

# Art Therapy Online: ATOL

## **Is There a Need to Define the Role of Art Therapy in Specialist CAMHS in England? Waving not Drowning. A Systematic Literature Review**

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### **Abstract**

This paper offers a review of how the role of Art Therapy is represented in four important areas: In Specialist (Tier 3) Child and Adolescent Mental Health Services (CAMHS) in England, in government and related documentation and policies, within broader literature pertaining to Child and Adolescent Mental Health Services, as well as in Art Therapy publications. The author found that there are shortcomings in the understanding of the profession including the unique role that art therapy offers, as well as an evident lack of inclusion across the range of literature. The author contends that central factors exerting influence include powerful socio-politico-economic agenda and influence, unprecedented change in the field of psychological therapies, unconscious processes, and limited self-promotion.

The paper argues that lack of clarity and effective promotion of the unique role of art therapy may lead to there being a lack of consideration of art therapy or for art therapy to be decommissioned in CAMHS. The review has worldwide relevance to those concerned with practice, promotion and commissioning of art therapy in services that work children and young people with mental health and psychological needs.

**Keywords:** socio-politico agenda, promotion, representation, NHS publications, child and adolescent mental health services

## **Introduction**

The idea of this paper emerged when, as a Lead Art Psychotherapist in Specialist CAMHS within a Midlands NHS Trust, I was charged to create a 'Treatment Protocol' for art psychotherapy to include a clear outline of the role of art psychotherapy. Art psychotherapy could only be included in the 'Trust Register of Psychological Therapies' (DHCFT, 2011) via the acceptance of such a protocol. I was informed the register was the means for individual professions to be commissioned within the Trust. It soon became apparent to me that there was a dearth of material focusing on role specifically. Consequently, and sadly, I did not succeed in effecting the profession being included on the Trust Register. Ultimately the Lead Art Psychotherapist in Specialist CAMHS post was decommissioned, leaving neither art psychotherapist posts nor art psychotherapy provision within the entire Trust. This experience suggested that there is an urgent need to establish how the role of art therapy is represented in the relevant policy and related documents used to inform commissioning bodies and to shape services. Whilst too late for my post, I feel that any limitations in understanding, misrepresentations and gaps in representation should be identified so they can subsequently be addressed appropriately.

Currently in the UK art therapy as a profession, like other psychological therapies, is under pressure; many posts and departments are being decommissioned. As Rizq says 'We are living through a time of unprecedented change in the field of psychological therapies...professions have to continue meaningful practice whilst not be swamped by the Tsunami of 'high-volume, high turnover patient targets' (Rizq 2011:37). This situation emphasises the necessity for art therapy as a discipline to be represented clearly in relevant policy documents in order that art therapists can effectively promote who they are, what they uniquely offer and their particular role in CAMHS.

The parameters of the review are limited to England. This is because the Department of Health that issues guidance and policy, whilst maintaining links with other parts of the UK, currently only covers England. The review focuses on central policy documents which shape workforce policy development in mental health teams from 2000 onwards that directly relate to Art Therapy in Tier 3 CAMHS in England. It considers a secondary review of related literature focusing on role within Art Therapy literature. The paper aims to establish and critique an overview of the existing representation and understanding of Art Therapy so that refined questions can be asked about the nature of current information available to specialist CAMHS services, their policy makers, commissioners, and service-users. The influence of current political and other powerful bodies' agendas, biases and unconscious processes on Art Therapy's inclusion in publications and policy documents will be considered.

The paper will consider the representations of the role of art therapy within specialist (Tier 3) Child and Adolescent Mental Health Services (CAMHS). The National Service Framework for Children, Young People and Maternity Services (DoH, 2004a) incorporating the Health Advisory Service Report's (HMS, 1995) outlines four tiers of child and adolescent mental health services. Tier 3 (specialist) CAMHS is defined as a service working with cases where complex needs cannot be addressed by Tier 1 & 2, requiring specialist intervention and where more than one discipline within the multi-disciplinary team (MDT) and/or agency is involved in a case. As a specialist psychotherapy art therapy can be seen to be offered primarily at Tier 3 and 4 levels.

It is acknowledged that 'role' can be considered within aspects of art therapy practice with young people, from the art therapist's role in assisting clients to become art 'makers rather than consumers' (Jones 2005:100), to the central role of the image and image-making within the art therapy relationship. The focus on what happens within the art psychotherapy room falls beyond the scope of this particular review.

I begin by describing the research methodology before going on to summarise a review of the literature that was found in response to the question of whether there was a need to define the role of Art Therapy within CAMHS in England. This review summary is divided into four main sections: the role of art therapy in CAMHS; the role of disciplines in CAMHS; Government policies, NICE guidelines, CAMHS publications, Art Therapy publications. A discussion focusing on unconscious processes and agenda, discussion and conclusion follows.

### **Methodology**

The Cochrane Collaboration (2003) states that a systematic review aims to establish where the effects of health care are consistent and where research results can be applied across populations, settings and differences in treatment. The rationale for selecting the methodology is to offer a suitable framework in which to identify, appraise, select and synthesise all high quality evidence relevant to the review.

A search of the available literature was conducted using a Boolean method within Medline, Cinahl/ PreCinhal, PsychPsychINFO/PsychARTICLE and AMHED databases. Additional searches were conducted within the Department of Health (DoH), Mental Health Foundation, Sainsbury Centre for Mental Health, NICE, Mind, Young Minds, World Health Organisation (WHO), The British Association of Art Therapists (BAAT), and The Child Psychotherapy Trust websites. Google and Youtube searches for art therapy in CAMHS services was also conducted.

### **Search criteria**

The search was carried out using key word criteria. Key words are 'art therapy', 'art therapist', 'art psychotherapy', 'art psychotherapist', 'role', 'function', 'CAMHS', 'child and adolescent mental health', 'child psychiatry', and 'England'.

The search excluded primary source material before 2000 and data outside England.

## **Review Summaries**

The review of the literature focuses on art therapy and its role within Tier 3, specialist CAMHS with reference to the research question: “Is there a need to define the role of Art Therapy within CAMHS in England?”

### **1. The Role of Art Therapy in CAMHS – Small Fish in Rock Pools?**

Database search results using key phrase ‘role of art therapy in CAMHS’ in Medline, Cinahl/ PreCinhal, PsychPsychINFO/PsychARTICLE and AMHED yielded disappointingly little. One result only was found for England, that of O’Brien’s case study (2004). Whilst O’Brien’s case study mentions art therapy is undertaken within a specialist CAMHS team, she did not explicitly address the role of the art therapist in CAMHS.

I then undertook a broader search by using the full range of key word criteria within all the search engines and websites as outlined above.

I shall now illustrate how the following art therapists employed within CAMHS address aspects of the role of art therapy in their research and case studies. I will begin this section by focusing on the work of Brown, and the Art Therapists Working with Children, Adolescents and Families (ATCAF BAAT Special Interest Group) that are published solely on the BAAT website. I will follow this by citing from my own unpublished draft documents, to then consider work published as chapters and articles that fall outside of CAMHS specific publications.

Brown (BAAT website, 2005) received 102 responses of 139 art therapists working in CAMHS, including Tier 3, in her survey ‘Art therapists working with adolescents in CAMHS in Great Britain’ July 2003. No rationale is given for chosen categories, and the survey aims to gain an initial picture of art therapy practice within CAMHS. Results demonstrate diversity of practice, and the absence of a practice guideline. Responses on perceptions of Art Therapy

include the benefits of having art therapist managers. Some suggested that non-art therapist management made understanding and promotion of art therapy either consciously or unconsciously difficult. Others highlight, as often a sole art therapist in a CAMHS team/service combined with limited career progression pathways, that status, relative power and influence are ongoing issues. Role pertaining to direct work and 'types of co-work' are examined, highlighting the importance of partnership working including: multidisciplinary and multi-agency liaison, consultation and supervision and training; joint working within the team, joint assessment, consultation to Tier 1; and joint CBT programmes (BAAT website Brown, 2005:15). Brown's findings describe a beneficially multi-faceted profession; but one, she argues, that could be perceived by others as an idiosyncratic profession lacking practice cohesiveness.

The ATCAF Special Interest Group (ATCAF) recently published two significant documents on the BAAT website. These seem to demonstrate encouraging beginnings of addressing the substantial task of creating a guideline that has use across a number of settings. The first document describes the methodology used in the development of clinical guidelines for art therapists working with children, young people and their families (ATCAF, BAAT website 2013). It cites twenty seven ATCAF members as having contributed to its creation along with a Delhi survey of art therapists working with this client group, including those working within CAMHS. The second document is the synthesis of data, published as Principles of Best Practice (ATCAF, BAAT website 2013). Eighteen principles are outlined, and identified as representative of current consensus of practicing art therapists. A particular strength of the principles is cited as its creation by practicing and experienced art therapists within several child related services, including CAMHS. Weaknesses were identified as 'NICE rate expert opinion as the lowest level of evidence', acknowledging there is limited other evidence is existence to refer to, and lack of service-user involvement (ATCAF, BAAT website, 2012:4). The role of art therapy within CAMHS is not addressed specifically, though I imagine this document is sometime that could continue to develop to perhaps evolve into guidelines and treatment protocols for particular settings.

My focus on the role of the art psychotherapist argues that the

‘primary role...is to provide effective clinical interventions which meet the identified therapeutic needs of child and adolescent mental health service users’ (Cornish, unpublished draft, DHCFT 2011:16).

I elaborate further that the role encompasses facilitating engagement; risk management and reduction; addressing interpersonal relationships; enhanced self-reflexivity; effectively working through presenting difficulties; and fostering engagement in other services. Informed by my job description, the overarching frame for an employee’s role, I outline complementary roles in supporting colleagues in their understanding and practice with young people, including specialist art psychotherapy consultation and psychodynamically-informed perspective into: all levels of CAMHS Tiers, Safeguarding Children Board, and related services; service development and delivery strategy; working with families; specialist training across CAMHS and partner agencies; clinical supervision of Tier 3 clinicians; providing MA Art therapy trainee placements (Cornish, unpublished draft, DHCFT 2011). My draft protocol describes elements unique to art therapy practice with young people, underpinned by research, government policy and other literature to offer as much substantiation, and so authority, as could be found at the time of writing. The intent was to highlight what art therapy has to offer both uniquely and more generically.

Brown’s Survey results (BAAT website Brown, 2005) and my DHCFT draft documents (Cornish, unpublished draft, DHCFT 2011) represent the beginnings of mapping practice and clarifying roles of Art Therapists within CAMHS. Further contemporary research is needed to produce a comprehensive and meaningful overview.

Focusing now on printed publications, I found that few art therapists referred explicitly to the role of art therapy in CAMHS in their case studies or in published research. Whilst the case studies and research offered some

excellent descriptions of the practice of art therapists in CAMHS, as the topics of practice-in-action and research fall outside the scope of review they will not be considered here.

The following exceptions briefly address role.

Ambridge works in a CAMHS team 'specialising in child protection focusing on sexual abuse', describing the role of art therapy '...a particularly appropriate intervention for abused children...enables expression of the unspeakable through image, metaphor and symbolis[m], at a pace controlled by the child' (Ambridge cited in Liebmann 2008:27).

Knight introduces her role as undertaking 'risk assessments...consultations...provid[ing] an art psychotherapy service for children and young people who have self-harmed' (Knight cited in Liebmann 2008:72).

Wheeler and Smith (Wheeler and Smith cited in Murphy 2001:36) state they 'will examine the role of individual art therapy' although examination is implicit; and Dalley wrote '...in [CAMHS] settings the art therapist works as a member of the MDT (Dalley, 2007:66).

Google search results for art therapy in CAMHS services, via scoping sixty CAMHS service websites revealed no reference specifically to the role of art therapy within CAMHS. Briefly, some links to sites suggested art therapy was offered, but on accessing the website no evidence was found of art therapy provision. One service offers creative therapy rooms but does not appear to have any art therapists working there. Another cites allied health workers though if art therapists are included this is not made clear. How art therapy is included varies considerably; from one service from one line definitions to a full page dedicated to describing art therapy and its workings, highlighting image-making and non-verbal aspects. I was particularly struck that the psychotherapeutic nature of art therapy did not appear to be represented at all and wondered what understanding readers may get in terms of any real sense of what art therapy is and does. Many mention that art therapy is part of a



multi-disciplinary team though do not elaborate on roles. There is insufficient space to explore data in depth or to reference all the websites searched and this could be another area of research to be undertaken. (Google, 2013)

Edwards suggests that art therapy's uniqueness, the essence of its practice, is found in closely observed case studies (Edwards, 1999). I agree with this view but would argue that art therapy's role warrants independent focussed research. Furthermore, it is beyond this review's scope to critique qualitative case-study material on art therapy within CAMHS. Whilst Gilroy notes in the current socio-politico-economic climate where there is real and increasing pressure for art therapists to provide evidence of art therapy's effectiveness, to respond speedily requires organisation and strategy, and a range of research methods (Gilroy, 2006) the role of art therapy within a CAMHS service does not appear to be considered.

In summary, case studies offer evidence of practice to service commissioners and policy-makers but are insufficient on their own. Secondly, published material addressing the role of art therapy within the CAMHS domain is limited. Thirdly, most art therapy in CAMHS case studies are published within Art/s Therapies specific publications. Fourthly, no publications were found that include CAMHS and Art Therapy in their title. Fifthly, Case & Dalley's book (2007) contains informative chapters on the practices of Art Therapy within CAMHS, with young people of various ages, but may be missed by CAMHS commissioners and policy-makers as did not appear as a search result.

To conclude, research into the role of art therapy within CAMHS is small and some papers have been left unpublished. The narrow publication base of existing texts limits the breadth of promotion of art therapy in CAMHS. Extending the breadth of publication base will likely increase access to art therapy publications and may offer a broader understanding of art therapy's role in CAMHS.

I will now look at how the topic of role of disciplines in CAMHS is explored in recent literature in England.

## **2 The Role of individual disciplines in CAMHS – All at Sea**

Williams and Kerfoot, who are not art therapists, but who write about the role of various disciplines within CAMHS argue that: 'CAMHS are... multidisciplinary...multi-disciplinary teams (MDTs) need agreed roles and lines of responsibility' (Williams and Kerfoot, 2005:489). They argue that confusion of roles and responsibilities creates confusion for clinicians, agencies and patients alike, creating casualties from

'...the burden of unrealistic expectations, unresolved personal issues and rigid personalities, confusion of roles and conflicts of values, and isolation...often lead [ing] to inappropriate practice [and]...to frank mental illness [in the staff group]' (Williams and Kerfoot, 2005:489).

Baldwin, a nurse consultant within specialist CAMHS in England focusing on the nursing role, notes that role in CAMHS pertains to 'tasks' and 'functions' but argues that role 'has a much wider meaning', and one that bears influence on workforce policy (Baldwin, unpublished PhD, 2008:76).

Baldwin continues that CAMHS are a 'relatively new phenomenon' with limited existing documentation and rationale for 'original composition' of CAMHS teams (Baldwin, 2008:14), which begs the question of what was used to inform composition of services in the past and also currently. Recent workforce policies have changed in emphasis from profession specific 'multidisciplinary teams' (MDTs) to 'capable teams' with generic skills, which may

'...have sidelined' professional identity raising questions about the need for 'specific disciplines to provide distinct roles' (Baldwin, 2008:15).

He recommends profession-specific research to identify unique contributions

'...to the overall team function (Baldwin, 2008:388), to effectively meet service-user needs through service-user participant research, and thus better planned services.

Baldwin offers what seem to be tentative role definitions for doctor, psychologist, social work, and allied health professionals as an amorphous group (AHP), justifying focusing only on occupational therapists as AHPs, (apparent throughout his study), as his having only interviewed occupational therapists within the chosen grounded theory method. Influence such bias may have on readers is not acknowledged and art therapy has again been missed. Employed within the same patch team at the time, and thus available to interview, I find Baldwin's argument and approach curious. I am left wondering why, as an art therapist, I was not approached, while an occupational therapist not employed in the same team, apparently was.

The Choice and Partnership Approach (CAPA) devised by two psychiatrists (Kingsbury and York, 2011) as an attempt at skill layering to deliver the most efficient and effective interventions has recently been rolled out across CAMHS. It is a service transformation model whose essentials are promoted as a user-centred collaborative practice underpinned by demand and capacity theory, leadership and governance. CAPA states that all team members should have cognitive, systemic and dynamic skills, where matching skills with client need, and speed of throughput, should be priorities. I find the statement curious, as it seems to suggest that every individual discipline should be trained to the same, or at least some, level in the remaining therapeutic approaches, which would surely take years to achieve? It also begs the question about what happens to disciplines who do not teach/study cognitive, systemic or dynamic approaches as part of their core training, such as, arguably, the nursing profession. 'Dynamic skills' is neither defined nor linked to Art Therapy or other specific training which may suggest there is limited understanding of dynamic approach or art therapy, or that the level of skill being sought is minimal? It can be argued that art therapy has a significant role in offering dynamic skills, being a core part of art therapy training and practice. To my knowledge there is only one person across several Midlands

CAMHS teams with psychodynamic training now, so how are CAPA principles and priorities being adhered to, and delivered? This situation seems to mirror Baldwin's earlier observation that team composition is inconsistently created despite contemporary attempts at defining what is needed (such as CAPA), so more focused research into what actually informs service composition seems indicated, such as service-user focussed research perhaps?

Specific research into implications for Art Therapy practice and role arising from CAPA, drive for 'Clustering' linked to the 'Payment by results' agenda (DOH, 2012; 2013) also seems urgently indicated. Research into how and how many service users are referred for Art Therapy, or 'dynamic' therapy in the Partnership stage of CAPA may offer a useful bank of data for service commissioners to consider.

In summary, there are convincing arguments for defining role within CAMHS as well as apparent confusion regarding what is actually wanted and needed to meet the needs of such a diverse population. Other professions, including nursing (Baldwin, 2002; 2008), child psychotherapy (Midgeley and Kennedy, 2011; Kam and Midgeley, 2006), and occupational therapy (Harrison and Forsyth, 2005) argue the importance of making professional distinctiveness known and are similarly engaged in research for their particular professions. It is noteworthy that Baldwin's research (2008) concludes that defining role for any given discipline is inherently difficult in part due to inevitably of some evidently shared skills and practices across disciplines.

I will now focus on policies and related documents from 2000 in chronological order apart from the National Institute for Clinical Excellence Guidelines, which I will address separately.

### **3. Government policies, NICE guidelines, CAMHS publications, Art Therapy publications, Art Therapy in the media – Navigating Big Fish Making Waves**

**Recent government policies relating to child and adolescent mental health**

Policy document 'Meeting the Challenge: A Strategy for the Allied Health Professions' (DoH, 2000) states

'Arts Therapists have an important role...in services for children...with learning difficulties, [and] in improving mental health services... Arts Therapists [positive work in] health promotion ... mental health and child health is recognised.'

There is no elaboration on the nature of this role, though acknowledgment of the import seems encouraging.

It stated in the document 'Clinical Guidelines for Treatment Choice Decision in Psychological Therapies and Counselling' that psychological therapies in mental health 'include art and drama therapists' (DoH, 2001:6). Role is not elaborated on, and CAMHS is not mentioned specifically, so the document may have limited benefit to CAMHS commissioners amongst others.

In the 'National CAMHS Mapping Exercise' (Glover et al., 2002), findings from data collected from 296 PCT areas highlight a lack of integration of some CAMHS services. Staff Table 5a reports a significant percentage of all professions in CAMHS stating they 'Offer Creative Therapies'. This finding suggests a lack of understanding art therapy, or it being regarded merely an approach or technique (Edwards, 2004). In my own experience, I have found practitioners non art therapy-trained, qualified or HCPC registered, professing to offer art therapy, and sometimes believing they are offering art therapy, even within the NHS. Of concern, managers and practitioners alike seemed unaware of either the potential dangers of staff working outside their skill and knowledge base, or the illegality of their actions.

Despite each Arts Therapy being registered and legally protected professions since 1997 with rigorous, specific training (Masters level from 2002 and registration with HCP (now HCPC) 2003, and its predecessor CPSM (from June 1999) individual Arts Therapies disciplines are treated inequitably to other disciplines within the mapping exercise. Art Therapies are clustered under 'Creative Therapies', and it is unclear if data was collected under this umbrella group, or collated into it. Furthermore, no grade categories are used

as is the case for other professions, making statistics generalised. No rationale or justification for this disparity in approach is offered.

In the 'NHS Plan for Investment and Reform' (DoH, 2002a), Baldwin argues the political move towards genericism is also towards the lowest common denominator in terms of pay. He highlights concerns raised by specialist CAMHS clinicians about potential negative impact on clients,

'This goes against the experience of those working in the field...[the] level of work requires a great deal of experience' (Baldwin, 2008:77), and I would argue, appropriate training.

He makes a pertinent point that decreased pay and status will adversely affect staff morale, retention and recruitment, and where choice and quality of service delivery are compromised. From recent personal experience, I can concur that staff morale in local CAMHS decreased considerably and rapidly, while fears about fundamental safety and quality of service grew.

Baldwin (2008) notes the 'National Service Framework for Children, Young People and Midwifery Services' (DoH, 2004a) arose from there being no coherent policy for commissioning and provision of disciplines in CAMHS. Specific professional backgrounds of those involved in the External Working Groups for the Children's Task Force that informed the document are not stated. The document states that every PCT areas should have at least one comprehensive tier 3 multidisciplinary CAMHS team, so provide specialist co-ordinated assessments and interventions via the full range of appropriate psychological treatments, but does not suggest what this comprises. Standard Nine addresses the emotional wellbeing and mental health of children and young people, outlining that specialist CAMHS includes: occupational therapists, and other allied health professionals, and a range of creative therapists. Curiously, Art Therapy could be seen to fall into two categories as allied health professionals and creative therapists. This suggests the authors, and perhaps working party, have a disappointingly limited or erroneous understanding of arts therapies and possibly allied health professions. Of

additional concern, creative therapists are potentially unlicensed and unregulated.

'Quality Assurance Agency's Benchmark Statement: Healthcare Programme – Arts Therapies' (QAA 2004) is the only document outlining the profession and practices of an HPC registered Art Therapist. It suggests the art therapist should understand the role of Arts Therapies within mental health settings (2004:9) though disappointingly does not elaborate further on what these may be, limiting the usefulness of the information.

The 'New Ways of Working' pool of documents was created to redesign services in response to changes in psychiatrists' role (DoH, 2004d, 2005a, 2007a, 2007b) were informed by establishing discipline-specific working groups to look at their contribution, and implications of changes. Occupational therapists decided to split off into a separate group to the AHP group. There is one mention of occupational therapy, and of AHPs as an umbrella group. This raises the question of how useful affiliation with 'umbrella' bodies is in the absence of unity. The introduction of 'New Roles' means employing more non-professionally qualified staff, which Baldwin argues brings with it 'a threat to the concept of professional identity' (Baldwin, 2008:51), and I would argue must surely reduce quality of service provision. The documents intentions are as 'Best Practice Guidelines' (Baldwin, 2008:211) but is unclear how much input, or consideration, the art therapy profession has had.

More disappointingly in my view, in the 'Report of the Review of The Arts and Health Working Group' (DoH, 2007) art therapists are solely mentioned as having raised concerns about safety. No art/s therapists are listed on the Strategic Panel members list. One music therapy text is referenced but no other arts therapies texts. I would argue that having no arts therapist members, and only one reference to contemporary research in arts therapies challenges the entire document's authority.

'Children and Young people in Mind: the Final Report of the National CAMHS Review' (DoH, 2008) notes

‘Boys and young men...prefer activity-focused interventions to help them, rather than ‘talking therapies’... [we] recommend further development of these services as part of a comprehensive range of provision for mental health and psychological well-being’ (DoH 2008:45).

Despite this statement, none of the art/s therapies appear to have been considered.

The ‘Modernising Allied Health Professionals’ documents (DoH 2008, 2011) approached the diverse range of AHP disciplines as one homogeneous group only.

‘No Health Without Mental Health’ (DoH, 2011) is a key document for mental health services including CAMHS. Despite consultation with Huet (BAAT Chief Executive Officer), it only cites arts for recreational purposes. The document seems to have very limited ambition for, and understanding of CAMHS altogether and only one CAMHS-based text is referenced. Only cognitive behavioural approach and multi-systemic therapy are named specifically. There seems to be little evident appreciation of either young people’s mental health difficulties or specialist disciplines, where the document is thus limited in what it can offer commissioners of services. Art Therapy’s inclusion in guidelines for children and young people: psychosis and schizophrenia (2013), is not acknowledged at all, despite reference made to the central importance of NICE guidelines being applied to practice.

In ‘Children and Teenagers to Benefit from Successful Adult Mental Health Therapy’ (DoH, 2011) the focus is primarily CBT. Art Therapy is not mentioned.

‘Talking Therapies: A Four-Year Plan of Action’ (DoH, 2011) pertains to Increasing Access to Psychological Therapies (IAPT) but only includes CBT, brief dynamic interpersonal therapy, with brief mention that CAMHS needs generic skills. A question arises here about the ‘branding’ of art therapy. Is it regarded as one of the ‘Talking Therapies’ or not, given it is frequently



promoted as a non-verbal therapy, where there seems to be an inherent contradiction in terms?

In 'Involving Children and Young People in Health Services' (NHS Confederation, 2011), whilst the policy acknowledges young people have diverse backgrounds and needs, and that specific needs of individuals with disabilities, mental health problems, and communication difficulties should be catered for, neither specific disciplines nor CAMHS composition are addressed.

The directory Better Mental Health Outcomes for Children and Young People: A resource directory for commissioners (chimat, 2011) is a core and contemporary directory for CAMHS that provides links to the full text of over 250 resources that pertain to the mental health of children and young people. Art therapy is not included in this.

In summary, there is a consistent absence of clear clinical rationale for policy drivers and composition of CAMHS or occasional superficial consideration. If art therapists (and/or BAAT) have been consulted or have contributed and the professional 'umbrella' under which art therapy may have been considered is not made explicit. Information about the process for professions becoming members on project teams and advisory boards that influence commissioning is not given, so how do individual professions become so?

A sound understanding of art therapy is not evidenced in any of the documentation explored. I was not only surprised and dismayed but my attempts at writing a robust art psychotherapy protocol, focusing on role, were left a great deal less substantiated and lacking in authority than I had hoped to achieve. I was informed that the draft document I submitted lacked sufficient authority to secure art psychotherapy's place within the trust.

This situation raises important questions.

Is this situation due to being a relatively small profession, with a limited number of art therapists within CAMHS; a lack of a focus group to promote art

therapy in CAMHS; a lack of a focus group to promote CAMHS; a political move to marginalise some professions; indicative of a lack of knowledge or rigour by commissioning parties; or merely a politico-economic move?

To conclude, my findings concur with much of Baldwin's (2008). There is little, if any, consensus or coherence of approach to CAMHS composition within CAMHS and related policy documentation. There is limited understanding of the CAMHS client group needs and professions, and sometimes complete exclusion of individual disciplines. It seems likely that documentation, policy and subsequently CAMHS services are powerfully influenced by the bias of prevailing political agenda of "high-volume, high turnover patient targets" (Rizq, 2011:37) rather than robust clinical rationale and analysis. On the basis of reviewing these documents, I would further argue that the impact of the current financial crisis combined with the ideology and bias of working party members commissioned to inform policy documents and lack of input from the art therapy profession, may influence if, how, and how much art therapy is considered.

As art therapy is frequently overlooked in many influential policy documents and otherwise has been conflated with creative therapies or allied health professions, I will explore more factors that may bear influence on this state of affairs.

#### *NICE (National Institute for Clinical Health and Excellence) guidelines*

Art Therapy's role in CAMHS appears in few NICE guidelines.

In the full guideline 'Depression in Children and Young People' (The British Psychological Society, 2005) although the Clinical Effectiveness Forum for the Allied Health Professions is cited as a member of the National Collaborating Centre for Mental Health (NCCMH) group it is not clear if art therapists were involved in this. The British Association of Art Therapists is cited as one of the stakeholders and experts who responded to the first consultation draft. The guideline lists art therapy as one of a number of psychological therapies though states 'the evidence base for the majority of these therapies is

extremely limited' (The British Psychological Society, 2005:9). The guideline acknowledges 'there are some significant limitations to the current evidence base, which have considerable implications for this guideline...[including] the relatively small number of published studies of psychological therapies' (The British Psychological Society, 2005:9). It does not include art therapy as a recommended treatment and I wonder if this is as a consequence of the professions limited evidence-base and/or lack of art therapist membership. The document further notes that 'The structure of CAMHS is highly variable' suggesting this is a consequence of local arrangements (The British Psychological Society, 2005:135). Its recommendation concludes rather generally 'Psychological therapies used in the treatment of children and young people should be provided by therapists who are also trained child and adolescent mental healthcare professionals' (The British Psychological Society, 2005:149) where level and nature of training and professions is not elaborated. No art therapy texts appear in the long list of reference sources.

NICE guideline on Antisocial behaviour and conduct disorders in children and young people: recognition, intervention and management (NICE, 2013) recommends the use of 'communication aids (such as pictures, symbols, large print, braille, different languages or sign language)' where indicated (NICE, 2013:15). This may suggest a role for art therapy, though disappointingly art therapy is not mentioned in the guideline and there are no BAAT members listed as contributors.

The 'Psychosis and Schizophrenia' guideline for children and young people (NICE, 2013) has a short section on the role of Arts Therapies cited as having a role in the alleviation of negative symptoms. It includes a brief definition that goes some way to describing what might be considered a meaningful one.

'Arts therapies are complex interventions that combine psychotherapeutic techniques with activities aims at promoting creative expression...' (NICE, 2013:160)

It further elaborates on aspects that are deemed common to all Arts Therapies, but does not elaborate on distinctions and particular roles of individual Arts Therapies disciplines.

Despite the British Association of Art Therapists' (BAAT) 'Submission to NICE on Children and Autism Consultation doc 28.3.11' and 'Submission to NICE on Social Inclusion document 2010' Art Therapy is not included as a recommended intervention in published guidelines. This seems particularly surprising to me for the former client group especially, in light of communication difficulties being common. There are no art therapists listed as having had input into the document 'Autism diagnosis in children and young people: Recognition, referral and diagnosis of children and young people on the autism spectrum' (NICE, 2011). A Special Interest Groups (SIGs) and evidence accreditation workshop with NICE was organised so that representatives from SIGs could meet with staff from NICE to help develop art therapy practice guidelines to meet criteria for inclusion in NHS evidence, where it seems unclear if a representative from ATCAF attended and contributed, and what useful outcome of the event might be specifically is not clarified in detail (ATPRN email 9 July 2012).

In summary, it is unclear how much the Art Therapy profession has been consulted or approached for membership of review panels, or if the profession has been largely overlooked. Even where BAAT has been consulted/contributed, and even when BAAT was consulted art therapy does not appear as a recommended therapy in some guidelines. NICE Guideline Review Panels (NICE, website 2010) consist of four or five members who respond to consultation feedback and validate the final full guidelines. No arts therapists are cited as current panel members. Panel A, focusing on childhood, comprises three medical doctors, Head of Medical Affairs, a representative from Novartis Pharmaceuticals UK Ltd and one lay person which suggests the likelihood of significant inherent bias.

*There are on-going and rigorous challenges to the NICE process as being biased and therefore inherently flawed that results in disciplines that are not*

*considered and/or excluded from guideline review panels being impacted significantly. The subsequent published guidelines then effects psychotherapy services provision to service-users; this includes art therapy. Guy et al emphasise that panels 'should include individuals from all the relevant professional groups' (Guy et al., British Psychological Society 2011:8) highlighting the likelihood of current endemic bias. Mollon argues that 'NICE guidelines are misleading, unscientific and potentially impede good psychological care and help' (Mollon, 2008:9). However, the impact on Art Therapy provision in CAMHS is not argued specifically in these. I have not found a published challenge from art therapy, and this may be a matter for BAAT Council (BAAT) to urgently address.*

NICE purport to consult research evidence to inform which interventions to include in guidelines but both Baldwin (2008) and Gilroy (2006) note that research methodology that supports the current political agenda are favoured, such as Randomised Control Trials (RCTs), with others not recognised as relevant.

Furthermore, I argue

'Although NICE guidelines make limited mention of Art Psychotherapy due to a lack of the required research evidence for inclusion it is important to acknowledge that a lack of evidence does not necessarily mean that the intervention is not effective' (Cornish, unpublished draft, DCHFT, 2011:2).

Another significant and influential organisation that warrants consideration in this review includes Young Minds. Initial exploration of their website ([www.youngminds.org.uk/](http://www.youngminds.org.uk/)) suggests that inclusion of and meaningful appreciation of Art Psychotherapy is minimal, and concerns about service erosion for young people abound. Also The Sainsbury Centre for Mental Health raised similar concerns about reduction or cuts to some psychological therapies, such as is happening with art psychotherapy and other psychotherapy professions especially across England. They note cuts are

concurrent with generic IAPT increases, and raise concerns that young people with complex needs may lose out (The Sainsbury Centre 2012). The phrase 'Robbing Peter to Pay Paul' comes to mind. Wiktionary's **definition** is 'To use resources that legitimately belong to or are needed by one party in order to satisfy a legitimate need of another party, especially within the same organization or group; to solve a problem in a way that makes another problem worse, producing no net gain' (Wiktionary, 2013). Perhaps Peter in this case is the complex needs of children and young people requiring a high quality and diversity of service, and Paul the financial pot?

Gilroy also observes

'...there are real pressures to provide evidence of art therapy's clinical and cost effectiveness...in its absence, [there is] a potential for service erosion' (Gilroy, 2006:7). I would add to this and the real pressure to evidence the role of art therapy, including definitions of art therapy in influential documents and forums.

Finally, Article 13 of the United Nations Convention on the Rights of the Child (1990) highlights the child's right to freedom of expression. It includes their right to seek, receive and impart information and all kinds of ideas orally, via print, in the form of art, and other media of the child's choosing. Arts therapies are not cited specifically, but it could be argued that reduced provision of art therapy may impact a child's access to their legal rights of communication.

Research into exploring if/how other smaller disciplines currently influence policy so that art therapy can promote itself more effectively generally is indicated, and in this instance to promote its role within specialist CAMHS.

I will now focus on how role in specialist CAMHS is represented within CAMHS publications.

### **Art Therapy in CAMHS publications**

Baldwin found that very little is written about CAMHS teams specifically, with 'cursory consideration of individual roles of disciplines' (Baldwin, 2008:77). I concur with his findings that no publication includes a full, comprehensive range of disciplines currently practising in specialist CAMHS in England, or reference all evidence-bases, or offer clear discipline definition or role, and further lack coherence in what is included/excluded.

Literature reviewed for CAMHS, and in which Art Therapy does not appear at all, and where 'psychotherapy' or 'psychodynamic approach' merits brief consideration at best, include Rutter & Taylor (2002), Dogra (2002), Maleck & Joughin (2004), Dwivedi & Harper (2004), Green et al (2005), Iwaneic (2006), Prior & Glaser (2006), Turk et al (2007), Leo et al (2011), Vostanis (2007), Grimes et al (2011), Kieling et al (2011).

Williams and Kerfoot's textbook (2005) arguably represents the epitome of the current NHS. It seems to symbolise the centrality of CAMHS moving away from a health service to business, using business rather than therapy language and business agenda of 'genericism' and 'targets'. Only 'informal' psychotherapy practice is mentioned, where this is suggested as being offered by any profession. This may suggest a limited understanding of trainings, disciplines and interventions.

Beresford (2008) identified the need for non-verbal communication skills on working with deaf children, but has not considered art therapy. In Carr's 'What Works for Children and Adolescents?' (Carr: 2000) Art Therapy is not cited, and only a brief critical analysis of psychodynamic/psychoanalytic approaches is provided. More surprisingly, even a publication that purports to focus on art in mental health services neither includes Art Therapy nor refers to art therapy research ('Psychiatry and the arts: new interfaces?' Green, 2009)

Similar themes have emerged as previously. A clinical rationale for service composition is neither offered nor clarified; which professions are included varies significantly from text to text; service-user needs and views are almost

entirely absent. Generic terms such as 'individual therapy' 'psychotherapy' and 'psychoanalytic approaches' are not defined and which, if any, categories art therapy is considered within remains illusive. There is no apparent reflection on inherent bias arising from authors' particular paradigm, knowledge limitations, or selection of content and contributors, and no art therapists are cited as contributors.

Such texts could be perceived as key texts by CAMHS commissioners and others with little or no prior knowledge of CAMHS to consult for guidance. This seems to mirror government policy documents/publications process, regarding influence of: unclear or biased clinical rationale; lack of coherence; content and style influenced by authors and their professional paradigms; wielding of powerful political positions and agenda; where editors and contributors are predominantly psychiatrists, psychologists and medical academics. The strength, validity and authority of texts as providing accurate and comprehensive information on individual disciplines, and what may be needed and available for CAMHS service-users is limited, may be misleading, and under question. Future research could be a Hermeneutic analysis of published literature to identify and highlight bias and undisclosed agenda.

Psychodynamically-oriented authors highlight their approach (in common with many art therapists) as useful for young people include Brandell (2001), Kennedy (2004), Lanyado & Horne (2009), Fonagy et al (2002), Roth & Fonagy (2005), but none have cited art therapy, or explored roles within CAMHS.

Roth and Fonagy note

'the significant discrepancy between the amount of research undertaken by psychodynamic therapy and 'BT, CBT, and psychopharmacology' (Roth and Fonagy, 2005:423) arguing that this influences the size of evidence-base and thus commissioning of psychodynamic therapies.



Gilroy (2006) argues that Art Therapy research into mental health has been under-commissioned due to the evidence-based process being dominated by medicine and the pharmaceutical industry agenda that focuses research activity on some issues at the expense of others, and favours some forms of research over others, such as RCTs. Similar to Roth and Fonagy, she argues the construction of the Art Therapy evidence-base has been limited, resulting in the discipline being under-commissioned within the NHS, as outcomes of research inform social policy and health care initiatives in the UK.

Midgley and Kennedy's (2011) critical review of the evidence-base of psychodynamic psychotherapy for children and adolescents did not include art therapy.

### **Art Therapy in CAMHS in the media**

Two articles were found on art therapy in CAMHS in the media, both of which are published in YoungMinds Magazine.

In the first, a practising art therapist, Cliff Free, and the BAAT Chief Executive Officer, Val Huet were interviewed by YoungMinds Magazine in 2012 (YoungMinds, 2012, 115) for their views on the influence of the IAPT strategy on art therapy in CAMHS. Free, also a member of YoungMinds Policy and Strategic Advisory Group and a BAAT Council member raises concerns about how the art therapy profession is being consulted, and included in IAPT delivery in CAMHS. He notes 'BAAT understands that it needs to 'step up to the mark' and provide a more effective and rigorous evidence base.' (YoungMinds 2012:15) expressing a hope that its not too late for inclusiveness. Huet, who represented BAAT on the Critical Friends Group (CFG) of the CYP IAPT programme, argues that whilst 'CBT is the first model to be rolled out but there is great awareness that other approaches must follow' (YoungMinds 2012:15). She reports that the issue of children's non-verbal needs was discussed in the CFG:

'there was wide acknowledgement that age and deep distress were factors that made engagement in a cognitive process really hard and

that some children would benefit greatly from arts-based interventions' (YoungMinds 2012:15).

She acknowledges that the limited art therapy evidence-base is impacting, though feels hopeful that the situation will improve within five years' time commensurate with an increasing evidence-base.

The second article outlines an intensive art therapy group within CAMHS that runs during the summer holidays to cater for Looked After Children (YoungMinds 2012). While the role of art therapy is not stated explicitly it is evident that art therapy has a particular role for the service with its Looked After Children population. It is unclear if art therapists are approaching or being approached by YoungMinds, but promotion of the profession within CAMHS is evident here.

In summary it seems that few Art Therapy papers are published beyond Art Therapy realms. Notable few exceptions include Case's article in the Journal of Child Psychotherapy (2002) and Zago's article (2008) in Infant Observation Journal. I have found no evidence of Art Therapist authors, editors or co-equivalents of CAMHS/Child Psychiatry titled books. Art therapy in CAMHS is promoted via two articles currently within Young Minds Magazine, a magazine which has a broad readership. There is ambiguity about which categories disciplines may be included within for example, 'psychotherapy' 'therapeutic' 'psychotherapeutic' and I have not found mention of art therapy in the texts I have reviewed. Gilroy (2006) notes the growing reference in literature on the study of cultural and social factors that influence illness and treatment methods within psychiatry. She argues the socio-economic political agenda bears profound influence on how treatment methods are written about, and if they are included within CAMHS publications. One area of research could be to explore and ascertain how to bear influence on those with the socio-political-economic power.

It is not within the scope of this paper to include the Art Therapy evidence-base or to discuss the full implications of the strictures, structures and mores

of prevalent government, and other powerful bodies, such as medicine and the pharmacological industry. However, it is important to acknowledge the biased evidence-based practice paradigm and influence on policy formation and implementation on how Art Therapy proceeds with research in healthcare, as highlighted by Gilroy (2006; 2011). Gilroy concludes that

‘while EBP could be of enormous benefit to every aspect of state-based provision – including art therapy – its values and systems could also inhibit the development of evidence appropriate to different practices, services and settings’ (Gilroy, 2006:7).

I would argue that this may be the case for Art Therapists in CAMHS. Hosea states that research she undertook and published contributed to the evidence-base in CAMHS, enabled managers and commissioners to have a greater understanding of art therapy, and her comment that her post may have been decommissioned had she not published, supports this view (Hosea, 2006). In my own experience securing support for art therapy research proved impossible, not being deemed a priority for the trust in which I was employed, and where arguably, lack of evidencing the role of art therapy in CAMHS contributed to its demise. However, the local authority did offer two years funding towards my more general proposed doctoral study into self-harm in adolescents. Strangely and rather incomprehensibly this was awarded simultaneously with CAMHS management refusing any time for study, and their knowing plans for the post being decommissioned.

Lastly, Williams & Kerfoot note considerable uncertainty still exists regarding best practice for many interventions currently offered in CAMHS (which seemed to be the view presented in NICE guidelines explored earlier), highlighting more research is needed. They also challenge the authority of much research

‘the majority of randomized controlled trials have been conducted outside the UK, frequently conducted in carefully controlled, ideal conditions, using heterogeneous cohort of subjects’ arguing methods

and findings are thus inherently biased and where validity is therefore under question (Williams and Kerfoot, 2005:513).

Cuipers et al (2011) also highlights, though differently, questionable authority of published research suggesting the effects of psychotherapy are probably overestimated because of publication bias and the relatively low quality of many studies in the field.

To conclude, another area for research may be to explore the impact of situations where a profession is faced with a bias against being afforded funded opportunities for research, but where not producing evidence of their effectiveness may result in posts being decommissioned, such as, sadly, with my post. I would argue profound complexities lie in how art therapy in CAMHS finds a way to present its unique role. There is evidently no 'level playing field' regarding what is deemed 'high quality research', and where paradoxically much 'accepted' international research is inherently biased and therefore questionable (Williams and Kerfoot, 2005; Cuipers, 2011), combined with powerful socio-economic political and other professions agenda influences consideration of art therapy, and possibly limited self-promotion of the profession of art therapy.

I will now explore the possibility of misunderstandings of art therapy and unconscious processes that may bear further influence.

### **Other Influences: Looking Beneath the Surface**

Edwards suggests misunderstandings prevail despite art therapy's lengthy life where 'art therapy' continues to be used uncritically by colleagues who use art materials (2004) [a notion reinforced by data within the CAMHS mapping exercise 2002], that misleads clients regarding what they are being offered. Integrating the profession remains difficult even when art therapy is well understood (Edwards 2004; Jones 2005), perhaps highlighting inherent difficulties for an oft-times sole art therapist in CAMHS.

Diversity of practice within art therapy where individual art therapists are seen to practice differently may compound misperceptions (Edwards 2004, Jones 2005, Gilroy 2006, Case & Dalley 2006), and, I would argue, add to the complexity in how the profession can promote itself in a coherent manner which, arguably is needed in some way, but where paradoxically, attempts at homogenisation may crush the very life out of its unique role, creativity and meaning. I would further argue that art therapists using different professional titles such as art therapist or art psychotherapist may add to the confusion.

Hogan (2009) attempts to define separate positions within practice, but Edwards suggests 'merely gaining professional recognition', or difficulties explained 'simply in terms of theoretical differences or confusion over roles', will be insufficient (Edwards, 2004:72), where the difficulty in understanding may be influenced by unconscious 'social defence systems' that develop to manage worker's anxieties about the work (Menzies 1977 cited in Edwards, 2004:72)

Rizq (2011) Mollon (2008) Obholzer (1994) also explore unconscious processes within professional realms, especially idealisation, envy and anxiety, identifying the need for mental health workers to defend against shame, guilt and anxiety at individual and organisational, and, I would argue, at commissioning and government levels.

Art therapists, as part of their role, champion intra-psychic and non-verbal needs of young people, and may highlight their unconscious processes as well as those emerging in team dynamics, and may present an unwelcome challenge to how IAPT is imagined to be the generator of

'unconscious hope...keep[ing] the hope for a cure alive" (Rizq, 2011:53).

It seems reasonable to argue that governments and their representatives, unable to meet increasing demand for CAMHS services yet being charged to do so, may marginalise disciplines, such as art therapy, that continue to raise concerns about availability and quality of services, that impact on staff and

young people alike (Cornish, unpublished draft, DHCFT 2011). Rightly beholden to abide by the Code of Ethics and Principles of Professional Practice for Art Therapists (BAAT, 2005), in their duty of care, this part of the CAMHS art therapist's role may need considering further: to use these skills may highlight precisely that which is endeavoured to be denied thus proving a potentially unwanted presence – a convenient scapegoat (Schaverien, 1999).

Research on how art therapists in specialist CAMHS can effectively share psychodynamically-informed understanding of unconscious processes of clients and that also arguably manifest across teams, services, and governing bodies, seems indicated.

Returning to socio-politico-economic influence, a Child and Adolescent Psychiatrist, Timimi, working in an English specialist CAMHS, emphasises 'neo-liberalism' failings and how 'beliefs and practices around children and families are shaped, [and conceptualised] by economic, political and cultural pressures' (Timimi, 2010:686). He argues that such dynamics

'facilitate the rapid growth of child psychiatric diagnosis and the tendency to deal with aberrant behaviour or emotions in children through technical – particularly pharmaceutical – interventions' (Timimi, 2010:686).

Timimi imagines the current societal approach as the 'MacDonaldisation' of children's mental health. He suggests that medication-centred practice in children's mental health is similar to the fast food industry, where society plays a role in creating children's difficulties, which then influences which services are commissioned. Continuing his metaphor, I would argue that Art Therapy may offer a more fulfilling and nutritious meal - one that may take longer to cook, eat and digest but which has longer-lasting benefits than some other interventions – good food costs money, a commodity in very short supply in the NHS.

I am left increasingly wondering about the current rationale, and clinical argument, behind commissioning certain interventions and not others. The short-termism of the NHS needing to cut cost, with its target, rather than service-user, driven business agenda comes to mind.

An area of research to consider here would be longitudinal studies into the long-term effects of art therapy. To my knowledge, and surprise, there are no longitudinal studies published in England either on the long-term effects of individual interventions in CAMHS or following up young people once they enter adulthood. This is an area for future research that should be commissioned urgently to inform future service modelling.

Linked to this, Vostanis, a Child Psychiatrist, highlights dangers of the prevalent political agenda, arguing

‘...the costs of not providing effective specialist mental health [CAMHS] inputs can be high... there are also costs to providing unhelpful services’ (Vostanis, 2007:25).

I imagine he is referring to the possibility that services may at best deny, hide or delay addressing the depth of young people’s distress, and at worst may exacerbate their difficulties, making matters worse if services are not sufficiently skilled to do either safe or effective work. He concludes that services should

‘be delivered via a mixture of specialist therapies in specialist clinics and...multi-agency and community approaches’ (Vostanis, 2007:25),

Vostanis does not list specialist therapies specifically but seems to suggest multidisciplinary provision of specialists rather than generic practice is required to meet the diversity of need. I would argue specialists should include art therapy given its unique central offering of image-making to optimise choice, and well as offer quality, evidence-based intervention for service-users.

Gilroy cites the challenge made by a service-user that the focus is more about 'protecting the public from mental health users than caring for them,' (Gilroy, 2006:19). She argues that the lack of funding for research 'into what really works for people', combined with research that supports the medical model of psychiatry being privileged, may lead researchers and mental health workers being at the mercy of political and market forces 'becoming agents of social control' (Allard 2002 in Gilroy, 2006:19).

Research into the process, and impact, of prevalent socio-political agenda on commissioning of research seems warranted, though who could undertake this enormous and controversial task may prove difficult to establish.

To conclude, both powerful political and unconscious processes may bear influence on the inclusion or otherwise of Art Therapy in policy-informing and making forums, within specific service literature, broader CAMHS publications, and Art Therapy within CAMHS services. At a ground floor level Edwards advises a way forward is for education of

'other professions on the nature of Art Psychotherapy for appropriate referrals to be made...and for service users to appreciate it's a quality-assured, effective service they want' (Edwards, 2004:74).

This further supports the argument for clarifying the role of art therapy in CAMHS as well as explaining its central workings at all levels from team to central government. Research on how best to offer education on the role of art therapy in specialist CAMHS is indicated.

### **Summary of Findings**

I will now highlight central findings, organising them as found within particular sections for ease of reading. I will then suggest ways forward, again organised within the same sections to clearly link them to findings.

#### *Summary 1: The Role of Art Therapy in CAMHS*



While case studies offer evidence of practice they are insufficient on their own to provide authoritative evidence to CAMHS policymakers and commissioners. The majority of case studies and core texts on art therapy with children and adolescents are published only in art/s therapy specific publications and do not appear in CAMHS-based search. Published material specifically addressing the role of art therapy in CAMHS is very limited, and some research has only been published on the BAAT website. ATCAF has produced a useful preliminary document towards the creation of the development of clinical practice guidelines. Definitions found on CAMHS websites varied, were very brief, and focussed on image-making and non-verbal aspects of art therapy only.

*Summary 2: The Role of individual disciplines in CAMHS*

CAPAs outlining principles are for teams to provide cognitive, systemic and dynamic interventions, (although this seems at odds with government drive towards genericism). There is a lack of evidence of numbers of young people referred to the Partnership stage of CAPA as well as measured outcomes of these. There are convincing arguments for defining role within CAMHS as well as apparent confusion regarding what is actually wanted and needed to meet the needs of such a diverse population.

*Summary 3: Government policies, NICE guidelines, CAMHS publications, Art Therapy publications*

*Government policies, NICE guidelines*

A significant percentage of all professions in CAMHS may still state/believe they 'Offer Creative Therapies'. There is currently no coherent policy for commissioning and provision of disciplines in CAMHS, where it is acknowledged that both government documents and NICE guidelines have limited profession-specific evidence-based research to draw on to help with this. There is very little evidence of research that considers the role of art therapy in CAMHS specifically. In central CAMHS informing documents, it is unclear if/how much art therapy profession is represented on consultation and planning panels; art therapy is frequently overlooked in many central

documents and NICE guidelines; art therapy is not considered even where evident communication difficulties (such as Autism), activity-focussed or visual interventions are highlighted as needed.

Information about the process for professions becoming members on project teams and advisory boards that influence commissioning is not given.

There is limited understanding of the needs of children and young people presenting to CAMHS from a psychological perspective. A sound understanding of art therapy, and its particular and generic roles in CAMHS is not evidenced in any of the documentation explored.

#### *Art Therapy in CAMHS publications*

No CAMHS titled publication includes a full, comprehensive range of disciplines currently practising in specialist CAMHS in England, or reference all evidence-bases, or offer clear discipline definition or role. Art therapy does not appear in any of them though may have been thought about within generic terms such as 'individual therapy' 'psychotherapy' and 'psychoanalytic approaches'. Few art therapy papers are published outside art/s therapy specific realms. Research has been under-commissioned Gilroy (2006) limiting Art Therapy in CAMHS' evidence-base resulting in the discipline being under-commissioned and to decommissioning of posts.

#### *Art Therapy in CAMHS in the media*

Two articles are published on art therapy in CAMHS in Young Minds Magazine, though no others found elsewhere.

#### *Summary 4: Other Influences*

Diversity of practice, unconscious processes, unwanted role of highlighting unconscious processes and keeping the needs of YPs in the centre, raising concerns, socio-politico-economic agenda may all bear influence.

There are no longitudinal studies published in England either on the long-term effects of individual interventions in CAMHS or following up young people once they enter adulthood.

There is an evident lack of funding for research into what really works for young people, combined with research that supports the medical model of psychiatry being privileged.

Education on the role of art therapy in CAMHS, its uniqueness and more generic aspects, of those with a vested interest in CAMHS across all levels of interest is needed, both to assist understanding of art therapy and also to minimise possible unconscious dynamics bearing influence.

### **Suggested Ways Forward: Waving Not Drowning**

#### *Remedies for Summary 1 findings*

1. Extending the breadth of publication base will likely increase access to art therapy publications and may offer a broader understanding of art therapy's role in CAMHS.
2. Creation of a core text/book on art therapy in CAMHS may offer effective promotion to interested parties and stakeholders outside the art therapy profession. Co-ordinated research into what the content of this might most usefully be is indicated
3. ATCAF to be supported in continuing the development and, thus production, of clinical practice guidelines, for art therapy practice with specific populations such as those presenting to specialist CAMHS, and to include art therapy's unique and more generic roles.
4. Brown's initial scoping of art therapists in CAMHS to be undertaken anew, building on criteria in a more refined and critical manner.
5. Research into information that should be included within CAMHS websites to define and promote Art Therapy's roles and practice to be undertaken including dissemination policy

#### *Remedies for Summary 2 findings*

6. Research into how art therapy can best promote its central approach of psychodynamics to meet CAPA principles
7. Linked to 5. Research into how and how many service users are referred for Art Therapy, or 'dynamic' therapy in the Partnership stage of CAPA may offer a useful bank of data for service commissioners to consider.

8. Whilst Baldwin's research (2008) concludes that defining role for any given discipline is inherently difficult in part due inevitably to some shared skills and practices across disciplines, research into how to best define the unique and generic roles of art therapy in CAMHS is needed.
9. Focused research into what actually informs service composition seems indicated, research methods involving service-users

*Remedies for Summary 3 findings*

10. Education of CAMHS staff groups and management on the legal aspects of the art therapy profession, and the need for specialist training to use images safely and usefully.
11. BAAT to create a database for art therapy in CAMHS research, so that clarity can be gained regarding what exists currently and so that future research can be appropriately identified, co-ordinated and proposed to art therapists in CAMHS to undertake.
12. Research to be undertaken focusing specifically on the particular unique role and generic role that art therapy has in CAMHS, including a dissemination strategy.
13. BAAT to ascertain the process for smaller professions to be represented on project teams and advisory boards that influence commissioning.
14. BAAT to identify forums that currently have direct art therapy representation and to forward a list of these, feeding back outcomes to CAMHS art therapists (and ATCAF)
15. BAAT to identify forums that currently have no direct art therapy representation but are represented in a more general way by another AHP, and to forward a list of these, with feed back outcomes to CAMHS art therapists (and ATCAF)
16. BAAT to identify forums that most urgently need art therapy representation and to negotiate roles for CAMHS art therapists to follow up
17. BAAT to present, and publish, its own position on the bias and influence of 'inherently flawed' NICE guidelines to NICE and other pertinent forums
18. Research into identifying and analysing central factors in art therapy in CAMHS current situation, such as: Is this situation due to being a relatively small profession, with a limited number of art therapists within CAMHS; a

lack of a focus group to promote art therapy in CAMHS; a lack of a focus group to promote CAMHS; a political move to marginalise some professions; indicative of a lack of knowledge or rigour by commissioning parties; or merely a politico-economic move?

19. Education of other staff and managers on the psychological needs of young people could be undertaken more by art therapists in CAMHS
20. More research into how to produce a comprehensive, meaningful, authoritative treatment protocol for the role of art therapy in CAMHS that can be presented in a coherent manner that caters for its unique and generic workings, is urgently needed. Its authority will depend on strategic co-ordinated building of the evidence-base research base as outlined above, and perhaps consideration of 'united enough' terminology and 'branding' of the profession to minimise confusion and misunderstanding seems essential for effective promotion e.g. to agree on one overarching professional title such as Art Therapy or Art Psychotherapy; is it a 'talking therapy' or a 'non-verbal therapy'; is it an 'arts in health' intervention or a psychotherapy etc?
21. BAAT/ATCAF to liaise with authors of CAMHS-specific texts to ascertain if/how art therapy has been reviewed and to promote the profession
22. BAAT to encourage publication of CAMHS-based research beyond art therapy audiences.
23. BAAT Council and Chief Executive, and BAAT SIG representatives to continue promoting disadvantage to the profession of under-commissioning of research, to research commissioners and research stakeholders. Research could also be undertaken to more clearly identify the disadvantage and its impact, including audit of number of posts decommissioned and rationale given for this.

#### *Remedies for Summary 4 findings*

24. Research, specifically longitudinal studies into the long-term effects of art therapy may help provide data on the efficacy of art therapy
25. National research commissioned by policy-makers, specifically longitudinal studies into the long-term effects of every specialist therapy in CAMHS specifically longitudinal studies into the long-term effects of individual

interventions, to provide data on each discipline's efficacy, to inform future policies, NICE guidelines and hence CAMHS service modelling. BAAT Council to identify how best to present this?

26. National research by policy-makers should be identified, co-ordinated and commissioned urgently and equitably across disciplines to create meaningful data focusing on service-user research (Holliday, Harrison, & McLeod, 2009) to inform future policies, NICE guidelines and hence CAMHS service modelling. BAAT Council to identify how best to present this?

27. Research on how best to offer education on the role of art therapy in specialist CAMHS is indicated, and may include research that informs an education pack specific to the role of art therapy in CAMHS along with a dissemination strategy

Whilst BAAT and ATCAF are clearly beginning to take steps in addressing the need for more clarity of what art therapists have to offer within CAMHS, I imagine this initial systematic review may offer useful data and suggestions of ways forward to art therapists working in CAMHS, as well as ATCAF, BAAT, and commissioners, managers and policy-makers of CAMHS services in England in particular.

I would also hope that the article offers a useful general overview of the current situation for art therapists and the art therapy profession within the National Health Service, CAMHS, within England to refer to by art therapists, managers, and commissioners and policy-makers concerned with equivalent and related services. The inherent complexities in both how some aspects have influenced the current situation as well as some suggestions that may go some way to remedying it, may offer useful insights into what others across the world working in the field of child and adolescent mental health and children and young people with other psychological needs may need to consider by way of promotion of, and research into, art therapy and some of the stumbling blocks along the way.

I offer a final quote that seems to sum up the paper's overall convincing argument that, in addition to increasing the research evidence-base, the role of art therapy, its unique (and generic) processes and practices within specialist CAMHS urgently requires both verbal and conceptual clarity for effective articulation:

'to obtain a clear understanding of what it is that makes our work unique, different from and *similar* to that of other allied health professions' (Pavlicevic 1995 in Jones, 2005:89).

### **List of acronyms**

AHP/s	Allied Health Professional/s
ATCAF	Art Therapy with Children and Families (BAAT special interest group)
ATPRN	Art Therapy Practice Research Network
BT	Behavioural Therapy
CBT	Cognitive Behavioural Therapy
CPSM	The Council for Professions Supplementary to Medicine
DHCFT	Derbyshire Healthcare NHS Foundation Trust
DoH	Department of Health
EBP	Evidence-Based Practice
HPC	The Health Professions Council
HCPC	The Health and Care Professions Council
IAPT	Increasing Access to Psychological Therapies
MDT/s	Multidisciplinary Team/s
NCCMH	National Collaborating Centre for Mental Health
NHS	National Health Service
NICE	National Institute for Clinical Health and Excellence
PhD	Doctor of Philosophy
RCT	Randomised Control Trials
UK	United Kingdom

## **Biography**

Since qualifying in 1991 Shelagh has continued her art psychotherapy practice with vulnerable children, adolescents and young people. She was initially employed within a residential therapeutic community for traumatised adolescents, when she also undertook further training in systemic therapy. For more than 16 years she has practiced within inpatient and outpatient services within the NHS, in specialist CAMHS services in the East Midlands as Lead Art Psychotherapist within Specialist CAMHS more latterly and until recently.

Shelagh has continued to be a part time Senior Lecturer teaching on the MA Art Therapy training at the University of Derby since its inception in 2002. She has particular responsibility for the Reflective Practice Groups that support fieldwork placements, and module leadership for Art Therapy Theory and Research in Relation to Practice One.

Shelagh is a BAAT Recognised Clinical Supervisor and BAAT Recognised Private Practitioner. She has operated her private practice since 1995 offering clinical supervision to a number of registered professionals including art therapists, and individual art psychotherapy and psychotherapy to adults, young people and families. Her web address is [www.heartening.ac.uk](http://www.heartening.ac.uk)

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