8%	84.2%	100%
Specialist CAMHS staff	Male	Female	Total
No.	3	11	14
%	21.4%	78.6%	100%

Table 2: Ethnicity of informants

Counsellors	White British/UK	White other	Mixed Caribbean	Not known	Total
No.	11	2	1	5	19
%	57.9%	10.5%	5.3%	26.3%	100%
Specialist CAMHS	White British/UK	White other	Other	Not known	
No.	8	2	0	4	14
%	57.1%	14.3%	0%	28.6%	100%

Table 3: Respondents' professional training (specialist CAMHS sample)

Training	Clinical psychologist	Occupational therapist	Social worker	Psycho-therapist	Art psycho-therapist	Counsellor	Nurse
No.	3	1	3	2	1	4	1
%	21.4%	7.1%	21.4%	14.3%	7.1%	28.6%	7.1%

'Psychotherapist' includes family therapist, cognitive-behavioural psychotherapist. Figures do not add up to 14 as one respondent reported more than one professional training.

Table 4: Respondents' current roles in specialist CAMHS (specialist CAMHS sample)

Roles	Manager of one or more teams	Clinical psychologist	OT	Mental health practitioner	Psycho-therapist	Child mental health specialist	Counsellor	Primary mental health worker	Total
No.	3	2	1	2	1	1	2	2	14
%	21.4%	14.3%	7.1%	14.3%	7.1%	7.1%	14.3%	14.3%	100%

¹² All figures are rounded to one decimal point.

Table 5: Respondents' years of experience in specialist CAMHS or equivalent (specialist CAMHS sample)¹³

Years	Less than 1	1–4	5–9	10–14	15–19	20+	Not known	Total
No.	1	2	1	4	3	0	3	14
%	7.1%	14.3%	7.1%	28.6%	21.4%	0%	21.4%	100%

Table 6: Types of specialist CAMHS team respondents worked in

Team	Tier 2 CAMHS	Generic CAMHS	Adolescent	Under 12s	Looked after and adoption	Cross team/ multi team role	Total
No. of respondents	2	6	1	2	1	2	14
%	14.3	42.9	7.1	14.3	7.1	14.3	100%

Table 7: Respondents' years working in the context of counselling children and young people (counselling sample)

Years	Less than 1	1–4	5–9	10–14	15–19	20+	Not known	Total
No.	0	2	3	3	2	6	3	19
%	0%	10.5%	15.8%	15.8%	10.5%	31.6%	15.8%	100%

Table 8: Respondents' primary roles in relation to counselling children and young people (counselling sample)

Role	Counsellor/psychotherapist	Lead for counselling service	Other senior /lead role	Total
No.	10	6	3	19
%	52.6%	31.6%	15.8%	100%

Table 9: Types of counselling service reported on by counselling sample

Service	Community-based	School-based	Both school- and community-based	Total
No. of respondents	5	9	5	19
%	26.3%	47.4%	26.3%	100%

Table 10: Geographical location of informants' work

Counselling sample	London	S.E. England (other)	Midlands/ Central	N.E. England	N.W. England	W./ S.W. England	E. England	Wales/ N.Ireland	National	Total
No.	4	3	3	2	1	2	0	2	2	19
%	21.1%	15.8%	15.8%	10.5%	5.3%	10.5%	0%	10.5%	10.5%	100%
CAMHS sample	London	S.E. England (other)	Midlands/ Central	N.E. England	N.W. England	W./ S.W. England	E. England	Wales/ N. Ireland	National	Total
No.	4	2	1	0	1	4	2	0	0	14
%	28.6%	14.3%	7.1%	0%	7.1%	28.6%	14.3%	0%	0%	100%

¹³ These figures are indicative only as no precise measure of experience was specified.

Appendix 3b: Demographic data of survey participants

Table 11: Gender

Gender (please select one)		
Answer Options	Response Percent	Response Count
Male	7.5%	10
Female	92.5%	124
answered question		134
skipped question		0

Table 12: Highest level of counselling qualification

Highest level of counselling qualification (please select one)		
Answer Options	Response Percent	Response Count
Diploma	29.9%	40
Undergraduate degree	6.0%	8
Postgraduate diploma	31.3%	42
Masters	24.6%	33
Doctorate	3.7%	5
Other (please specify)	4.5%	6
answered question		134
skipped question		0

Table 13: Theoretical modality of training

Which theoretical modality are you trained in? (Please select all that apply)		
Answer Options	Response Percent	Response Count
CBT	20.9%	28
Gestalt	9.0%	12
Humanistic	26.9%	36
Integrative	47.8%	64
Person-centred	43.3%	58
Psychodynamic	30.6%	41
Other (please specify)	14.9%	20
answered question		134
skipped question		0

Table 14: Work location by country

Whereabouts in the UK do you work? (Please select one)		
Answer Options	Response Percent	Response Count
England	87.3%	117
Wales	7.5%	10
Scotland	2.2%	3
Northern Ireland	3.0%	4
answered question		134
skipped question		0

Table 15: Place of work

Which of the following best describes your place of work? (Please select all that apply)		
Answer Options	Response Percent	Response Count
School-based counselling service	70.1%	94
Community/ third sector-based counselling service for children and young people	22.4%	30
Private practice	27.6%	37
Specialist CAMHS	5.2%	7
Other service which provides counselling/ psychotherapy for children and young people	9.7%	13
Other (please specify)	14.9%	20
answered question		134
skipped question		0

Table 16: Work role

Which of the following best describes your work role? If you work in more than one role, please select the one that is most relevant.		
Answer Options	Response Percent	Response Count
A counsellor working with children and young people	70.1%	94
A psychotherapist/ art psychotherapist/ music therapist working with children and young people	6.8%	9
A manager or team leader in a service offering counselling to children and young people	14.9%	20
Supervisor	3.7%	5
Trainer	1.5%	2
Researcher	0.0%	0
Other (please specify)	3.0%	4
answered question		134
skipped question		0

Table 17: Years as a counsellor for children and young people

How long have you worked as a counsellor for children and young people? (Please select one)		
Answer Options	Response Percent	Response Count
Less than 5 years	31.9%	30
Between 5 and 10 years	40.5%	38
Between 10 and 15 years	18.1%	17
Between 15 and 20 years	7.4%	7
More than 20 years	2.1%	2
answered question		94
skipped question		40

Appendix 4: Survey of counsellors: summary of themes and subthemes from open-ended questions, with example responses¹⁴

‘What do you see as the positive aspects of the relationship between your service and specialist CAMHS?’

Theme no.	Theme	Subtheme	%	Examples
1	Service issues	CAMHS as an ‘expert’/specialist support service	40.9%	‘I can get more specialised help for pupils, that I can’t provide’ ‘Being able to make a referral for more complex cases, which I believe need more specialist help’ ‘Anything out of my expertise can be re-assessed by somebody more qualified’ ‘It provides a back-up for us – somewhere to refer more serious cases to or to get an assessment/ second opinion’
		Availability of CAMHS – locally/during school holidays	5.4%	‘I know that the service is available locally’ ‘That the service is available’ ‘Can see clients during school holidays’
		CAMHS can prescribe medication	2.2%	‘...they can sometimes prescribe medication’ ‘Pupils can obtain psychiatric assessment and medication if required’
2	Working towards a shared goal		32.3%	‘We are both in the business of providing excellent care for our client group’ ‘Both attempting to find available solutions to young people’s needs’ ‘The opportunity to provide wrap-around care for young people, to liaise to ensure young people get the service they need’
3	Good communication		24.7%	‘Some of the inter-agency relationships are really good depending on the member of staff at CAMHS.’ ‘...we are able to discuss concerns and receive a CAMHS assessment with an outreach psychiatric nurse. She is very supportive towards all school staff, and is a great point of contact. Also, I can ring the CAMHS team if I have particular concerns about a client. I have always felt listened to, taken seriously and supported when I have made such calls.’ ‘...sharing information – whilst respecting client confidentiality. Building positive inter-agency works. Communication of safeguarding issues...’

¹⁴ Percentages in all tables may total more than 100% as some responses may have expressed multiple themes. Percentages calculated as a proportion of the total number of appropriate responses given to the question.

Theme no.	Theme	Subtheme	%	Examples
4	Referrals	Referrals to CAMHS	11.8%	'Direct referral route into Tier 3 mental health support' 'To make referrals if needed...' 'I have been able to refer in 'at risk' clients and have had the referral accepted'
		Referrals from CAMHS	4.3%	'...they refer to us' 'Occasionally they will refer back to the school counselling service with some information on the student and their progress to date' 'When they send clients to me'
5	Mutual respect		8.6%	'Mutual respect gained by CAMHS realising I was as well qualified as their therapists' 'There is usually mutual respect' 'There is mutual respect, trust and willingness...' 'They know about us, they trust us for counselling young people'
6	Training opportunities		2.2%	'Training provided by specialist CAMHS workers has been good' '...working together to deliver training'

'What do you see as the negative aspects of the relationship between your service and specialist CAMHS?'

Theme no.	Theme	Sub-theme	%	Examples
7	Communication issues	Lack of direct communication between the two services	31.1%	'Not being contacted by CAMHS when a client is referred to them, say by parents, even though the client tells them they are receiving weekly 1-1 counselling' 'Often we may be doing the same work without knowing the input of the other' 'Not enough communication and sharing good practice'
		Poor quality of communication between services	21.4%	'Inappropriate sharing of information, insecure boundaries, inappropriate, incorrect and unchecked quoting of school therapists to the parents thus negatively impacting and in some cases breaking down a previously strong therapeutic attachment. Because of this I now avoid contact with CAMHS...' 'The staff are unhelpful' 'Poor communication' 'They often barely give us any info or any warning – a fax appears out of the blue!'
		Poor communication between CAMHS and clients	3.9%	'Extremely reluctant to hear the voice of Fraser competent young people without parents present, which in turn closes down the 'voice' of the young person.' 'Overreacting to teenage development and natural teenage concerns and difficulties within secondary schools' 'Clients accessing CAMHS are often encouraged to stop receiving on-going therapy from my service, even if this is well established and unwanted'

Theme no.	Theme	Sub-theme	%	Examples
8	Service issues	Referral difficulties	17.5%	'CAMHS criteria for acceptance of referrals (which in my area are exclusively through PCAMHS) are not in line with NICE guidelines.' 'CAMHS is able to reject referrals from our service, but the system doesn't permit us to reject referrals from CAMHS' 'CAMHS have informed me that I cannot make direct referrals. Only the GP, school nurse etc can do so. This adds an unnecessary step to a referral...'
		Long waiting lists in CAMHS	17.5%	'Waiting lists are ridiculously high.' 'Long waiting lists for services mean that we cannot offer a seamless service' '...sometimes we "hold" clients in desperate need of CAMHS support because the waiting lists are just too long'
		High workload of CAMHS	8.7%	'They are too overworked...' 'My experience with some services in London, was that they were very pushed for time and didn't seem to be able to offer a completely consistent service' 'There are too many barriers to working effectively such as time constraints, overload and a very small team of staff'
		High staff turnover rates in CAMHS	4.9%	'Changing CAMHS staff so that they do not know of our expertise...' 'CAMHS workers seem to change regularly which affects depth of relationships and consistency, with both counsellor and client'
		Perceived limitations of CAMHS input	3.9%	'Lack of availability to see worst case scenarios – not seeing the full risk or choosing to prevaricate' 'When a client is referred on safeguarding issues, they assess and then hand back. There does not seem to be any specialist intervention work done, the case is just referred back' 'Very limited 1-1 therapeutic support or indeed any therapeutic support'

Theme no.	Theme	Sub-theme	%	Examples
9	Client issues	Negative experiences of clients/families who have accessed CAMHS	10.7%	'...our clients' Mum is very concerned and is unhappy with the service, as are we' 'Clients feedback has not always been positive, unapproachable staff, then disengagement likely' 'Often I see students who have had negative experiences with CAMHS so refuse referral'
		Difficulties with family involvement	5.8%	'Are not willing to visit a young person in school, when specifically asked by a young person if they would do so, in cases where young people do NOT want or are not able to talk freely in front of parents' 'They are very narrow in their attitude to dysfunctional families. If the family doesn't turn up twice, then the child is assumed not to be in need. The fact that dysfunctional families are so chaotic doesn't seem to register' 'The local CAMHS team insists on involving parents where the child is under 16, which inhibits referrals to them...'
		Confidentiality issues	4.9%	'The negative aspect may be that the young person wants to keep separateness and may not wish school/school counsellors to know that they are accessing the CAMHS service' 'The fact that as school counsellors we...have to go through the school nurse, or the outreach psychiatric nurse. Sometimes this feels like sharing too much information with too many people for my clients' 'confidentiality conflicts'
10	Therapist issues	Perceived lack of respect for counsellors	14.6%	'They are precious about their work. Their attitude to others outside their circle is superior. My experience, except rarely, is that I am not a professional colleague' '...individual psychiatrists have differing attitudes toward my capabilities as a counsellor' 'We are often used as a dumping ground when waiting lists too long or nowhere else to go' '...I have a perception that they feel they are the specialists and I am just the counsellor' 'I have experience of several male CAMHS workers in different settings and counties who seem arrogant in their approach to clients, parents and other services involved. School counsellors sometimes not valued as professional, rigorously trained and boundaried practitioners'
		Counsellors not included in inter-agency work	1.9%	'One member of staff who is not a therapist does not consider inter-agency work as being beneficial' 'The meetings are held with the teachers and parents and sometimes the agencies within the school, the counsellor, art therapist and music therapist are not involved so their individual input is not included'

Theme no.	Theme	Sub-theme	%	Examples
11	Financial issues	CAMHS underfunded	2.9%	'CAMHS as a concept is great, however as they are underfunded, undermanned and overworked, their morale is low and this often shows in their communications' 'CAMHS is overloaded with work – underfunded'
		Lack of funding for counselling and psychotherapy services	1.9%	'In the locality that I work in, CAMHS have a tendency to refer back to us and as a charity we struggle with funding and are given no financial support whatsoever' '...lack of funding to continue the training' 'Constraints of service availability and funding, which I recognise as a national issue'

'How do you think the relationship between your service and specialist CAMHS could be improved?'

Theme No.	Theme	Sub-theme	%	Examples
12	Improve communication		68.3%	'More co-operation and communication' 'Contact between CAMHS and the school service to be more co-ordinated with information on waiting times and students being shared' 'CAMHS need to have a streamlined way in which to respond to professionals, organise regular professionals' meetings that include the school's representatives such as SENCOs and safeguarding officers as well as counsellors. They also need to participate in schools and work within a school's time framework between the hours of 9-3.30pm, and be willing and able to have important meetings in the school setting with professionals and families if they require it'
13	Improve understanding of what each service provides	If CAMHS better understood counselling services	18.8%	'For CAMHS to have a greater understanding of the service we provide' 'I think it could be dramatically improved if CAMHS staff had a greater understanding of the complexity of issues that counsellors/ psychotherapists are trained to work with effectively' 'Frequent meetings to provide an understanding of the limitations of the service they are referring to and other community counselling services'
		For counselling services to understand CAMHS better	12.9%	'...a clearer understanding of distinction between Tier 2 and tier 3.' '...more information needs to be shared about their provision.' 'Better understanding on both services from practitioners about what is on offer'
14	Work more collaboratively		18.8%	'A group of school-based counsellors in my area have formed a network group. We recognise 'gaps' in communication and working together between school-based counsellors and CAMHS in an effort to bridge this gap and for the ultimate benefit of our clients we have been proactive in approaching CAMHS in our area to discuss how we could work more collaboratively' '...a focus on working together with clarity of roles' 'Joined up working with an identified CAMHS link...' 'Increase contact and joint working opportunities'

Theme No.	Theme	Sub-theme	%	Examples
15	For CAMHS to respect counselling services and staff		13.9%	'More availability and mutual respect for service provision' '...CAMHS taking a more positive view of school counsellors' 'If independent, experienced counsellors like myself were valued professionally' 'If they would listen to people like me more – they tend to be very 'ivory-tower-ish' and I don't feel many of them are in the 'real' world of the children I see on a daily basis' 'If CAMHS accept counsellors as fellow professionals with knowledge and experience of the young people being referred'
16	Make CAMHS easier to access		10.9%	'By being able to refer directly...' 'A clearer framework for referrals for clients to access specialists for immediate intervention' '...clear referral pathways.' 'If a counsellor is referring a client on then there must be a serious issue and it should be dealt with quickly' 'Faster referral available' 'Accept under 16 referrals without parental involvement' '...lower criteria'
17	More funding	More funding for services/training in general	6.9%	'If the constraints to...funding were less intrusive' 'More funding for CAMHS staff to come to our premises and discuss cases...' 'More...funding' 'In short, appropriate, ring-fenced, funding for the service' '...guaranteed funding'
		For CAMHS to fund/part-fund counselling services/training	2%	'For CAMHS to fund our work' 'They could commission our services so we could provide the services they are not able to'
18	Joint training		4.0%	'Some joint training' 'Joint training' 'Maybe more training together or conferences specifically for the counsellors/therapists working in schools or with young people.' 'More involvement in schools, training...'

Theme No.	Theme	Sub-theme	%	Examples
19	For CAMHS to understand and support the need for counselling		4.0%	'...joint working with complex clients who are not being seen by CAMHS due to long waiting list or who would prefer to be seen by a school counsellor' 'It's not about our relationship – it's about their capacity – they do not seem to take on young people unless they are really severe, and we have to plug the gap' '...to share care on discharge from their service to ensure that the client is able to access support in school if needed' 'CAMHS do not have enough capacity and use our service as an overflow – sometimes young people who need specialist support can't be seen by CAMHS due to limited availability'

'What, if anything, do you think it would be useful for specialist CAMHS to know about counselling/psychotherapy for children and young people?'

Theme		%	Examples
20	Counsellors are valuable professionals	22.0%	
21	Understanding of school and community counselling services	16.5%	'To understand the work that others are doing and how to work complementary in the best way to meet the needs of children, young people and their families' 'More about what is offered in our service, what we can and cannot work with effectively' 'An understanding of the nature of counselling and therapy needed for children who have complex medical needs/disabilities/life threatening illnesses' 'To understand what service is being offered in school and how we can support each other'
22	The importance of approaches besides CBT	15.4%	'CYP need to be listened to with empathy and valued and accepted for who they are. Person-centred, core conditions' 'To address the assessment process and formulate the most effective intervention for the individual and not be confined to one counselling orientation' 'That counsellors are open to the concept of multi-disciplinary approaches and are able to fit into teams for benefit of client. However CAMHS teams need to realise that clients must always be at centre of any work!' 'That CBT is not the only answer...' '...from my experience a person-centred approach with children is neglected'
23	That counselling services are limited/ stretched too	13.2%	'Young people's counselling services have long waiting lists for appropriately referred Tier 2 clients. Pressure from CAMHS, parents and school staff to see Tier 3 is ever increasing' 'That we have limitations and long waiting lists too' 'We can only do so much. If we refer to CAMHS it is because we feel the client is out of our remit and we hope they can get the specialist care that CAMHS are supposed to give' 'I think they sometimes forget we have waiting lists too' 'The number of children and young people and their families who urgently need counselling'

Theme	%	Examples
24	The importance of sensitivity, flexibility and accessibility in counselling and psychotherapy services for children and young people	11.0% ‘The struggle to attend their static location as the families that are referred are often in poverty. As my service goes into the school setting and community, we are more accessible’ ‘...appointments can only happen during term time, and then the pupil can be left vulnerable during the holidays’ ‘The school counsellor’s daily accessibility for students, pupils and staff’ ‘Grief is a natural reaction to early bereavement but this doesn’t mean that clients should not have support, some in the form of counselling/ psychotherapy’ ‘...many young people speak of feeling confused, and let down by CAMHS practitioners. Appointments are often cancelled, they speak of feeling threatened by the multiple of people sitting in on sessions and bleak unfriendly rooms. Parents speak of feeling talked down to and confused by the jargon used... One client (12 years old) following an alleged sexual abuse found herself in a room with three professionals who asked her to undress for a physical examination...she was re-traumatised by this event and both mother and daughter altered the evidence given, as a result. This seemed highly insensitive and abusive to me’
25	The importance of ‘continuity in care’ and the therapeutic relationship	11.0% ‘That continuity is key...’ ‘It is the relationship that is important...’ ‘That they often want to maintain access to previous therapists for ongoing support and feel forced to make an either/or choice in order to gain access to CAMHS’ ‘The importance of continuity of/and the relationship to young people’ ‘The importance of maintaining a therapeutic alliance, relationship development’ ‘That counselling is a complex process and emotional wellbeing cannot always be defined by outcome measures – that it takes time to build a trusting relationship with a child/young person’
26	The problems of only being seen if with a parent	6.6% ‘To know that for many young people the experience of being seen with a parent can be both intrusive and disempowering’ ‘That CAMHS put a lot of young people off being referred to them because of parental involvement’ ‘That families of these children find it hard to engage, this has an impact on the work with children and young people and CAMHS has to be both flexible and understanding...’ ‘Older teenagers often don’t appreciate having to have their parents present’
27	Understanding of school systems	5.5% ‘I think that it would be useful for them to know the systems of support that are in each individual school and have working knowledge not only of the school counsellors but in terms of the pastoral support that is also available’ ‘How different schools work’ ‘It is essential that CAMHS fully appreciate the different pastoral care structures within the different schools they have contact with’ ‘At present there is no set standard of what is offered by schools. Is the counselling bought in on a part-time basis for a few hours a week, or is it like the service I offer where the school employ me on a full-time basis. This would be useful for CAMHS to have as set so they know what level of support is available in each school setting’

Theme	%	Examples
28	The links that counselling services have in schools	4.4% ‘...positive links we have within schools’ ‘It is important to liaise with teachers about what is happening in school, as children and parents often don’t provide all the information’ ‘That we are a positive source of knowledge and expertise within the school that the client attends and therefore are a direct support for the client’ ‘The importance of the bond with school counsellors. Students have often been in and out the service and we know the bigger picture really well, and often have parents on board already’
29	Awareness of school and community counselling services	4.4% ‘...I think that it is important that CAMHS know the school counsellors out in their community and what schools have/don’t have this support’ ‘Would be useful for them to be aware of the counselling service provided by myself and my colleagues’ ‘To be aware of what is offered at school and elsewhere to young people and how this blends with what CAMHS provides’

‘What, if anything, would you/your service like to know about specialist CAMHS?’

Theme	Sub-theme	%	Examples	
30	Service details	General information about CAMHS	26%	‘Better working knowledge of their processes and procedures’ ‘Some precise guidelines would be useful’ ‘Clear idea of their modus operandi would be useful’ ‘Knowledge of their systems and how they work with clients...’ ‘More about the organisational set-up as this can seem arcane at best and chaotic at worst’
		Interventions offered inc. medication	21.9%	‘Range of interventions offered’ ‘The range of services/treatment pathways available’ ‘More about medication/clinical supervision re prescriptions’ ‘More information about the treatment offered and how outcomes are measured’
		Referral criteria	15.1%	‘Current referral guidelines...’ ‘Clearer guidance on referral pathway’ ‘More detailed referral info available to all therapists’ ‘Referral criteria – what they might look like in practice’
		Practitioners in CAMHS	9.6%	‘...training and qualifications of their specialists in various Tiers’ ‘How they select appropriate people to work with clients’ ‘The theoretical/clinical orientation of staff members. Different consultant psychiatrists will sometimes give different diagnoses and treatment plans for the same client’ ‘...I think it’s important to know the makeup of your CAMHS team, does it include child and adolescent psychotherapists or family therapists or clinical psychologists as well as nurses and doctors’
		How the appointment system works	8.2%	‘Why are the appointments so inconsistent?’ ‘How their appointment system works – they tend to offer appointments monthly rather than weekly – how does this benefit young people?’ ‘Waiting times...’
		Location specific problems/issues	5.5%	‘Local pressures and problems...’ ‘What each area has to offer and how it varies from area to area’ ‘...what specialist services are available locally and regionally’ ‘Pressures imposed by their commissioners’
		Assessment process	5.5%	‘More about...assessment process referred young people go through’ ‘How decisions are made by CAMHS on what type of intervention to provide/allocation process’ ‘How a client is assessed, what their package of care contains, how they assess when to discharge a client...’
		Why parental involvement is deemed necessary	2.7%	‘Why will they not see young people who are deemed Gillick-competent without a parent?’ ‘Why are they extremely reluctant to listen to adolescent young people and value their choices and opinions in regard to what they want to happen i.e. mainly to be heard in private usually without parents present’

Theme	Sub-theme	%	Examples
31	Contact details for local CAMHS team	17.8%	'...who to contact where for what' 'A liaison officer from CAMHS to schools to be set up maybe' '...personnel contacts or focal point of contact would be useful' 'We have information leaflets about the service but would be good to have a proper dialogue between us' '...we would like contact and discussion...' 'Personally, I'd like a visit/chat to understand what they do more'
32	How counselling services and CAMHS can work together/ support each other	11.0%	'It would be helpful to know...where (if anywhere) school counsellors fit into the jigsaw. It would be positive if there was more communication to improve effective working' 'We are hearing negative stories, waiting times, reduction of qualified staff to cut costs etc etc. We would like contact and discussion as to how we can help' 'Is CAMHS Tier 3 saying they are taking over referrals from school based referrals or are they willing to provide specialist input, to work in parallel with counsellors who understand the school context better' 'How can my organisation become a preferred provider of services to local CAMHS teams?'
33	Why some CAMHS clients report negative experiences	5.5%	'Why clients who are referred to CAMHS so often feel that the support they are provided with is inadequate at best' 'Why are they not providing a good service? Why do they fail to see a client through from beginning to end?' 'When GPs see clients – and there is no improvement in the thinking/feeling of the client group, why don't they build therapeutic support alongside?'
34	Possibility of funding from CAMHS	2.7%	'More about the possibility of funding' '...a plan and funding to enable liaison between workers to continue.' 'How can my organisation become a preferred provider of services to local CAMHS teams?'



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