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The Availability of Cognitive Behaviour Therapy Within Specialist Child and Adolescent Mental Health Services (CAMHS): A National Survey

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Abstract. The National Institute for Clinical Excellence has recommended cognitive behaviour therapy (CBT) for a number of common child and adolescent mental health disorders. The aim of this study was to clarify the practice of CBT within specialist child and adolescent mental health services in the United Kingdom. A survey was distributed to specialist child mental health workers through national organizations and professional bodies. Approximately 10% of specialist CAMHS professionals replied ($n = 540$). One in five reported CBT to be their dominant therapeutic approach, whilst 40% rarely used CBT. Specialist post-qualification training had been undertaken by 21.0% of respondents, with over two-thirds identifying training needs in the core skills of CBT. This survey suggests that the capacity of specialist CAMHS to meet the requirements of NICE in terms of the availability of CBT skills is doubtful. There is a need to develop CBT training and supervision infra-structures.

Keywords: Child and adolescent, CBT, supervision, practice, survey.

Introduction

Mental health difficulties in children and young people are common. Community surveys indicate that 10% of children aged 5–15 years have a diagnosable mental health disorder (Meltzer, Gatward, Goodman and Ford, 2000). This suggests that approximately 1.1 million children in the UK under the age of 18 may benefit from interventions from specialist child and adolescent mental health services (CAMHS) (Department of Health, 2004).

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The provision of specialist CAMHS is typically through multi-disciplinary generic teams. In 2004, the National CAMHS mapping exercise identified 492 generic teams in England/UK consisting of 5410 established posts (National Child and Adolescent Mental Health Service Mapping Exercise, 2004/2005). These teams are expected to meet the wide range of mental health and psychological needs of children and adolescents within defined geographical areas and provide a range of direct therapeutic skills including cognitive, behavioural, pharmacological and systemic interventions alongside indirect services such as consultation, liaison and training (Department of Health, 2004).

The National Institute for Clinical Excellence (NICE) has recently undertaken systematic reviews of interventions for a number of major mental health disorders of children and adolescents. Although the evidence base is sometimes limited, reviews of depression, obsessive compulsive disorder, eating disorder, and posttraumatic stress disorder have each recommended cognitive behaviour therapy (CBT) as one of the most important treatment modalities (NICE, 2004, 2005a, b, 2006). In order to ensure the quality and effectiveness of CBT, it is important that it is provided by suitably trained and competent therapists (NICE, 2005b; Grazebrook and Garland, 2005). This study aims to establish the degree to which CBT is currently practised within specialist CAMHS and the training and expertise of those providing it.

Participants, methods and results

A questionnaire surveying the practice of child focused CBT was developed and piloted. The questionnaire was then widely distributed to specialist child and adolescent mental health professionals through national organizations (the Association for Child and Adolescent Mental Health (ACAMH) and the British Association of Behavioural and Cognitive Psychotherapy (BABCP)), and through professional interest groups (British Psychological Society, Faculty for Children and Young People, Royal College of Psychiatry Child and Adolescent Faculty, and the Nursing Consultant network). In addition, the survey was posted on the ACAMH and BABCP websites.

Five hundred and forty-eight questionnaires were returned, of which five were from retired clinicians, two from overseas practitioners, and one was not completed. These were excluded, resulting in a final sample of 540 questionnaires. This figure represents approximately 10% of professionals working in generic CAMHS teams in England/UK in 2004 (University of Durham, 2005). Of respondents, clinical psychologists were the largest professional group (195, 36.1%), followed by child and adolescent psychiatrists ($n = 183$, 33.9%) and nurses ($n = 56$, 10.4%). The proportion of professionals responding to this survey does not reflect the national profile of CAMHS. Within specialist CAMHS, nurses represent the largest professional group (approx 26%), with clinical psychologists representing approximately 14% of the workforce, and doctors 11%.

Table 1 summarizes respondents' use, level of training, and perceived expertise in child focused CBT. A significant proportion of respondents (228, 43.5%) used CBT with less than 20% of their caseload. Compared with those who used CBT more often, this group reported the most limited training in CBT, consisting of attendance at up to three scientific meetings or two workshops (45.6% v 17.1%). They were also more likely to rate their expertise as fairly basic or inadequate (65.0% v 11.1%) and the majority (59.6%) did not identify any training needs in terms of developing their CBT skills.

Table 1. Practice, self-rated expertise, and level of training in child focused CBT

	Used with less than 20% of caseload	Used with 20–60% of caseload	Used with more than 60% of caseload
Clinical practice of CBT ($n = 524$)	228 (43.5%)	184 (35.1%)	112 (21.4%)
	Limited training i.e. attendance at 3+ meetings and/or 2 workshops	Basic training i.e. part of professional training	Specialist training i.e. part of post qualification training
Training in child focused CBT ($n = 538$)	165 (30.7%)	260 (48.3%)	113 (21.0%)
	Inadequate or fairly basic	Adequate	Fairly good/good
Self-rated expertise in child focused CBT ($n = 534$)	191 (35.8%)	190 (35.6%)	153 (28.6%)

CBT was the dominant therapeutic approach (used with more than 60% of caseload) of 21.4% of respondents, with clinical psychologists constituting the largest professional group (48.2%). A higher percentage of this group had received specialist training in CBT as part of their post-qualification training (56.3%) and described their level of expertise as fairly good or good (77.7%) In terms of supervised practice, 58.9% of this group had a named or identified supervisor for their CBT. Of those with no identified supervisor, a small group (21) felt that their general supervision fulfilled their needs, whilst 27 reported that no supervisor was available.

The highest level of training in CBT for almost half (260) of respondents was through their core professional training. This was particularly evident for clinical psychologists (59.5%) and child and adolescent psychiatrists (50.8%). There were, however, differences in terms of how well respondents felt this training had equipped them to practise CBT. Of the 93 psychiatrists who received training in CBT as part of their core professional training, 39 (41.9%) described their expertise as inadequate or fairly basic compared to only 18 (15.5%) of the 116 clinical psychologists.

Finally, two-thirds of those surveyed identified further training needs in child focused CBT. These predominantly related to training in the basic skills of CBT (Socratic questioning, identifying and working with cognitions, and case formulations) and in treating the disorders that NICE has recently reviewed and for which it recommended the use of CBT (depression, PTSD, eating disorders and OCD).

Discussion

This national survey provides an indication of the use, skill level and supervised practice of child focused CBT within specialist CAMHS. Before discussing the implications of this survey,

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the limitations need to be considered and, in particular, the degree to which these results are representative of the national workforce. There are differences in the proportion of professional groups who responded. Whilst nurses represent the largest profession within CAMHS (26%), they are significantly underrepresented in this survey (10%). Similarly, whilst the sample size is good, it nonetheless represents only a small percentage of the CAMHS generic workforce. It is therefore probable that for two reasons these results provide the most optimistic estimate of CBT practice and skills. First, a high proportion of clinical psychologists, the professional group most often associated with the practice of CBT, responded to this survey (36%). Second, there is a probable interest bias, since it is anticipated that those clinicians who wish to develop and/or practise CBT would be more likely to respond.

In the light of these considerations, extrapolating the results of this survey to the UK specialist CAMHS workforce would suggest that CBT is the dominant approach (i.e. used with more than 60% of caseload) of approximately 1100 clinicians. It has been estimated that to provide the CBT intervention recommended by NICE for 20% of 12–18-year-olds with depression would require 760 full time trained therapists (Murray and Cartwright-Hatton, 2006). The estimated CBT capacity within CAMHS would therefore appear barely sufficient to meet the needs of even this small, narrowly defined group. When considering the needs of pre-adolescent children with depression and the need for CBT for other mental health disorders where there is an established evidence base, it becomes apparent that there is a significant shortfall in the provision of child focused CBT within specialist CAMHS.

In addition to the issue of capacity, the level of expertise and specialist post-qualification training in CBT appears limited. Although there is no central register for child CBT therapists, it is estimated that there are approximately 140 therapists accredited by BABCP, the leading UK organization for CBT, who have competence to work with children (Murray and Cartwright-Hatton, 2006). This figure is a conservative estimate since some clinicians experienced and competent in CBT will not be registered with the BABCP. Nonetheless, the results of this survey support the suggestion of a limited number of highly skilled CBT therapists, with approximately one in five having undertaken specialist post-qualification training in CBT or receiving regular supervision of their clinical work.

At present, specialist CAMHS practitioners are most likely to have acquired their CBT skills as part of their professional training. The extent to which this has equipped them to undertake CBT was variable; child psychiatrists, in particular, were more likely to rate their expertise with this approach as fairly basic. The adequacy of this professional training is also reflected in the responses to a question about future training needs, where almost two-thirds identified needs relating to the basic skills of CBT. Similarly, of the two-thirds who identified training needs for specific disorders, half identified a need for training in the use of CBT for either depression/self-harm, obsessive compulsive disorder, posttraumatic stress disorder, or eating disorders.

The need to extend the availability of CBT within adult mental services has recently been highlighted (Layard, 2005). The results of this survey indicate a similar picture as regards children and young people, with a potentially significant shortfall in the provision and quality of CBT within specialist CAMHS in the UK. The findings highlight an urgent need to develop a training and supervisory infra-structure in order to ensure that CBT is available in specialist CAMHS and is delivered by skilled clinicians. It is therefore reassuring to note that the shortfall in specialist child focused CBT skills has been identified in the interim report on the implementation of the *National Service Framework for Children, Young People and Maternity Services* (Department of Health, 2006). The executive summary notes that "nationally and

locally cognitive behaviour therapy (CBT) training and supervision is developed to enable CAMHS to meet National Institute for Health and Clinical Excellence (NICE) guidance". The need has therefore been identified and acknowledged; the challenge is how and when this will be taken forward and addressed.

Contributors

PS was the principal investigator, designed the questionnaire, conducted the data analysis, contributed to discussion of core ideas at research meetings and drafted the paper. OU helped design the protocol, participated in discussions of core ideas at research meetings, and contributed to the paper. MG and SH collated the data and managed the project database.

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