
# Working with the parental couple in CAMHS –

# themes emerging from interviews with CAMHS clinicians and CAMHS commissioners in 2016

**Background**

There is a sizeable evidence base demonstrating the impact of inter-parental conflict on the mental health of children (see later in this document for an overview).

There is also a sizeable evidence base showing the effectiveness of couple therapy for helping improve the relationship quality between adults (see *What works in relationship support: an evidence review* for a summary (Tavistock Relationships, 2015)).

There is, however, almost no evidence regarding the impact of giving couple therapy to parents on their children's mental health (although it should be acknowledged that Tavistock Relationships' Parents as Partners groupwork programme – which helps parents to improve their communication and co-parenting relationship – has demonstrated successful results regarding children's mental health; see the Early Intervention Foundation's review of *What works to enhance inter-parental relationships and improve child outcomes* (Harold et al., 2016)).

Against this, it should be stated that the clinical experience of couple therapists who work for Tavistock Relationships is that the mental health difficulties of children of couples experiencing relationship problems are significantly alleviated when those couples engage in couple therapy.

Of course, however, the testimony of couple therapists is not, in and of itself, sufficient to make the case why work with the parental couple should be undertaken in CAMH services.

Given the existence of the evidence base linking inter-parental conflict and children's mental health, the clinical experience of couple therapists and the lack of studies which have sought to ascertain whether couple therapy for parents results in improvements to their children's mental health, Tavistock Relationships is seeking to explore the possibility of work with the parental couple being added to the interventions and approaches currently offered in CAMHs.[1]

We would argue Tavistock Relationships is not alone in being exercised by this, and related issues. For example, the authors of a critical analysis of the last fifteen years of child and adolescent mental health services policy in England (Callaghan, 2016) conclude that the focus of the most recent major policy report in this area, *Future in Mind* (Department of Health, 2015), "reproduces the idea, already embedded in earlier policy frameworks, that family life is reducible to a set of skills parents can be trained in, rather than thinking about whole families with histories and contexts, needing insight and support. This functions to entrench an individualising model of mental health, and

[1] CAMH services consist of the following practitioners:

- psychiatrists
- psychologists
- social workers
- nurses
- support workers
- occupational therapists
- psychological therapists – this may include child psychotherapists, family psychotherapists, play therapists and creative art therapists
- primary mental health link workers
- specialist substance misuse workers (NHS Choice website)

enables a further retreat of the state from providing good-quality care to children and families. Focusing on parenting *skills* without attending to the relational and social context of parenting is not an optimal strategy".

We don't suggest that CAMH services are entirely blind to the importance of the inter-parental relationship. However, it is telling that the only time that the inter-parental relationship is mentioned in the CYP-IAPT national curriculum is in relation to the Parenting Training for conduct problems in children aged 3–10 years (IAPT, 2013). And while we acknowledge that the curriculum does stress the importance of practitioners' ability to understand family relationships (albeit in relation to systemic family practice only), we question whether this goes far enough.

At the outset we feel we should stress that in no way do we seek to blame parents for the difficulties their children are experiencing, nor CAMHs practitioners or CAMHs commissioners. Rather, our interest in this area of policy and practice comes from a sense that we can no longer ignore the weight of the evidence regarding the impact of the quality of the parental couple relationship (living together or apart, and whatever the sexuality of the parents) on children's mental health; a belief, increasing borne out by evidence, that difficulties in parents' couple relationship profoundly affect their capacity to parent and therefore without specifically attending to the couple domain parental interventions on their own have limited reach (Casey, 2015); and an understanding that only by ensuring that CAMH services are adequately staffed and skilled to support parents who have conflicted relationships can we provide the most effective help for children.

We feel that the need to develop our response in this area is urgent given what children seem to be experiencing, for example:

- in ChildLine's most recent annual report setting out the reasons why children contacted the service, the issue of 'family relationships' – defined as 'conflict/arguments with family members, parents' divorce/separation' – was the only problem area identified in the top three concerns in each of the three age groups surveyed (ChildLine, 2016);

- while 'Family Relationships Problems' were reported by CAMHS clinicians as being the biggest presenting problem in a survey of more than 90,000 children across CYP-IAPT services, being cited in 52% of cases (Wolpert, 2016).[2]

[2] Although the term 'family relationships' encompasses a number of different relationship dynamics, the relationship between a child's parents is likely to be highly represented among these.

**Inter-parental conflict and children's mental health – what does the evidence say?**

Having difficulties and arguments is an ordinary and natural feature of couple relationships. Where these are managed well by couples, they provide a model of relatedness that does not result in the loss of love and affection (Cummings et al, 1991). Moreover, positive adult relationships can be a protective factor when there is a high-level of conflict in the mother-child relationship (Kiernan & Garriga, 2015).

However, a considerable body of research now clearly shows that conflict between partners which is frequent, intense and poorly resolved is very harmful to children's mental and physical health, (Cowan and Cowan, 2002; Harold and Leve, 2012; Harold et al., 2016).

In response to this kind of conflict, babies may become agitated, and children younger than five may respond by crying, acting out, freezing or withdrawing from, or intervening in, the conflict. For very young children their sleep can be affected (Harold et al. 2016); older children may show a range of distress including anxiety, depression, aggression, hostility, anti-social behaviour, and perform worse academically than their ability level (Harold et al, 2007).

Conflict does not just have to be violent or outwardly expressed; conflict that is characterised by deliberate coldness and withdrawal between partners can affect children, creating long-term emotional and behavioural problems (Cummings and Davies, 1994; Amato, 2001).

Furthermore, conflict in which children feel blamed, responsible, or that the conflict is at risk of turning on them is the most damaging of all (Grych, 2003). These negative impacts include girls blaming themselves for the difficulties between their parents, while boys tend rather to externalise their feelings leading at times to behavioural problems (Grych, 2003). These authors speculate that, as a result of gender differences in socialization, 'it may be that girls who feel responsible for inter-parental conflicts are saddened that they have done (or failed to do) something that adversely affected family relationships, and they attempt to do something to repair the disruption. Boys may focus less on feelings than on the implications arising from the disagreement and may emphasize action instead'. These findings correlate in some aspects with the Early Intervention Foundation Review's finding on gendered responses by parents where there is serious inter-parental conflict (see below).

A number of researchers have explored possible mechanisms through which inter-parental conflict affects children. For example, Erel & Burman (1995) have posited one such mechanism, often referred to as the 'spillover' effect by which parents embroiled in a hostile and distressed relationship are typically more hostile and aggressive toward their children and less sensitive to their children's needs.

Researchers have also demonstrated that children's attachment processes – i.e. those which underpin their emotional security – are disrupted by destructive inter-parental conflict (Davies & Cummings, 1994).

In addition, it has been suggested (e.g. Harold and Conger, 1997) that the attributions children assign to conflict occurring in the marital relationship orient their expectations and representations of conflict in relationships, which in turn affects their long-term psychological adaptation.

In 2016, the Early Intervention Foundation was commissioned by the Department of Work and Pensions to carry out a review into *What works to enhance inter-parental relationships and improve child outcomes.* The Early Intervention Foundation's review (Harold et al., 2016) summarised the considerable evidence base linking inter-parental relationship quality to children's mental health and behaviour, stating:

- the quality of the inter-parental relationship, specifically how parents communicate and relate to each other, is increasingly recognised as a primary influence on effective parenting practices and children's long-term mental health and future life chances.
- parents/couples who engage in frequent, intense, and poorly resolved inter-parental conflicts put children's mental health and long-term life chances at risk.
- children of all ages can be affected by destructive inter-parental conflict, with effects evidenced across infancy, childhood, adolescence, and adulthood.
- the wider family environment is an important context that can protect or exacerbate child outcomes in response to exposure to inter-parental conflict. In particular, levels of negativity in parenting practices can exacerbate or moderate the impact of inter-parental conflict on children.
- inter-parental conflict can adversely affect both the mother–child and father–child relationships, with evidence suggesting that the association between inter-parental conflict and negative parenting practices may be stronger for the father–child relationship compared to the mother–child relationship.

**The interviews – the views of clinicians and commissioners**

The material in this section is derived from ten interviews undertaken during the summer of 2016 with clinicians working in CAMHS, commissioners commissioning such services, and a former director of the leading children's mental health charity, YoungMinds.

While some of those interviewed have an ongoing relationship with Tavistock Relationships, the majority took part in the research out of interest in the subject matter rather than any particular link to the organisation.

While the interviews conducted with CAMHS clinicians and commissioners were semi-structured, they tended to focus on common areas and themes, and these form the headings for the following sections.

*Acknowledgement of the quality of the relationship between parents having an adverse impact on the mental health of children*

Some clinicians and commissioners felt that these links were understood:

*"I would suggest about 90% of the cases I see would require a couple intervention - there's very few of the kids we see that don't have some parental aspects that need also to be addressed."*

*"It's just glaringly obvious with some of the cases that come into CAMHS that there are major couple relationship problems".*

*"I would say that the inter-parental relationship affects the mental health of children is widely acknowledged in CAMHS. That we need to look at the family background, of course the parental relationship, is very much dominant in the reality of a child's life."*

*"I think for some clinicians it's very much there, in terms of their thinking."*

However, responses from others suggest that this evidence base is only just starting to gain acknowledgement, with practical steps to address the challenges it presents being some way off:

*"It's something we're aware of, but I would say at the moment we haven't done much about it".*

*Work being undertaken with the parental couple on their own in CAMHS*

Given that parental couple work is not specified as a CAMHS intervention, it was not surprising that clinicians and commissioners had little to report in relation to this subject:

*"We don't have any couple work. We have a reconnect service which looks at the infant and child, and it might be that both parents are involved, but they're not involved in that as a couple."*

*"There's very little if any couple therapy going on within CAMHS that I work in."*

However, it is notable that a number of respondents spoke of work of this kind nevertheless being undertaken, often without it being reported:

*"A lot of couple work does happen in CAMHS but it's done underneath the radar."*

*"So we've ended up with people doing it under the radar, and probably not doing it to any particular standard."*

*The extent to which the quality of the parental relationship is assessed by CAMHS*

While some described an approach which was common to all practitioners undertaking assessments -

*"I would say there* is *a CAMHS assessment"*.

*"There's often a structure that people follow. You think about the family history, the presenting problems, what's going on at school for the child, and then you think about formulation and care plan".*

- other practitioners spoke of the heterogeneity of CAMHS assessments:

*"Your professional training informs how you do assessments. So, my formulations are often quite systemic. Whereas nurses, in my experience, do a lot of thinking about risk. Psychiatrists use a lot of medical language and psychologists often talk about attachment issues. There isn't a generic CAMHS assessment."*

*"I rarely hear any of my colleagues say* I'm working with a couple*. Because their formulation hasn't led to them thinking, okay, they need to be some couple work. It's often we need to do some parenting work, or we need to do some parent-child work, or we need to work with the child on their own, or the child needs medication."*

Some of those interviewed referred to difficulties in getting fathers to attend CAMHS as being a factor which limits the assessment process, for example:

*"More often than not dads will not come. Now the explicit reason is 'Dad is busy, he's at work' and you have to go with it. So, while the answer would be,* Oh yes, of course, seeing the family is very much part of our assessment*, I would doubt whether in reality it happens".*

*CAMHS' response if the quality of a child's parents' relationship is thought to be detrimental to a child's mental health*

Interviewees talked frankly about the difficulties involved in responding to this challenge, for example because of the nature of what service is commissioned to deliver:

*"You know that you're not going to be able to change a child's circumstances at home, you can only try and work with how the child understands the situation and himself or herself in that situation".*

*"That person [a couple therapist] was removed from CAMHS, and with it went that dedicated professional. And now we're in stupid situations where kids are on the waiting list for 6 months, waiting for an assessment for psychotherapy - the psychotherapist offers the assessment, commences the treatment without a dedicated professional for the parental couple work."*

Or the difficulties of engaging the couple:

*"Most of the time when clinicians understand that the relationship between the parents is directly affecting the mental health of a child, nothing gets done about it. Mostly, in my experience, because of absent fathers".*

*"You know, say the parents are divorcing, the child is depressed and the parents are divorcing. What do we do in that situation? Nothing, you know, okay, maybe we will call the family therapist, I think the family therapist may do that job. Sometimes do some parent work, but hardly ever do you see the father. So there's always an idea that you're making the best of a bad job."*

Some interviewees spoke of limited work being undertaken:

*"I think the only time I myself have worked with parents in their relationship is when I saw a family who came because their four year old had separation anxiety. It's the only time I managed to see both parents and talk to them about what was going on between them."*

*"So family therapy, yes, they'll work with the whole family about all the family relationships. And actually some of those conversations I wonder also, not wonder, I know, some of it gets indirectly addressed in the family therapy sessions, and that's where, perhaps, not confusion, but it's kind of 'Yeah, we kind of do that' in the context of family therapy working with the whole family - but there's something slightly different about the parental relationship."*

While others discussed the consequences of not being able to offer anything for the couple:

*"I've noticed that, over a number of years, not one of the couples that I've referred out for relationship support has taken it up. But I do feel comfortable about making that referral, about putting it in black and white, because I then take responsibility, and that blame, from the child. Because I have highlighted it - it's not that this child has an inherent problem, and they will always be with this problem; I have identified how the dynamics impact on the child's presentation."*

*"More often than not they would be referred out. Especially if there is no identifiable mental health issue for the child, then I will write in the assessment that I suggest parents seek relationship support.."*

*"People might get sign-posted to Relate. How many people actually take that up, I'm not sure. And, you know, they would pay, so it already limits the number of people".*

<u>*How do parents respond when it is suggested to them that their relationship might be something for them to seek help with?*</u>

Interviewees reflected on the considerations arising from the fact that while CAMH services are not commissioned to provide couple work, practitioners nevertheless routinely identify couple relationship distress as being an aspect of concern:

*"Parents are quite surprised when they realise you want to talk about their relationship. They find it intrusive, they're embarrassed, they don't see the connection, or they don't want to see the connection".*

*"When we either run out of time, or we get beyond the remit of our skill mix, then we would start to think about referring out. Um, I've noticed, just anecdotally, that over a number of years, all the couples that I've referred out haven't taken it up. In fact none of them have taken it up, as far as I know."*

*"People very much feel they're coming with the child, the child is the problem, that's why they're there. they maintain the pressure as being very much on the child, as well as their genuinely being concerned for the child. So they might feel a bit bewildered".*

*"They kind of come with the kid and then they get kicked in the teeth, you know, the real problem is your relationship, and that's why your kid's bad. Making that adjustment's one thing, and then to then say because we don't have what you need here, you've got to go to another place to get it, and you have to ring and sort that out yourself, you know, it's just a joke."*

*<u>Reflecting on the qualifications and/or suitability of those practitioners who undertake couple work in CAMHS</u>*

*"While there's a kind of encouragement or an expectation that you work with the child, how much of that is because you're worried about opening up something and not actually being resourced or commissioned to provide an ongoing treatment?"*

*"Some of them came back [from CAMHS trainings on identifying and responding to parental couple relationship problems], because I watched them, very enthusiastic, wanting to develop things, and then the momentum very quickly gets lost, and we have one of them saying, coming to me just because I was there saying 'Well, I've seen this couple and I'm stuck now after about two sessions because I don't really know what to do next'."*

*"Whether or not you address directly with parents the quality of their relationships is definitely a competency issue, because there are so many subjects for which the client will try to stop you to talk about. In the same way that we haven't stopped in other matters, we shouldn't stop in that one either".*

*<u>The implications of not doing couple work in CAMHS</u>*

*"It feels like there's something missing in the team. And when we talk about parents, I think something I miss is the oversight of kind of holding the couple in mind."*

*"And there's lots of re-referrals - that's another interesting thing with CAMHS. So cases that are closed get re-referred back into the service quite quickly, and no-one's doing anything about why they're being re-referred, because maybe we've obviously not tackling what the issues are".*

*"The psychotherapist's treatment is in isolation and will often collapse because the one or both of the parents are not supportive of it. Or they're doing really well in therapy, in the clinic, and then they go home and it's shit - it's missing the couple dimension."*

*"Family therapists talk about the system of the family and also child and adolescent psychotherapists will do that, so the relationship between the parent and the child, but no-one specifically identifies the couple, and I think it should be addressed. Because, as*

*we know, a lot of the dynamics get going between the couple and then they implode and get expressed with the child. And suddenly the child is presenting in CAMHS."*

*Issues relating to the current CAMHS commissioning specification*

A number of clinicians reflected on the practicalities of undertaking couple work in CAMHS:

*"Managers will pick up on that. Why have you had three sessions with just, without the child present? What are you doing there? You need to give a clinical formulation that has to incorporate the child somehow in the thinking. Commissioners as well, if they were to look into your notes and they see again three sessions with just the adults, they would ask questions."*

*"From a commissioning perspective, we're not commissioned to do couples work."*

However, some commissioners were clear that they were not entirely constrained by NICE guidance and had the freedom to explore additional interventions and approaches:

*"If you look purely at the specification, couple work is not in there, but you know, actually if it's benefitted the child then it's got to be of use."*

*"[The fact that couple therapy is not recommended by NICE] doesn't mean that we shouldn't consider all of these options on a person-centred basis. NICE guidance doesn't mean you can't offer other things."*

*"I think if it's benefitting the child I wouldn't have an issue with that. I suppose the difficulty is how do you record that, I suppose, to actually be captured in the data because actually I don't know whether they would record that against the child, because effectively it isn't a contact with the child".*

*"I wasn't aware of any work that's going on directly in terms of couple relationships but now that I'm aware of the evidence base, I certainly wouldn't challenge it if I did come across that, even though it's not specified in the service spec."*

Other clinicians expressed frustration about the absence of couple work in the current CAMHS specification:

*"Everyone's doing parental couple work but it doesn't necessarily mean they're doing couple therapy. And that's the problem, and that's the answer to CAMHS in terms of the way it's commissioned and constructed at the moment. Because there isn't an easier way of getting this in so that people can start taking it seriously. And it will only happen if you've got trained clinicians either within CAMHS or you import qualified couple therapists into the system."*

*"I would love to do more couple work within the service but it's about how do I justify it? So it needs to be justified. So how do you measure it? All our measures - we have to do all these IAPT measures for CAMHS services - we've all been signed up to this pot of money to complete that kind of indicate child wellbeing - and how do you assess that if you don't have the measures for adults?"*

*Challenges involved in incorporating couple work into CAMHS*

A number of clinicians described some of the foreseeable difficulties involved in introducing couple work to CAMHS:

*"In order to do couple work, you need to see fathers. I think there's a bias around fathers and working with just fathers on their own."*

*"There's lots of parents who have an acrimonious relationship, and can't be in the same room, and that's another difficulty. So to think about the child is going to be difficult because they can't even stand each other and be in the same room, so that create problems for us to do the work."*

*"This is not about blame. Because you could say that about family therapy as well. A lot of our clients, families - when you say family therapy, they say 'What's wrong with our family?' So actually it's about our skills as professionals in being able to engage families."*

*"The specific focus on the identified child as the locus of treatment, stymies any kind of possibility of doing, really doing, properly doing, um, couple therapy".*

*"And so I've been doing some work with the couple, and all the time I'm seeing them I'm thinking if the commissioner or the manager came in, or someone came in and said 'Well, how is this related to the girl?' So that's a dilemma because we don't very often have the capacity in CAMHS to be splitting work, because we're all under so much pressure."*

*What are the potential models for this kind of work?*

Some interviewees described ways in which a couple therapy approach might be incorporated into CAMHS:

*"If I were to open a clinic, I'd have a couple therapist in addition to a family therapist. I think the parental couple element in child development, in child psychopathology, is highly significant".*

*"I think it [couple work] would have to be alongside some work with the child I think, because actually it would be very difficult to say, right, the child's been referred but actually we're sticking the child to one side because actually we're going to work on the parents, because how do you log that activity?".*

*"If you're going because you think your child's got issues and someone says to you,* Actually, you know, you need to look at yourself*, then you might not want to hear that and therefore not necessarily turn up to Relate. But if it's badged under the CAMHS umbrella then people are more likely to go,* Yeah, I'm going here because of my child*".*

*"I can see why that's not necessarily going to engage families because if they take their child for an appointment and then they're told, actually, the problem is them, in a direct way, then I can see why they might be reluctant to take advice. But if the help was in a different context, for example, a family referral service, and the referral is screened and a decision is made about whether it's more appropriate to provide an intervention to the child or a parenting programme to one of the adults, then that might work."*

*“So if we were to have the discipline, both in terms of a person who comes from a kind of couple background, and the discipline of being able to understand how to offer that treatment in a way that's going to make sense and is going to be helpful, effective, it needs in my view to be a dedicated professional and a recognised intervention in CAMHS.”*

*“We used to have a dedicated parental/couple therapist, who was a social worker who subsequently trained here, doing that work to support the individual for all the children in the clinic - so that individual had two dedicated days for that ongoing, supportive parental/couple work to support the child. And that model held for a long time and it wasn't just that that person got the whole of this, the rest of us did as well, and we would meet and talk about the sort of learning from doing it.”*

*“I just can't see a way of managing it in any sensible without a dedicated professional whose job it is to offer that. And I think if that person is part of a team but is connected in a way, you know, not seeing the children, doing the work with the parents and couples in the evening, or it doesn't have to be the evening, but separate, but linked in some way to the system, then I think you have got an intervention that could make a difference.”*

*“But it's a very different matter to give somebody a leaflet with a number on it, completely disconnected from the setting you've come to. So I would argue this intervention needs to be part of a range of interventions that CAMHS provides and that it's in-house and that it's at a time when there's less pressure on rooms and when you're likely to get the parent/couple to come, so it would be an evening clinic, essentially, or a weekend clinic. And that there would be a natural link back the key-worker working with the child.”*

*“I don't the skills needed to do this work are common to most of the CAMHS workforce. Maybe the family therapists though, yes. There could be a training up - I think that that would probably be a sort of training up of CAMHS workers to a level where they could start to address the sort of couple relationships in that sort of generic level of work.”*

**Some reflections on the material**

The material presented here is derived from ten commissioners and clinicians (who included a former director of YoungMinds, a consultant child & adolescent eating disorders psychiatrist (also an associate medical director & director of clinical networks), CAMHS commissioners, family therapists and child psychotherapists).

While we appreciate this relatively small piece of qualitative research cannot provide an exhaustive account of the views of the CAMHS workforce, we hope that it gathers some useful and powerful testimony regarding the need to pay more attention to this neglected area of service provision.

The following paragraphs contain some brief reflections on some of the themes emerging from the interviews with the aim of facilitating a discussion during the meeting.

We would contend that the fact that CAMHS interventions do not, in the main, assess for whether the quality of the inter-parental relationship is a critical issue or not allows child problem-focused work to continue, thereby legitimating the idea that the parents' relationship is not a contributing factor. That said, it would appear from the views expressed by those interviewed for this paper that there is a fairly widespread acknowledgement of the impact of inter-parental conflict on children's mental health among clinicians, whereas commissioners are less familiar with this research.

The fact that many clinicians understand that the quality of the parental relationship is sometimes a significant factor in the presentation of the child, allied to the fact that the CAMH service specification does not include couple work, seems to result in some amount of couple work being carried 'under the radar'.

This state of affairs leads us to suggest that there needs to be a greater understanding on behalf of commissioners of the clinical realities facing CAMHS practitioners. It was encouraging that a number of commissioners did not feel hidebound by NICE guidelines and were open to the idea of couple work being undertaken where clinicians felt such an approach would be beneficial.

In terms of assessment, there was some suggestion that the particular disciplines of those carrying out assessments had a significant impact on the clinical understanding of the presenting child's problems. In light of this, we believe there may be a case to be made that training should be introduced across CAMHS to ensure that the assessment looks at the quality of the parents' relationship, whether the parents are both present in the consulting room, or are together/separated. We do not under-estimate the difficulties involved in this, but nevertheless feel that the consequences of not assessing for this aspect of the child's environment are too profound to be ignored. We accept that this would require further training and resourcing, that complex NHS systems might require adaption and that services, once assessing for this issue, will need to have something to offer in response. None of these are reasons for not making this necessary change, we would argue however.

It was clear that the current response from CAMHS where parental relationship difficulties (which are thought to be having a detrimental impact on the child) are identified is sub-optimal. The area of overlap between family therapy and couple therapy seems to be one which it might be important to explore in more depth.

Furthermore, the practice of signposting or referral couples to voluntary sector providers of relationship support, while laudable and understandable, is clearly ineffective, as very few couples ever take up such support, whether due to financial, practical, or emotional reasons. The fact that many clinicians do recommend to couples that they seek support, and yet the vast majority of couples do not act on this, should give us pause for thought. Is it time perhaps that more

appropriate referral pathways are described and developed which parents may actually want to make us of?

This aspect of provision also raises an important issue of equity. Were one or both parents to be identified by CAMHS practitioners as needing support for a mental health problem or a substance misuse issue, it would be appropriate to refer them to a statutory service for support. The fact that no couple therapy is available in the NHS (aside from the tiny amount of couple therapy for depression available in adult IAPT services) ensures that couples experiencing relationship problems – which are impacting on the mental health of their children – are effectively discriminated against. Leaving aside the rights and wrongs of this situation as they apply to the adults concerned, it does nothing to help the children affected by parental relationship distress for this anomaly to left unchallenged.

Related to this subject, it was clear from the interviews that parents often react very negatively to suggestions that the problems between them are a factor in the difficulties of their children. However, this would seem to have as much to do with professional competence as anything else, and highlights the need to train the CAMHS workforce to be more able to address such issues in a way that leads parents to feel that working on their relationship can be a very real and active way of helping their children, rather than being seen a badge of their failure as parents.

The implications of the continued exclusion of couple therapy, or couple therapeutic approaches, to the CAMHS offer were thought to be significant by those interviewed, including the suggestion that the failure to explore and address parental relationship issues lay at the heart of a number of revolving door patients in CAMHS.

Interviewees described a number of potential models for this kind of work, ranging from training up the existing workforce to be able to provide couple therapeutic interventions as part of generic CAMHS work to having a dedicated couple therapist/couple therapy service as part of the offer.

It might be instructive at this point to highlight our experience, between 2012 and 2014 Tavistock Relationships, of running a number of training courses for senior CAMHS managers around the links between the quality of the parental relationship and children's mental health. Feedback, based on 141 CAMHS practitioners, to these courses highlights an ongoing skills gap in this area, and a significant desire for further training:

- 77% of CAMHS practitioners attending the course felt better able to *recognise* relationship issues as a result of the training
- 79% of CAMHS practitioners attending the course felt better able to *respond* to relationship issues as a result of the training
- 95% of attendees indicated that they would be interested in further training with Tavistock Relationships.[3]

These figures suggest that CAMHS practitioners generally do not feel either qualified or mandated to work with the couple issues, and suggest that there is an appetite and need for training in this area.

However, it may not be a question of practitioner training on the one hand and a dedicated couple therapy service on the other. The range and severity of parental relationship difficulties experienced by the parents of children presenting to CAMHS will be wide; the ability of CAMH services to identify and alleviate some of these difficulties as part of generic work will undoubtedly enhance the home environment of many children.

[3] %s based on those scoring 4 or 5 on the 5-point scale.

However, where the couple relationship issues are more entrenched and pathological, being able to conduct work with the parental couple and work with the child *concurrently, and in a linked fashion*, would appear to be something which CAMHS clinicians – from whatever professional discipline – would welcome.

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