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A competence framework for Child and Adolescent Mental Health Services

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Anthony D. Roth[1], Fiona Calder[2] and Stephen Pilling[1]

The competences described in this report are designed to be accessed online and should be downloaded from

www.ucl.ac.uk/CORE

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Expert Reference Group (ERG)

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The ERG[1] was chaired by Ms Judy Thomson, and comprised:

Ms Geraldine Bienkowski, Mr David Brand, Ms Gwyneth Bruce, Dr Fiona Calder, Professor Tony Charman, Dr Anne Claveirole, Ms Susanne Forrest, Dr Peter Fuggle, Ms Margo Fyfe, Dr Isobel Heyman, Ms Lorna Hunter, Dr Kathy Leighton, Ms Heather Love, Ms Susan McGinnis, Dr Helen Minnus, Mr Graham Monteith, Mr Barry Nixon, Professor Steve Pilling, Ms Cathy Richards, Dr Gavin Richardson, Professor Tony Roth, Mr Andrew Smith, Dr Patrick Smith, Dr Matthias Schwannauer, Professor Paul Stallard, Ms Gill Walker.

The competency writing team

This was headed by Dr Fiona Calder and Professor Tony Roth, with contributions from

Dr Gavin Richardson, Professor Stephen Pilling, Dr Marita Brack, Ms Brenda Renz, Dr Patrick Smith, Dr Isobel Heyman, Professor Paul Stallard, Dr Emma Silver and Dr Kristina Soon.

[1] Appendix A shows the professional affiliations of members of the ERG

Peer Reviewers

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- **In the United Kingdom:** Dr Dickon Bevington, Dr Steve Carnaby, Dr Terri Carney, Professor David Clark, Ms Anne Clarke, Dr Cathy Creswell, Professor Anke Ehlers, Professor Eric Emerson, Professor Pat Howlin, Dr William Mandy, Dr Nick Midgley, Professor Janet Reibstein, Professor Shirley Reynolds, Professor Maria Rhode, Ms Margaret Rustin, Professor Steven Scott, Professor Paul Stallard, Professor Mary Target, Professor Judith Trowell, Dr Alison Wood, Professor William Yule.

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Executive summary

The report describes a method for identifying competences for staff working in child and adolescent mental health services. It organises the competences into six domains.

The first two cover competences that should be demonstrated by all members of a CAMHS team:

- Core competences for work with children and young people
- Generic therapeutic competences required for managing clinical sessions and any form of psychological intervention.

The third domain covers Assessment and Formulation competences, relevant to all caseholding members of a CAMHS team. A subsection of this domain details skills relevant to specialist mental health assessments that will be carried out by some, but not all, members of a team.

Two further domains identify skills for specific interventions:

- Universal and selective prevention programmes
- Specific interventions (usually for particular presentations)

The final domain identifies meta-competences – overarching, higher-order competences which practitioners need to use to guide the implementation of any assessment or intervention.

The report then describes and comments on the type of competences found in each domain, and organises these into a 'map' which shows how all the competences fit together and inter-relate. Finally it addresses issues that are relevant to the implementation of the competence framework, and considers some of the organisational issues around its application.

How to use this document

This report describes the model underpinning the CAMHS competence framework, and indicates the various areas of activity that, taken together, represent good clinical practice. It describes how the framework was developed and how it may be used.

The report does not include the detailed descriptions of the competences associated with each of these activities. These are available to download as pdf files from the website of the Centre for Outcomes Research and Effectiveness (CORE) (**www.ucl.ac.uk/CORE**) and are also accessible from the NES website (**http://www.nes.scot.nhs.uk/**).

Scope of the competence framework

Services for children and young people are currently organised in tiers, as follows:

Tier 1: non-specialist primary care workers (such as school nurses and health visitors) working with common problems of childhood such as sleeping difficulties or feeding problems.

Tier 2: specialised workers offering assessment and treatment in primary care (such as family work, bereavement or parenting groups)

Tier 3: specialist multi-disciplinary teams dealing with problems considered too complicated to be dealt with at tier 2 (such as assessment of development problems, autism, hyperactivity, depression, early onset psychosis).

Tier 4: specialised day and inpatient units, where patients with more severe mental health problems can be assessed and treated.

The competence framework is designed primarily to be relevant to specialist CAMHS workers in child and adolescent mental health settings at Tiers 2, 3, 4. It may also be of relevance to specialist workers who see children in other contexts. Specific parts of the competence framework will be relevant to professionals in the wider network of children's services working at Tier 1 (such as health visitors, primary school teachers and social workers).

The framework is intended to apply to all professions working with children and adolescents in these contexts: it defines clinical knowledge and skills relevant to a range of professions, including nurse therapists, occupational therapists, clinical psychologists, psychiatrists[2], social workers, speech and language therapists, child psychotherapists and family therapists).

The competence framework is not an exhaustive list of all the activities undertaken by CAMHS clinicians. It is primarily focused on clinical work, and excludes service management and development skills. Audit and research skills are not specified in depth, though the ability to make use of measures (and to monitor outcomes) is identified as a core clinical skill, as is the ability to make informed use of the evidence base relating to therapeutic models.

Supervision clearly plays a critical role in supporting the development of competences, and the ability to make use of supervision is included in the framework. Competences associated with the delivery of supervision are detailed in a separate framework, available on the CORE website (www.ucl.ac.uk/clinical-psychology/CORE/supervision_framework.htm).

[2] Specialist skills relating to prescribing medication are not detailed in the framework; these have been specified by the Royal College of Psychiatrists as part of the training curriculum for psychiatrists (Royal College of Psychiatrists (2008) A Competency Based Curriculum for Specialist Training in Psychiatry Specialist Module in Child and Adolescent Psychiatry: Specialist Module in Child and Adolescent Psychiatry).

The development of the competence framework

1. **Oversight and peer-review:** The work described in this project was overseen by an Expert Reference Group (ERG) comprising experts in work with children and adolescents from all the devolved nations of the UK, selected for their expertise in research, training and service delivery (the ERG membership is detailed in Appendix A). The ERG met regularly throughout the project to ensure that key texts, policy documents, service user documentation, and trial manuals were identified, advise on process, and to debate and review materials as they emerged.

   In addition to review by the ERG, competence lists for specific areas of clinical activity and for specific interventions were reviewed by individuals identified as having particular expertise (on the basis of having published widely in an area of clinical activity, or as the originator or developer of the approach being described in the competence list). This process of open and iterative peer-review ensured that the competence lists were subject to a high level of scrutiny (peer reviewers are listed in the acknowledgments section).

2. **Incorporating service user perspectives:** From the outset the team drew on the considerable body of literature that identifies the perspectives and concerns of CAMHS service users (see appendix C), ensuring that these were reflected in the development of the competence framework and in the guidance produced for service users.

3. **Adopting an evidence-based approach to framework development[3]:** A guiding principle for the development of previous frameworks (Roth and Pilling 2008) has been a commitment to staying close to the evidence-base for the efficacy of therapies, focussing on those competences for which there is either good research evidence or strong expert professional consensus about their probable efficacy.
   While we have applied this principle to this framework, it is important to note several important issues in relation to the evidence-base for work with children and adolescents (all of which needed to be taken into account):

   a) **Number of published research trials:** Compared to the field of adult mental health there are fewer large randomised controlled trials contrasting one active intervention to another, or to a control condition. There are some exceptions to this trend, notably research on parenting interventions, where there are multiple reports demonstrating the efficacy of social-learning theory based parenting groups (NICE, 2006)). Such trials are critical for making causal inferences about the efficacy of an intervention, and although evidence based on other research designs is relevant, the conclusions that can be drawn from them are necessarily less robust. As a consequence some widely used CAMHS-interventions lack high-quality evidence for their efficacy, raising questions about whether they should be included in the framework. Clearly over-rigid adherence to the evidence base would narrow inclusion to a point where the range of interventions being described did not reflect those in common use; equally, being over-generous could undermine any claim to an evidence-based approach.

[3] An alternative strategy for identifying competences could be to examine what workers in routine practice actually do when they carry out a psychological intervention, complementing observation with some form of commentary from the workers in order to identify their intentions as well as their actions. The strength of this method – it is based on what people do when putting their competences into action – is also its weakness. Most psychological interventions are rooted in a theoretical framework which attempts to explain human distress, and this framework usually links to a specific set of actions aimed at alleviating the client's problems. It is these more 'rigorous' versions of an intervention that are examined in a research context, forming the basis of any observations about the efficacy of an approach or intervention. In routine practice these 'pure' forms of an intervention are often modified as workers exercise their judgment in relation to their sense of the client's need. Sometimes this is for good, sometimes for ill, but presumably always in ways which does not reflect the model they claim to be practising. This is not to prejudge or devalue the potential benefits of eclectic practice, but it does make it risky to base conclusions about competence on the work done by practitioners, since this could pick up good, bad and idiosyncratic practice

b) **Developmental targeting of interventions:** The reported efficacy of specific interventions for children and young people is often related to the age and developmental stage of the participants included in the trial; interventions effective with younger children may not be effective with older children, and the reverse is also the case.

c) **Organisation of the evidence base in relation to diagnosis:** As is the case across the field of psychotherapy research, the evidence-base for work with children and adolescents tends to be organised in relation to diagnosis. However, it is well-recognised that most presentations in CAMHS are comorbid (for example, rather few children present with depression or anxiety in isolation; usually there will be a mix of symptoms, often accompanied by significant difficulties in functioning in significant areas such as family or school life). This presents a dilemma: organising the framework in relation to diagnosis is the only way to keep it close to the evidence, but this risks making it appear less relevant to clinicians (in the sense that it may be less obvious how to apply it to individual CAMHS clients). Unfortunately this dilemma has no obvious solution, and despite active debate about the merits of alternative structures the clustering of problems within the framework is essentially diagnostic.

d) **Importance of, and evidence for, core, generic therapeutic and assessment skills:** There is a clear professional consensus that interventions in CAMHS rest on a set of 'underpinning' skills (core and generic therapeutic competencies), as well as a set of assessment skills. Denoting the former as 'underpinning' skills should not be taken to indicate that they are simple or easy to deploy. For example, knowing how to adapt communication to the child's developmental age/stage is far from straightforward, and the process of engaging children and their families can be challenging. Further underpinning competences (such as interagency working) are a major component of intervention packages such as Multi-Systemic Therapy (MST). However, there is often little *direct* evidence of the benefit of these skills from randomised control trials or from other types of study, possibly reflecting researchers' understandable reluctance systematically to manipulate clinician behaviour in this area, and also because researchers may assume that the inclusion of these elements in an intervention does not need to be explored further. However, although evidence on the causal contribution of underpinning and assessment skills is lacking, correlational studies have established the importance of several of the areas included in the framework (notably the importance of the therapeutic relationship to outcome (e.g. Horvath, Del Re, Flückiger & Symonds,2011; Shirk, Carver & Brown, 2011). Within the assessment field, evidence of the accuracy of the diagnostic process has been gathered through measuring the reliability and validity of standardised tests, scales and interview schedules (both of which are usually accompanied by detailed guidance for their delivery, equivalent to a therapy manual). Nonetheless, in the main the inclusion of specific "underpinning" skills usually rests on expert professional opinion and consensus rather than evidence.

e) **Lack of 'manualisation' in basic areas of practice:** Reinforcing the sense that many 'underpinning' and assessment skills are seen as critical to CAMHS clinical practice and treatment delivery, most treatment manuals make general reference to their application, but rarely detail the specific skills involved. As a consequence the competency team needed to draw on a mix of resources to generate lists of relevant skills, sourcing service user studies, relevant published materials, textbooks, and drawing on their own clinical experience where gaps in the lists remained. As such this is a process led by professional experience rather than RCT evidence, making the process of peer review (described above) especially critical.

These issues all have bearing on the capacity of the framework to stay as close to the evidence base as possible, and in practice research has had to be is supplemented by expert professional consensus, congruent with models of evidence-based practice (e.g. Roth, Parry and Fonagy, 2005), and with the methodology adopted by NICE for clinical guideline development (NICE (2009).

4. **Inclusion and exclusion of specific interventions:** An initial task for the ERG was to identify those CAMHS interventions with evidence of efficacy, based on outcomes obtained in clinical controlled trials. This scoping exercise was based on extant clinical guidelines and reviews of the available evidence, in particular:
   - Relevant NICE and SIGN clinical guidelines
   - "The Matrix" (a guide to delivery of evidence-based therapies commissioned by NHS Education for Scotland and the Scottish Government (NHS Education for Scotland, 2008: **www.nes.scot.nhs.uk/media/606133/thematrix-final.pdf**)
   - "Drawing on the evidence" (a digest of NICE guidance and related evidence produced by the CAMHS Evidence Based Practice Unit: **www.ucl.ac.uk/clinical-psychology/EBPU/publications/pub-files/drawing_on_the_evidence_booklet_2006.pdf**)

   This exercise identified those interventions for which there was good evidence of efficacy, and which therefore needed to be included. However, it also identified interventions for which evidence was less compelling (for example because of a lack of controlled studies, a lack of replication or methodological problems which restrict interpretation of outcomes). In most cases the ERG was in agreement with NICE, SIGN and MATRIX guidance, but there were areas where variance from this guidance was deemed appropriate. Two examples (one of a decision for inclusion, the other for exclusion) may help to illustrate the process by which decisions were made:

   a) NICE and SIGN guidance for moderate to severe child and adolescent depression recommends CBT, Interpersonal Psychotherapy or short-term systemic therapy as first-line treatments. However, a lack of evidence in relation to psychodynamic therapy means that it is indicated only when other interventions have not proved helpful, and after multi-disciplinary review. Given this cautious recommendation there was some debate as to whether psychodynamic therapy should or should not be included in the framework. The decision to include it partly reflects the fact that (albeit with the caveat above) it is identified as part of a pathway of care in the NICE guidance, but more significantly because it is widely-practised in many CAMHS.

b) For mild depression, NICE guidance includes a recommendation that children be offered individual non-directive supportive therapy (as well as group CBT or guided self-help for a limited period). The MATRIX also includes this recommendation but classifies this as a judgment based on expert consensus rather than research evidence. The ERG also noted that research on which the NICE recommendation is based is drawn from two trials where nondirective therapy performed less well than an alternative intervention. Further, recent review of the evidence for a closely related intervention (counselling in schools: (Cooper, 2009) concluded that while there was evidence of the effectiveness and acceptability of this approach for a range of presentations, none of the reports included a control condition, making it hard to interpret (among other things) whether or not any benefits are attributable to the specific modality of therapy employed. There is also some imprecision in the meaning of the terms "counselling", since the techniques practised under his header are quite variable (and hence hard to capture in a competence framework. The ERG decision not to include non-directive approaches in the framework rested on a) the relative weakness of the evidence (and a judgment that the NICE guidance is not well-supported) and b) a lack of precision about the techniques employed.

The ERG noted that decisions about inclusion or exclusion of particular approaches will change over time, as new evidence becomes available and our knowledge of the efficacy of specific interventions improves. This flags an important point - that the exclusion of an intervention should not be taken to indicate that it is ineffective, but only that at present lack of evidence for its efficacy does not support its inclusion at this time.

A further area of debate concerned parenting programmes. These are included in the framework, but are represented as a single competence list identifying the principles common to parenting programme based on social learning theory, as delivered both individually and in group settings. The ERG noted that there are a large number of programmes in this area, albeit that two have the strongest evidence-base (the Incredible Years (Webster-Stratton 2007, 2008)) and Triple P (Sanders, Markie-Dadds & Turner 2001). Though based on a common set of principles, all have somewhat different formats which clinicians are expected to adhere to, usually with reference to detailed manuals. Detailing each of these independently would be a major undertaking, and more importantly would be of limited value, since the manuals already offer a high degree of detail about what clinicians need to do to carry out the programmes. However, it was felt that identification of common principles would be of benefit, especially as this would 'benchmark' the procedures and standards that any of the many available programmes should exemplify.

Some inclusion-exclusion decisions related to areas of intervention rather than to specific modalities:

- **Eating Disorders:** Interventions for Anorexia Nervosa are included, but there is no description of interventions for Bulimia Nervosa (or indeed other eating disorders). This reflects the fact that the evidence base for interventions for Bulimia is largely based on adult presentations. As the relevance of this evidence base to CAMHS is uncertain the ERG felt it would be inappropriate to include specific interventions for this disorder.
- **Competences relevant to Universal and Selective Prevention Programmes** are included, despite of a current lack of good-quality evidence for the efficacy of specific approaches. This reflects the emphasis placed on health promotion by a number of government initiatives (for example, the Framework for Promotion, Prevention and Care (Scottish Executive, 2005). As such the ERG felt it would be important to include reference to this area, but with the caveat that the competences should focus on the principles underlying the implementation of these approaches rather than describing specific health promotion programmes.

5. Extracting competence descriptions

a) "Underpinning" competences (core competences and generic therapeutic skills) and assessment skills As noted above (and discussed below) there is a clear professional consensus that a prerequisite to practice in CAMHS is the ability to deploy a range of "underpinning" skills, as well as assessment and formulation skills. The process of competency extraction for these areas involved the following steps:

1. The core team identified an initial set of high-level descriptions of areas of clinical and professional activity (for example, 'the ability to work within and across agencies', or 'knowledge of, and ability to operate within, professional and ethical guidelines'). These were considered by the ERG, and on the basis of iterative review a final set of competence areas considered to constitute 'underpinning' and assessment skills were agreed.

   - service user documentation which identifies the preferences and views of children/young people and carers in relation to CAMHS and CAMHS workers. For example, themes in this documentation commonly include a preference for collaborative working with the clinician, being informed and involved in decision making, and wanting to be seen as a 'whole person' whose strengths as well as difficulties are acknowledged. Wherever relevant (especially in areas of the framework focused on engagement and assessment) competence descriptions were written so as to reflect these concerns (see Appendix C)
   - relevant literature which contains behavioural descriptions of the relevant skills, such as textbooks, professional guidance materials, manuals and teaching materials (individual competence lists identify the sources used for each topic area)
   - other CAMHS related competence frameworks which include broad descriptions of 'underpinning' and assessment skills (see Appendix B)

2. An initial set of competence statements for each area was generated by the writing team; these drafts were subjected to internal review by the team to check for accuracy, completeness and clarity.

3. Each competence list was discussed by members of the ERG and peer-reviewed by members of the ERG and by external experts, identifying omissions and any points of contention.

b) Specific interventions

The basis for inclusion of specific interventions is evidence of efficacy in a research trial, and most such trials will have developed or adopted a manual that describes the treatment model and associated treatment techniques. The manual represents best practice for the fully competent therapist – the things that a therapist *should* be doing in order to demonstrate adherence to the model and to achieve the best outcomes for the client. Many research trials monitor therapist adherence (by inspecting audio or video recordings), making it possible to be reasonably confident that if the procedures set out on the manual are followed there should be better outcomes for clients.

The procedure for extracting competences starts by identifying representative trials of an effective technique (bearing in mind that in some areas more than one research group may be publishing data on the same or a closely related intervention package). The manuals associated with these successful approaches are identified; where there is more than one manual describing the same 'package' a decision made as to whether there is overlap between the approaches (in other words, whether they are variants of the same approach) or whether there are distinctive differences (justifying a separate competence list for each). Finally the manuals are examined in order to extract and to collate therapist competences – a process detailed in Roth and Pilling (2008). As described above, draft competence lists were discussed by members of the ERG and subject to peer-review by members of the ERG and by external experts.

The competence model for CAHMS

Organising the competence lists

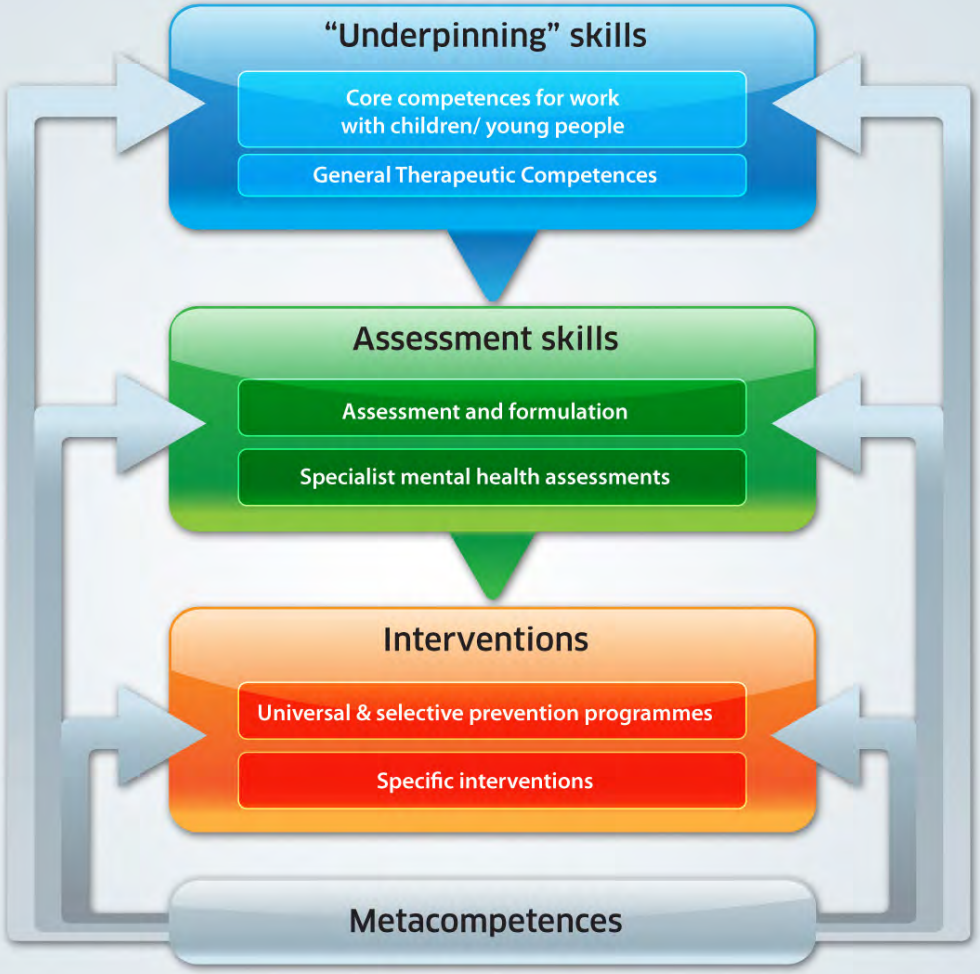
Competence lists need to be of practical use. To achieve this they need to be structured in a way that reflects the practice they describe, be set out in a structure that is both understandable (in other words, is easily grasped) and be valid (recognisable to practitioners as something which accurately represents the approach, both as a theoretical model and in terms of its clinical application).

Figure 1 shows the way in which competences have been organised into six domains. From the outset it was clear that a CAMHS framework would be substantively different from the model developed for modality-specific frameworks for Adult Mental Health because it would need to:

- be applicable to a wide range of CAMHS staff (not simply those engaged in delivering psychological therapies)
- include a wide range of psychological interventions
- encompass a number of different therapeutic modalities and approaches
- recognise that, rather than focusing on an individual client, most psychological interventions in CAMHS settings are 'systemic': when children and adolescents present with problems, these are best understood in the context of their family life and the wider interpersonal contexts in which they function (for example their functioning in school, or their peer relationships)
- recognise that work in CAMHS frequently requires close liaison with other team members, and also with individuals from a range of agencies who may also be involved with a child/young person
- identify the professional and legal responsibilities inherent to CAMHS working – for example, safeguarding children and identifying and responding to concerns regarding risk

For all these reasons the whole framework rests on two domains of 'underpinning' competences. The first is 'Core Competences For Work With Children And Young People', which identifies the knowledge and skills needed by staff to a) orient them to the styles of work which characterise contacts with children, young people and their families b) liaise with CAMHS colleagues and other agencies, and c) apply the professional and legal frameworks which exercise governance over CAMHS procedures. The second domain ('Generic Therapeutic Competences') identifies the competences required to manage clinical sessions and any form of psychological intervention. Taken together, the skills in these two domains should be demonstrated by all CAMHS workers; their description as "underpinning" skills draws attention to the fact that they secure the integrity of *all* CAMHS assessments and interventions.

Figure 1 - Outline model for the CAMHS framework



The next two domains relate to assessment. The first identifies the "Assessment and Formulation" skills expected of all caseholding CAMHS workers; a second domain specifies a number of 'Specialist Mental Health Assessments' that will be the preserve of those CAMHS workers trained in their use.

Psychological interventions are divided into two domains. The first describes the implementation of prevention programmes, either offered 'Universally' (for example, to all children in a school), or as 'Selective Prevention' to a narrower (targeted) group of individuals identified as being at risk. The second domain ("Specific Interventions") identifies psychological interventions for specific conditions and presentations.

The final domain in the model focuses on 'Meta-competences', so-called because they permeate all areas of practice, from "underpinning" skills through to specific interventions. Meta-competences are characterised by the fact that they involve making procedural judgments – for example, judging when and whether something needs to be done, or judging the ways in which an action needs to be taken or to be modified. They are important because these sorts of judgments are seen by most clinicians as critical to the fluent delivery of an intervention; effective implementation requires more than the rote application of a simple set of "rules": meta-competences attempt to spell out some of the more important areas of judgment being made.

Specifying the competences needed to deliver CAMHS assessments and interventions

Integrating knowledge, skills and attitudes

A competent CAMHS worker brings together knowledge, skills and attitudes. It is this combination which defines competence; without the ability to integrate these areas practice is likely to be poor.

Clinicians need background knowledge relevant to their practice, but it is the ability to draw on and apply this knowledge in clinical situations that marks out competence. Knowledge helps the practitioner understand the rationale for applying their skills, to think not just about *how* to implement their skills, but also *why* they are implementing them. Beyond knowledge and skills, the clinician's attitude and stance to an intervention is also critical – not just their attitude to the relationship with the client, but also to the organisation in which the intervention is offered, and the many cultural contexts within which the organisation is located (which includes a professional and ethical context, as well as a societal one). All of these need to be held in mind, since all have bearing on the capacity to deliver interventions that are ethical, conforms to professional standards, and which are appropriately adapted to the client's needs and cultural contexts.

The map of CAMHS competences

Using the map

The map of CAMHS competences is shown in Figure 2. It organises the competences into the six domains outlined above and shows the different activities which, taken together, constitute each domain. Each activity is made up of a set of specific competences. The details of these competences are not included in this report; they can be downloaded from the website of the Centre for Outcomes Research and Effectiveness (CORE) (www.ucl.ac.uk/CORE).

The map shows the ways in which the activities fit together and need to be 'assembled' in order for practice to be proficient. A commentary on these competences follows.

Some sections of the map are shaded in order to show which sections apply to all members of a CAMHS team, and which to workers with specific training, as follows:

Blue shading:	Competences in these areas should be demonstrated by all members of a CAMHS team
Orange shading:	Competences in these areas should be demonstrated by all caseholding members of a CAMHS team
No shading:	Competence in these areas should be demonstrated by those clinicians who have had the appropriate training and supervision to carry out the procedures and interventions that are listed in these sections.

Layout of the competence lists

Specific competences are set out in boxes.

Most competence statements start with the phrase "An ability to…", indicating that the focus is on the clinician being able to carry out an action.

Some competences are concerned with the knowledge that a practitioner needs to carry out an action. In these cases the wording is usually "An ability to draw on knowledge…". The sense is that clinicians should be able to *draw* on knowledge, rather than having knowledge for its own sake (hence the competence lies in the application and use of knowledge in the furtherance of an intervention).

As far as possible the competence descriptions are behaviourally specific – in other words, they try to identify what a clinician actually needs to do to execute the competence.

At a number of points the boxes are indented. This usually occurs when a fairly high-level skill is introduced, and needs to be 'unpacked'. In the example below, the high level skill is the notion of being "collaborative and empowering"; what follows are concrete examples of the sorts of things a clinician needs to do to achieve this.

An ability to work in a manner that is consistently collaborative and empowering, by:
translating technical concepts into "plain" language that parents can understand and follow
taking shared responsibility for developing agendas and session content

The competences in indented boxes usually make most sense if clinicians hold in mind the high-level skill that precedes them. So with the same example, although using plain language is always a sensible thing to do, there is a very good conceptual reason for doing this: it will impact on (and therefore contribute to) clients' sense of collaboration and engagement in the therapy process. Bearing in mind the conceptual idea behind an action should give clinicians a 'road map', and reduce the likelihood that they apply techniques by rote.

Core competences for work with children/ young people

- Knowledge of development in children/young people and of family development and transitions
- Knowledge and understanding of mental health problems in children/young people and adults

Professional/legal issues

- Knowledge of legal frameworks relating to working with children/ young people
- Knowledge of, and ability to operate within, professional and ethical guidelines
- Knowledge of, and ability to work with, issues of confidentiality, consent and capacity

- Ability to work within and across agencies
- Ability to recognise and respond to concerns about child protection
- Ability to work with difference (cultural competence)

Engagement & communication

- Ability to engage and work with families, parents & carers
- Ability to communicate with children/young people of differing ages, developmental level and background.

- Knowledge of psychopharmacology in child and adolescent work

Generic Therapeutic Competences

- Knowledge of models of intervention, and their employment in practice
- Ability to foster and maintain a good therapeutic alliance and grasp the perspective & 'world view' of members of the system
- Ability to deal with the emotional content of sessions
- Ability to deal with the emotional content of sessions
- Ability to manage endings and service transitions
- Ability to work with groups of children or and/or parents/ carers
- Ability to make use of measures (including monitoring of outcomes)
- Ability to make use of supervision

Assessment & formulation

Assessment & planning

- Ability to undertake a comprehensive assessment
- Risk assessment and management
- Ability to assess the child's functioning within multiple systems
- Ability to formulate
- Ability to feedback the results of assessment and agree a treatment plan

- Ability to undertake a single session assessment of service appropriateness
- Ability to co-ordinate casework across different agencies and/or individuals

Specialist mental health assessments

- Ability to conduct a mental state
- Ability to undertake a diagnostic assessment
- Ability to undertake structured behavioural observations
- Ability to undertake structured cognitive, functional and developmental assessments

Universal & selective prevention programmes

- Self-help for a range of problems
- Health promotion across settings
- Emotional health promotion in schools

Specific Interventions

Disruptive behaviour disorders (ADHD, Oppositional Defiant, early onset Conduct Disorder)

- Parent training (based on social learning theory)
- Problem Solving
- Problem solving and social skills training (Dinosaur school)

Conduct Disorder

- Functional Family therapy
- Multi Systemic Therapy

Depressive conditions

- Systemic therapy for depression
- CBT for depression
- IPT-A for depression
- Psychodynamic therapy for depression

Anxiety and trauma

- CBT for OCD
- CBT for anxiety disorders: Individual therapy (Kendall); Group therapy (Barrett)
- CBT for PTSD or other trauma related problems: Ehlers & Clark; Cohen

Anorexia

- Systemic family therapy for anorexia

Autistic spectrum disorders

- Interventions for Social Communication (Howlin et al.)
- Education & Skills programme (Breterton et al)

Interventions for challenging behaviour

- Behavioural interventions for sleeping problems
- Behavioural interventions for enuresis
- Behavioural interventions for encopresis
- Behavioural interventions for feeding problems

Substance abuse

- Assessment of Alcohol & Substance Misuse: Motivational interviewing; Systemic approaches; Contingency management

Interventions for psychosis

Meta competences

- Meta-competences for child and adolescent work

Blue shaded boxes = competences that should be demonstrated by all members of a CAMHS team

Orange shaded boxes = additional competences that should be demonstrated by all caseholding members of a CAMHS team

Unshaded boxes = additional competences that will be demonstrated by some, but not all, members of a CAMHS team

An outline of the framework

Core competences for work with children/young people

Knowledge of development in children/young people and of family development and transitions

Knowledge of development is fundamental to assessment and intervention: it guides the practitioner's understanding of the child/young person's needs, behaviour and attachment relationships, and is critical for the detection of developmental delay. Knowledge of family development is also central; it helps practitioners understand the usual developmental tasks of families and the impact on the family of common transitions. All CAMHS interventions rely on and refer to the practitioner's knowledge of child/young person development, because of the need to tailor these to the developmental stage of the children/young person.

Knowledge and understanding of mental health problems in children, young people and adults

All CAMHS workers aim to promote well-being and emotional resilience. Understanding how mental health problems present and develop in children, young people and adults is also central to specialist CAMHS work. Although the mental health of children/young person is the ultimate focus of CAMHS assessments and interventions (achieved both through direct sessions with the child/young person and indirect work through the carers), the impact of adult mental health problems in the parent/carer also needs to be recognised and understood by the CAMHS practitioner.

Knowledge of professional and legal issues

Knowledge of professional and legal issues, and particularly the way in which these apply to clinical practice, is critical to all aspects of the assessment process, and to intervention. The framework includes three domains of competence in this area. The first is knowledge of legal frameworks relating to working with children/young people, the second is knowledge of (and the ability to operate within) professional and ethical guidelines, and finally knowledge of (and ability to work with) issues of confidentiality, consent and capacity.

Practitioners need to know about these issues, but more critically they also need to know how they apply to all areas of work. By way of example, the process of engaging children and their families inevitably involves the discussion of confidentiality and its limits. It is one thing to offer an assurance of confidentiality, but practitioners also need to know when this can and should be breached, and how this should be managed.

Working within and across agencies

CAMHS workers routinely communicate with professionals from other agencies such as schools and social work, as well as drawing on the expertise of other disciplines within the CAMHS team itself. Inter-agency and inter-disciplinary working requires a knowledge of the responsibilities of the other agencies and disciplines, as well as knowledge of relevant policies, procedures and legislation**.** It also demands skills in information sharing and communication as well as the ability to contribute to the co-ordination of case work, and the ability to recognize and manage challenges to effective inter-agency working.

Child Protection
Legislation relating to child protection places a variety of duties and responsibilities on services and organisations, and all CAMHS workers have a responsibility to follow local procedures for reporting and sharing child protection concerns. Depending on the type of service, their role will range from identifying and sharing concerns about a child/young person to making an active contribution to joint decision-making and/or planning an investigation to supporting the child/young person and family.

The competencies listed in this section describe the knowledge and skills expected of all CAMHS workers, but their effective delivery depends on their integration with other area of the framework (particularly knowledge of child/young person and family development and transitions, consent and confidentiality, legal issues relevant to child and family work, interagency working, and engaging families and children/young people)

Working with difference (cultural competence)
Respecting diversity, promoting equality of opportunity for children and families, and challenging inequalities and discrimination, is a significant aim in UK legislation and policy. The 'cultural competence' list teases apart and details the concrete values, knowledge and skills associated with this broad aim, and that should be demonstrate by CAMHS professionals in routine clinical practice.

Engagement and Communication
Engaging children and families requires the deployment of a range of skills focused on building and maintaining contact, and responding to any challenges in this area. Working with families (as opposed to individuals) poses particular challenges, as it requires clinicians to maintain the active (and parallel) involvement of all family members, and to communicate with each of them in a way that is congruent with their different developmental stages and roles within the family. Throughout contact, the clinician engages the family by demonstrating skills in communication and collaborative working, engagement in routine service user evaluation, and by monitoring potential threats to engagement.

Knowledge of psychopharmacology
Children and young people can present with a range of disorders some of which may be treated effectively with medication as part of an intervention package. As such, practitioners need to be able to identify the conditions for which medication may be indicated, and understand the role of medication in an intervention. Non-medical CAMHS professionals also need to know when they should consult with, or refer to, psychiatric colleagues who have extensive training in specialist assessment and prescribing, and understanding of medication side-effects.

Generic Therapeutic competences

Knowledge of models of intervention
All CAHMS workers need to know about the principles underlying the main intervention options available in the service, as well as the evidence base for them, whether or not they actually practise the intervention themselves. Obviously the depth of their knowledge will vary in relation to the activity they are carrying out – for example, the knowledge required to discuss intervention options with a child/young person and is different from that needed to deliver the intervention.

Maintaining a therapeutic alliance and understanding the perspective and 'world view' of members of the system
The "therapeutic alliance" is the capacity to build and to maintain a therapeutic relationship in which the practitioner develops a 'bond' with the family and reaches agreement on the goals and tasks of the assessment and intervention. Successfully building a positive alliance is associated with better outcomes across all therapies, and developing the alliance depends on an ability to apprehend the ways in which the child/young person and carers understand themselves and the world around them.

Managing the emotional content of sessions
Managing the emotional content of sessions is central to all contacts with a child/young person or family. The practitioner has to reflect on the meaning of the child/young person's emotional expression/behaviour, and during interventions elicits emotions that facilitate change. Throughout both assessment and intervention, the clinician has to manage any strong emotions such as excessive anger and related aggressive behaviour, and also avoidance of strong affect.

Managing endings and transitions
Endings and service transitions can be a difficult time for children/young people, families, and the practitioner. Because disengaging from therapy is often as significant as engaging with it, this process is an integral part of the 'management' of the therapeutic relationship. The practitioner has to manage both planned endings and premature or unplanned endings where the family terminates contact with the service earlier than planned. An important consideration in all endings involves the assessment of any risk to the child/young person from terminating contact with the service.

Working with groups
CAMHS interventions are often delivered in a group format, both to children/young people or to their carers. Groups can be based on a range of therapeutic models from CBT to psychodynamic theory. Many of the CAMHS interventions with the strongest evidence base are delivered in a group format (such as parenting groups, and groups which teach problem solving and social skills). Generic group competences include an ability to plan the group structure and to recruit appropriate service users, as well as a capacity to engage group members and manage group process.

Ability to select and use measures (including monitoring of outcome)
There is considerable value in families 'informal' reports regarding their problems and any changes they have noticed. However, it is good practice for practitioners to record changes systematically, using measures, questionnaires, or diaries. These are somewhat distinct sources of information; measures usually capture phenomena that are common to individuals with a particular problem, whereas diary records are a way of helping the parent/carer or child/young person to elaborate on their own idiosyncratic concerns. Both help to anchor assessment and therapy by making use of information that is current and (broadly speaking) objective.

Making use of supervision
The ability to use supervision is a generic skill pertinent to all practitioners at all levels of seniority, reflecting the fact that clinical work is demanding and usually requires complex decision making. Supervision allows practitioners to keep their work on track and to maintain good practice. Being an effective supervisee is an active process, requiring a capacity to be reflective and open to criticism, willing to learn and willing to consider (and remedy) any gaps in competence which supervision reveals.

Assessment and Formulation

Assessment and planning
The ability to undertake a thorough assessment is crucial if the CAMHS worker is to understand the difficulties that concern the child/young person and family. A multidimensional assessment of the child/young person's needs aims to analyse different aspects of the child/young person and family's functioning, and combine information from different methods and types of source. The competence list also reflect a consistent theme in service user feedback: that clinicians need to ask about the family's strengths as well as difficulties, so that interventions can build upon protective factors.

A core part of a comprehensive assessment includes an appraisal of any risk to the child/young person or to others. Risk assessment is a challenging task and can be carried out to varying levels of detail, following different types of risk assessment model. Bearing this in mind, the ability of workers to know the limits of their competence and when to make use of support and supervision will be essential.

A second feature of a comprehensive CAMHS assessment is the ability to assess the child's functioning within multiple systems. Knowledge of the different contexts that surround the child/young person and family is crucial for reaching an understanding of their beliefs and behaviour.

Interlinked with assessment skills is the ability to create a tailored formulation of the child/young person's difficulties and to feedback the results of a treatment plan. Formulations and treatment plans are often constructed in collaboration with the child/young person and family, and the expectation is that they are periodically reviewed in the light of new assessment or intervention information.

Single session assessment of service appropriateness
CAMHS services often expect clinicians to offer condensed 'screening' assessments to ascertain presenting problems and risks of harm, and to identify which service can best meet the needs of the family. These assessments draw on similar skills to those detailed in the comprehensive assessment list, and require the clinician to have a good knowledge of both the specialist CAMHS service and other alternative community agencies.

Coordination of case work
A case manager is expected to be able to lead and co-ordinate casework both within their team and across other agencies. This goes further than the knowledge and skills detailed in the competence of "interagency working" (which focuses on themes relevant to any interagency interaction) as the coordination of a specific case requires careful attention to the organisational and systemic processes known both to promote - and just as critically, to disrupt – effective working. As such, this section identifies the specific competencies required to co-ordinate a case at each stage from referral to discharge.

Specialist mental health assessments
Under the header of "specialist mental health assessments" are a number of assessments usually offered by professionals with specialist training in the relevant area: the ability to carry out a mental state examination, to make a diagnostic assessment, to undertake structured behavioural observations, and to undertake structured cognitive functional and developmental assessments.

Although identified as additional assessments in this framework, for some professionals they may be a part of their usual assessment (for example, a mental state examination is routine within a psychiatric assessment).

Universal and selective prevention programmes

Universal and selective prevention programmes may be carried out by CAMHS professionals across a range of settings; this section of the framework describes the principles that such programmes need to follow.

Specific interventions

This domain contains competence lists for specific interventions for a range of common problem presentations (disruptive behaviour disorders including ADHD, oppositional defiant and early onset conduct disorder, conduct disorder, depressive conditions, anxiety and trauma, autistic spectrum disorders, interventions for challenging behaviour, sleeping toileting and feeding problems, anorexia, substance abuse and interventions for psychosis).

The lists in this domain are intended to read as a coherent description of the critical elements of (and pathways through) each intervention. For clarity each list is set out as a self-contained document, but all are prefaced by a reminder that their effective delivery will rest on employing relevant core, generic therapeutic, assessment and formulation competences (as well as metacompetences).

The lists in this section are organised by diagnosis. However (and as discussed earlier), many children and young people present to CAMHS with comorbid conditions. Where this is the case an intervention 'package' may either involve co-ordinating more than one intervention or adapting a specific intervention, with decisions about the plan guided by a formulation. For example, a child displaying anxiety, school refusal and oppositional defiant disorder may lead the practitioner to refer the parents to a parents group, whilst they deliver CBT for anxiety and also liaise with important agencies such as school and social work. Practitioners might also need to adapt and extend the CBT intervention if other common co-morbidities were present (such as depression).

In most instances each therapeutic approach to a specific problem is represented by a single list. For example, there is one list which sets out competences for CBT for depression, developed by drawing on a number of different manuals. In other areas there are multiple lists, either because there are significant differences in the approach taken (as is the case for CBT interventions for PTSD) or because children of different ages are targeted by each approach.

Metacompetences

CAMHS work cannot be delivered in a 'cook book' manner: by analogy, following a recipe is helpful, but it doesn't necessarily make for a good cook. Skilful implementation of most areas of clinical work rests on an ability to implement "procedural rules" – using clinical judgment to decide when, how and whether to carry out a particular action or set of actions in order to make an intervention or a procedure responsive to the needs of each individual child and their family.

On the whole metacompetences are more abstract than those described elsewhere and, as a result, there is less direct evidence for their importance. Nonetheless, there is clear expert consensus that metacompetences are relevant to effective practice. Some of the list has been extracted from manuals, some are based on expert professional consensus and some on research-based evidence (for example, an ability to maintain adherence to a therapy without inappropriate switching between modalities when minor difficulties arise).

Implementing the competence framework

A number of issues are relevant to the practical application of the competence framework.

Do all CAMHS clinicians need to be able to do everything specified in the competence list?

As described above, not all clinicians in CAMHS are expected to carry out all the competences in all the domains of the framework. However, all members of a CAMHS team (or its equivalent in other service contexts for children and adolescents) *would* be expected to be able to demonstrate "underpinning" skills (core and generic therapeutic competences (shaded blue on the map)), and all caseholding clinicians would be expected to be able assess clients and use assessment information to develop appropriate treatment plans (areas of the map in orange shading). Whether or not an individual clinician will demonstrate competence across the unshaded areas of the map will depend on their having had the appropriate training and supervision to carry out the procedures and interventions that are listed in these sections.

How the metacompetences apply is more complex: some apply to all CAMHS working, while others relate to the implementation of specific interventions or specific procedures, and so only apply when these are being carried out. For example, metacompetences that apply to all workers are "the ability to interpret legal and ethical frameworks in relation to the individual case", or to "adapt communication and interventions to the child/young person's developmental stage". Others apply only when more specific interventions are being carried out (for example, "[adapting] treatment protocols so that they can be applied to the individual case"). As such, whether or not a metacompetence applies depends on the work a particular clinician is conducting.

Is every competence in a competence list of equal importance?

Many of the lists are quite detailed, and each of the competences are included either because they formed part of an intervention that shows evidence of efficacy, or because expert opinion indicates that these are important and relevant skills. Given that some of these lists are quite long, it is reasonable to ask whether al the skills are of equal value. This is a hard question to answer, because there is often little research evidence for the mutative value of *specific* skills – most evidence relates to *packages* of skills. This means that we cannot be sure which specific skills are likely to make a difference, and which are potentially neutral in their effect. Until we have more evidence it isn't possible to declare some skills more critical than others, but equally we cannot declare some skills or procedures optional. To that extent, all the competences are of equal value.

Does this mean that clinicians can use their judgment to decide which elements of an intervention to include and which to ignore? This could be a risky strategy, especially if this meant that major elements or aspects of an intervention were not offered – in effect clinicians would be making a conscious decision to deviate from the evidence that the package works. Equally, manuals cannot be treated as a set of rigid prescriptions, all of which have to be treated as necessary and all of which must be applied. Indeed most of the competence lists for problem-specific interventions refer to an important metacompetence – the ability to introduce and implement the components of a programme in a manner which is flexible and which is responsive to the issues the client raises, but which also ensures that all relevant components are included. This involves using informed clinical judgment to derive an intervention mapped to the needs of an individual client while having due regard to what is known about 'best practice' (a process that parallels the judgment required to apply clinical guidelines to the individual case).

Another factor is that most interventions evolve over time, especially as research helps to identify the elements that make a difference and are associated with efficacy. However it can take some time before research validates the benefit of innovations, and as a consequence there is often a lag between the emergence of new ideas and their inclusion in clinical guidelines. This means that intervention packages should not be viewed as tablets of stone – though equally this is not a reason for clinicians to adopt "pick and mix" approach to the competences they incorporate into a 'standard' treatment.

The impact of treatment formats on clinical effectiveness

The competence lists in this report set out what a therapist should do, but most do not comment on the way in which an assessment or intervention is organised and delivered. For example, the duration of each session of a psychological treatment, how sessions are spaced (e.g. daily, weekly or fortnightly) or the usual number of sessions. However, these formats are often identified in clinical guidelines, and in manuals and research protocols, with the schedule constructed so as to match to clinical need and the rationale for the intervention.

When implemented in routine services, treatment formats often deviate from the schedules used in research trials. This can be for a range of reasons, but it is reasonable to ask whether making significant changes to the format may impact on effectiveness. This is a difficult question to answer because on the whole there is rather little research evidence on which to draw. However, where research has been conducted – for example in the area of parenting programmes – it suggests that better outcomes are achieved when therapists show greater fidelity to the procedures set out in the manuals (e.g. Eames, Daley, Hutchings, Whitaker, Jones, Hughes, & Bywater, 2009). It is also the case that fidelity in parent programmes is best conceived as adherence to a number of overarching areas of activity (including an ability to apply social learning theory, a capacity to work with group process while also attending to each individual parent, and an ability to assure access and active support to maintain the engagement and involvement of parents). As such there is much that could be neglected if clinicians deliver bespoke programmes that include some, but not all, these areas. Generalising this observation across all interventions, it suggests that when clinicians vary a 'standard' treatment procedure they should have a clear rationale for so doing, and that where procedures are varied there should be careful monitoring and benchmarking of clinical outcomes in order to detect whether this has a neutral or an adverse impact.

The contribution of training and supervision to clinical outcomes

Elkin (1999) highlighted the fact that when evidence-based therapies are 'transported' into routine settings, there is often considerable variation in the extent to which training and supervision are recognised as important components of successful service delivery. Roth, Pilling and Turner (2010) examined 27 major research studies of CBT for depressed or anxious adults, identifying the training and ongoing supervision associated with each trial. They found that trialists devoted considerable time to training, monitoring and supervision, and that these elements were integral to treatment delivery in clinical research studies. It seems reasonable to suppose that these elements make their contribution to headline figures for efficacy - a supposition obviously shared by the researchers themselves, given the attention they pay to building these factors into trial design.

It may be unhelpful to see the treatment procedure alone as the evidence-based element, because this divorces technique from the support systems that help to ensure the delivery of competent and effective practice. This means that claims to be implementing an evidence-based therapy could be undermined if the training and supervision associated with trials is neglected.

Applying the competence framework

This section sets out the various uses to which the CAMHS competence framework can be put, and describes the methods by which these may be achieved. Where appropriate it makes suggestions for how relevant work in the area may be developed

Commissioning

The CAMHS framework can contribute to the effective use of health care resources by enabling commissioners to specify both the appropriate levels and the range of competences that need to be demonstrated by CAMHS workers in order to meet identified local needs. It could also contribute to the development of more evidence-based systems for the quality monitoring of commissioned services by setting out a framework for competences which is shared by both commissioners and providers, and which services could be expected to adhere to.

Service organisation – the management and delivery of CAMHS services

The framework represents a set of competences that (wherever possible) are evidence -based, and aims to describe best practice - the activities that individuals and teams should follow to deliver interventions.

Although further work is required on their utility and on associated methods of measurement – they should enable:

- the identification of the key competences required by a practitioner to deliver interventions across CAMHS
- the identification of the range of competences that a service or team would need to meet the needs of the populations with whom they work
- the likely training and supervision competences of those managing and delivering the service

Because the framework converts general descriptions of clinical practice into a set of concrete specifications, it can link advice regarding the implementation of therapies (as set out in NICE guidance or National Service Frameworks (NSFs), along with other national and local policy documents) with the interventions actually delivered. Further, this level of specification carries the promise that the interventions delivered within NHS settings will be closer in form and content to that of research trials on which claims for the efficacy of specific interventions rest. In this way it could help to ensure that evidence-based interventions are likely to be provided in a competent and effective manner

Clinical governance

Effective monitoring of the quality of services provided is essential if service users are to be assured optimum benefit. The monitoring the quality and outcomes of CAMHS interventions is a key clinical governance activity; the framework will allow providers to ensure that interventions are provided at the level of competence that is most likely to bring real benefit by allowing for an objective assessment of clinician's performance.

The introduction of the CAMHS competence framework into clinical governance can be achieved through local implementation plans for NICE/ SIGN guidance and their monitoring through the local audits procedures as well as by the monitoring systems of organisations such as the Healthcare Commission.

Supervision

Used in conjunction with the competence framework for supervision (www.ucl.ac.uk/clinical-psychology/CORE/supervision_framework.htm), the CAMHS framework potentially provides a useful tool to improve the quality of supervision for psychological interventions by focusing the task of supervision on a set of competences that are known to be associated with the delivery of effective treatments. Supervision commonly has two aims – to improve outcomes for clients and to improve the performance of practitioners; the framework will support both these through:

- providing a structure by which to identify the key components of effective practice for specified disorders
- allowing for the identification and remediation of sub-optimal performance

The framework can achieve this through its integration into professional training programmes and through the specification for the requirements for supervision in both local commissioning and clinical governance programmes.

Training

Effective training is vital to ensuring increased access to well-delivered psychological therapies. The framework can support this by:

- providing a clear set of competencies which can guide and refine the structure and curriculum of training programmes[4], including pre and post-qualification professional trainings as well as the training offered by independent organisations
- providing a system for the evaluation of the outcome of training programmes

Research

The competence framework can contribute to the field of psychological therapy research in a number of areas; these include the development and refinement of appropriate psychometric measures of therapist competence, the further exploration of the relationship between therapy process and outcome and the evaluation of training programmes and supervision systems.

[4] This application has already been actioned: the national curriculum for the Improving Access to Psychology Therapies (IAPT) programme for children and young people is based on the framework described in this document, as is the Essential CAMHS Learning Resource being developed by NES.

Concluding comments

This report describes a model which identifies the activities which characterise effective CAMHS assessments and interventions, and locates them in a "map" of competences.

The work has been guided by two overarching principles. Firstly it stays close to the evidence-base and to expert professional judgment, meaning that an intervention carried out in line with the competencies described in the model should be close to best practice, and therefore likely to result in better outcomes for service users. Secondly, it aims to have utility for those who use it, clustering competences in a manner that reflects the way in which interventions are actually delivered and hence facilitates their use in routine practice.

Putting the model into practice – whether as an aid to curriculum development, training, supervision, quality monitoring, or commissioning – will test its worth, and indicate the ways in which it needs to be developed and revised. However, implementation needs to be holistic: competences tend to operate in synchrony, and the model should not be seen as a cook-book. Delivering effective interventions involves the application of parallel sets of knowledge and skills, and any temptation to reduce it to a collection of disaggregated activities should be avoided. Clinicians need to operate using clinical judgment in combination with their technical and professional skills, interweaving technique with a consistent regard for the relationship between themselves and service users.

Setting out competences in a way which clarifies the activities associated with a skilled and effective practitioner should prove useful for workers in all parts of CAMHS. The more stringent test is whether it results in more effective interventions and better outcomes for clients of these services.

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Appendix B : CAMHS relevant Competence Frameworks

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