Ability to assess the child's functioning within multiple systems

Assessment competencies are not a 'stand alone' description of competencies, and should be read as part of the CAMHS competency framework.

Effective delivery of assessment competencies depends critically on their integration with the knowledge and skills set out in the core competency and generic therapeutic competency columns.

The competences set out in this section describe basic systemic assessment skills that should be held in mind by clinicians from all therapeutic backgrounds.

A substantial body of systemic theory and research informs the practice of more specialised family therapy assessments and interventions. These are described elsewhere in the CAMHS map and in the framework for Systemic Psychotherapy (available at: www.ucl.ac.uk/clinical-psychology/CORE/competence_frameworks.htm).

Knowledge of the relevance of systems and the basic principles of social constructionism

An ability to draw on knowledge that psychological problems and emotional distress are usually better understood by taking into account the "systems" in which the child and their family are located	
An ability to draw on knowledge that the patterns of relationships within systems may play a significant role in shaping and maintaining psychological problems	
An ability to draw on knowledge of the basic principles of social constructionism:	
	that people understand themselves and the world around them through a process of social construction
	that meaning is generated through social interactions, and the language used in different social interactions
	that power relationships (e.g. an individual's position in a system) and different cultural contexts (such as gender, religion, age, ethnicity) have an important influence of the development of meaning, relationships, feelings and behaviour
An ability to draw on knowledge that the ways in which they have related to healthcare systems may play a significant role in shaping children and families understanding of, and attitudes towards, the management of their health condition e.g.:	
	the degree to which they have been involved in decisions about their healthcare, including referrals and medical regimens
	the extent to which they have been fully informed about clinical findings and test results
An ability to draw on knowledge that healthcare systems can be empowering or disempowering, and that children and family's behaviours may reflect their prior experience of healthcare	

Assessment

- An ability to draw on knowledge that the multiple contexts in which the child/young person and their family is located need to be considered taken in any assessment, and that these will include:
  - family, peer group, and other significant relationships
  - school or place of employment
  - social and community setting
  - professional network(s) involved with them
  - their cultural setting
  - their socio-political environment
  - the family's involvement with a patient or user organisation
  - the family's involvement with employment and benefit agencies
    - an ability to draw on knowledge that these different contexts are connected and are likely to interact
- An ability to draw on knowledge of the contexts/environments of which the child/young person is a part and which may be relevant to their presentation (e.g. the beliefs and practices of a particular school, medical team or the beliefs associated with their peer group)
- An ability to engage with, and gather further information from, relevant individuals in the child's system including:
  - the child/young person's family
  - non-professionals who have an active role in caring for the child/young person
  - other professionals (e.g. other members of the medical team, referring agencies, school, or other services involved with the child or family)
- An ability to use the assessment process to engage with relevant members of the system including, where appropriate, the wider team, referring agencies, education services and support services
- An ability to identify in conjunction with the child/young person, family and the wider system:
  - perceived problem areas and the beliefs concerning them
  - the potential strengths of the child/young person (and the wider system) which may support therapeutic change
  - the solutions that have been tried or have been thought about
  - the achievements in the child/young person's life
  - the decision to seek help and any concerns/dilemmas about engaging
  - whether and how to proceed with an intervention
  - who to involve
  - when and where to meet
- An ability to draw on knowledge that different members of the system will describe the child/young person differently as:
  - there are always multiple perspectives and descriptions of any interaction/ relationship
  - the child/young person's behaviour is influenced by the different set of contextual factors present in each setting

Ability to collaboratively engage CYP and carers with the treatment model and treatment model (shared decision making)

An ability to engage the child/young person in a collaborative discussion of the treatment options open to them, informed by the information gleaned through assessment, the formulation emerging from the assessment, and the child and family's aims and goals	
An ability to convey information about treatment options in a manner that is tailored to the child or young person's level of understanding and capacities and that encourages them to raise and discuss queries and/or concerns	
An ability to provide the child and family with sufficient information about the treatment and intervention options open to them, such that:	
	they are aware of the range of options available to them
	they are in a position to make an informed choice from among these options
An ability to ensure that children and young people (and their parents/carers) have a clear understanding of the models or approaches being offered to them (e.g. the broad content of each intervention and the way an intervention usually progresses)	
While maintaining a positive stance, an ability to convey a realistic sense of:	
	the effectiveness and scope of the intervention
	the limitations of the intervention (i.e. what may change, and what is unlikely to change as a consequence of the intervention)
	any challenges associated with the intervention
An ability to use clinical judgment to determine whether the child/young person's agreement to pursue an intervention is based on a collaborative choice (rather than being a passive agreement, or as an agreement which they experience as imposed on them by others (including the wider medical team)	
	an ability to identify when the child/family's understanding is at odds with the proposed intervention model, and to maintain a collaborative discussion in order to reach agreement over how to proceed

Ability to deliver psychologically informed care

An ability to promote the benefits of a psychologically informed healthcare system
An ability to promote a psychologically informed environment that includes team based formulation and teaching which integrates medical, biological and psychological perspectives for the benefit of delivering holistic care
An ability to utilise appropriate outcome measures to demonstrate benefit
An ability to share evidence of benefits with senior managers and supervisors

Engaging in psychologically informed practice as a healthcare team

An ability to draw on knowledge that the receptiveness of healthcare settings to a psychological approach will vary, and cannot be assumed	
An ability to draw on knowledge that in some healthcare settings:	
	the potential contribution of a psychological approach may be not be recognised, or may be seen as relating exclusively to mental health
	basic psychological concepts and relationships may not be understood (e.g. the importance of psychosocial factors as predictors of a patient's response to illness and illness outcomes)
	psychological approaches could be seen as lacking an evidence base, and therefore lacking credibility
	psychological approaches could be seen as potentially stigmatising for patients
An ability to start the engagement process by observing how different members of the team work in clinical settings in order to learn:	
	about the health conditions with which the team works and the ways in which the team and specific members approaches its management
	about the concerns of the healthcare team or specific members and any ideas they may have for change, or for a different way of working

Establishing a context for a psychologically informed workforce

An ability to draw on knowledge of the roles of staff groups involved in the healthcare setting and of the managerial and decision-making structures within and across professions	
An ability to integrate a psychological approach with current ways of working e.g.:	
	within the ways in which clinical services are currently delivered
	within the procedures for communication and reporting already used by the team (e.g. through ward meetings, psychosocial meetings, or by making concise, timely and informative records in shared clinical notes)
An ability to draw on the team's knowledge to modify psychological interventions (e.g. when instituting behavioural activation in the context of cardiac rehabilitation)	
An ability to draw on direct knowledge of the clinical system and the range of patients it sees as well as information from service users and carers to identify the range of potentially appropriate referrals (through direct observation of clinics and discussion with healthcare staff)	
An ability to help healthcare professionals understand the steps they can take to promote psychological wellbeing in the families they see without need for referral for specialist psychological interventions	

An ability to identify the input that may be needed to help the wider multi-disciplinary team to make appropriate and targeted referrals for psychological interventions e.g.:
helping healthcare professionals understand the psychological approaches and services that are available
modelling appropriate referral questions as a part of team discussions (e.g. reframing discussion to identify relevant psychological issues and examples of the questions that a referrer might ask)

Ability to communicate the potential benefits of a psychological perspective

An ability to establish the credibility and utility of psychological concepts or strategies by identifying recurrent themes or concerns where this perspective may have traction
An ability to introduce and explain psychological concepts to non-specialists in a way that is likely to engage their interest – for example, ensuring that:
ideas are introduced tentatively (i.e. as potentially representing an additional perspective)
the concepts being discussed have obvious relevance to their field of practice (for example by showing how they will impact on patient's response to treatment)
discussion takes account of (and is adapted to) their prior understanding and likely assumptions (i.e. working to find points of integration with their current knowledge)
the account avoids jargon or technical terms likely to be unfamiliar to healthcare practitioners
An ability to judge when drawing on evidence-based examples relevant (or clearly applicable to) the specific medical setting would be useful ways of illustrating the successful application of psychological ideas and/or strategies

Collaboratively identifying the potential contribution of psychological approaches

An ability to work as and with healthcare practitioners and health service managers to identify relevant areas of their practice which they regard as problematic
An ability to explore ways in which psychological strategies might provide solutions to areas of concern, e.g.:
gathering 'data' by attending clinics and relevant professional meetings, initially as an observer
identifying areas where a psychological perspective and/or intervention might be applicable
developing a psychological formulation that informs and addresses areas of concern, and which indicates possible intervention strategies
communicating information about possible intervention strategies in a manner that conveys a rationale for any intervention, the likely outcomes, and the ways in which this might benefit the work of the team and their patients
An ability to help staff to discuss their own experiences of successfully implementing psychological approaches to managing a condition in order to support the dissemination of this approach among their colleagues
an ability to encourage the promotion of areas where staff are already implementing interventions that are congruent with psychologically-informed approaches (e.g. engaging with a patient's anxiety by explaining a procedure rather than reassuring).

Using multidisciplinary team meetings to develop psychologically informed treatment plans

An ability to draw on knowledge of team working and decision making to facilitate discussion of psychological factors in assessment and treatment planning
An ability to facilitate contributions from those in the team less confident in their role
An ability to draw on knowledge that teams are more likely to implement decisions where:
plans are documented, disseminated and discussed with the patient
the team is cohesive and functioning well
there is a clear implementation plan that identifies:
what is to be done
who is responsible
when it will happen
how it will be audited
where and to whom any problems or changes should be reported

Working as a team to integrate psychological thinking and approaches

An ability to encourage and support other professionals to use psychological approaches within their own practice, for example:
through modelling (e.g. managing post-operative distress with the professional present, or by working with them to introduce behavioural techniques such as pacing in the management of over/underactivity cycles in pain and other long-term conditions)
by offering teaching and training and enabling skill acquisition through ongoing support
An ability to support and encourage other professionals to use/develop appropriate measures of outcome and patient experience (e.g. through discussion of ways in which outcomes relevant to clinicians and patients can be monitored and audited)
An ability to identify and utilise standardised tools suitable within a paediatric healthcare settings that can be used by all staff to screen for psychological difficulties, measure levels of distress and evidence improvements
An ability to lead by example and support others in disseminating outcomes relevant to psychological approaches via regular audit and/or by supporting them in designing and conducting research

Providing evidence for the development of a psychological service

An ability to convey a clear sense of the contribution of psychological service to the work of the team, for example by:
presenting illustrative case examples in team meetings
presenting the evidence base for effectiveness of psychological interventions in supporting children and young people with physical health conditions
providing clear and concise summary reports that set out specific treatment options and plans
providing information about outcomes for all referrals
providing a service report at agreed intervals for senior clinical staff and managers (including data on outcomes, reports of patient experience, cost impact, teaching and research output)

Ability to develop a formulation
(describe difficulties in a psychologically informed way)

Formulation competencies are not a 'stand alone' description of competencies, and should be read as part of the paediatric competency framework. Effective delivery of formulation competencies depends critically on their integration with the knowledge and skills set out in the core competency column, generic therapeutic competency column as well as assessment activities set out in the assessment column.

Knowledge

An ability to draw on knowledge that the aim of a formulation is to explain the development and maintenance of the child's difficulties, and that formulations:	
	are tailored to the individual child and their family
	comprise a set of hypotheses or plausible explanations which draw on theory and research to explain the details of the clinical presentation obtained through an assessment
An ability to draw on knowledge that models of formulation include:	
	"generic" formulations, which draw on biological, psychological and social theory and research
	"model-specific" formulations, which conceptualise a presentation in relation to a specific therapeutic model (e.g. psychodynamic, cognitive- behavioural or, systemic models) and which usually overlap the generic formulation
An ability to draw on knowledge that different therapeutic models vary in the extent to which the formulation is explicitly shared and constructed with the family	
An ability to draw on knowledge that formulations should be reviewed and revised as further information emerges during ongoing contact with the child and family	
An ability to draw on knowledge that a generic formulation usually includes consideration of:	
	risk factors that might predispose to the development of psychological problems (e.g. low IQ, insecure attachment to caregiver, caregiver marital difficulties)
	risk factors that might predispose to difficulty adjusting to a physical health condition (e.g. previous experience of illness or hospital; unhelpful beliefs about prognosis, lack of support systems for the child and family)
	precipitating factors that might trigger the onset or exacerbation of difficulties (e.g. acute life stresses such as relapse of physical illness, developmental transitions such as starting school or the birth of a new child or bereavement within the family)
	maintaining factors that might perpetuate psychological problems or unhelpful coping strategies once they have developed (e.g. poor relationship with clinical team, inadvertent reinforcement of problem behaviours, "unintended" positive outcomes from the illness)
	protective factors that might prevent a problem from becoming worse or may be enlisted to ameliorate the presenting problems (e.g. high IQ, good family communication, high parental self-efficacy, good relationship with clinical team)

- An ability to draw on knowledge that one of the main functions of a formulation is to help guide the development of an intervention plan
  - an ability to draw on knowledge that the intervention plan usually aims to reduce the effects of identified maintaining factors, and to promote protective factors

Ability to construct a formulation:

- An ability to generate a comprehensive list of all the presenting problems
- An ability to appraise and resolve any apparently contradictory reports of a problem, e.g.:
  - when informants focus on different aspects of a problem or situation, or represent it differently, e.g.:
    - self-reports of emotional difficulties made by child and adolescents (which are often higher than those made by parents or teachers or the medical team)
    - parent or teacher ratings of conduct problems (which are often higher than those made by the child/young person)
  - when a young person's behaviour differs depending on the context
- An ability to understand the child's inner world, affective and interpersonal experiences and frame them in a developmental and contextual perspective
- An ability to evaluate and integrate assessment information obtained from multiple sources and methods, and to identify salient factors which significantly influence the development of the presenting problem(s), drawing on sources of information such as:
  - the child and family's perception of significant factors and their explanation for the presenting problem(s)
  - theory and research that identifies biological, developmental, psychological and social factors associated with an increased risk of mental health difficulties
  - theory and research that identifies biological, psychological and social factors associated with mental well-being (e.g. secure attachment with primary caregiver, good physical health, good parental adjustment, good social support network)
  - knowledge of normal child development and developmental processes (in order to identify delays in the child's development)
  - associations between the onset, intensity and frequency of presenting problem(s) and the presence of factors in the child's psychosocial environment (e.g. traumatic life events (including diagnosis of illness, physical health treatments and hospital admissions) or parental ill health)
  - the results of a functional analysis which records the antecedents and consequences of a particular behaviour
- An ability to construct a collaborative formulation that:
  - clearly acknowledges the child and family's understanding of the factors pertinent to their presentation
  - provides the child and family with a rationale for considering alternative perspectives that may lead to more adaptive coping

Ability to feedback the results of the assessment and formulation and agree a treatment plan with the CYP, carers and medical teams

Assessment feedback competencies are not a 'stand alone' description of competencies, and should be read as part of the Paediatric competency framework. Effective delivery of assessment feedback competencies depends critically on their integration with the knowledge and skills set out in the core competency and generic therapeutic competency columns as well as the assessment activities set out in the assessment column

Knowledge

An ability to draw on knowledge of research into the efficacy of psychological and pharmacological interventions, and the possible side-effects or negative effects of interventions	
An ability to draw on knowledge of the range of psychological interventions offered within the team and by other statutory and non-statutory agencies	
	an ability to draw on knowledge of interventions for promoting psychological wellbeing that can be offered by non-specialist members of the medical team
An ability to draw on knowledge of community resources and projects relevant to the promotion of mental health (e.g. youth clubs, drop-in centres, sports facilities etc.)	
An ability to draw on knowledge of other services within physical health that can promote coping and adjustment to physical illness (e.g. hospital based services such as chaplaincy and family support; or third sector and charitable organisations)	

Ability to provide feedback on the assessment and formulation

Ability to provide information on the assessment and formulation

An ability to discuss with the child/young person and their family/carers how they would like information about the assessment and the formulation to be conveyed:	
	identifying whether they would like information to be conveyed to the family as a whole, or to parents/carers and the child/young person separately
	identifying the most effective methods of conveying information for the family (e.g. verbal, written summaries, diagrams etc.)
An ability to outline the presenting problem(s), as seen by different family members, and the wider medical team	
An ability to maintain an empathic, neutral and supportive, non-blaming stance when talking about the presenting problems	
An ability to describe predisposing, precipitating and maintaining factors for the presenting problem(s), explicitly linking this description to information gathered during the assessment	
An ability clearly to explain any diagnoses, including information on aetiology, epidemiology and the usual course of the condition	

An ability to discuss protective factors and strengths shown by the child/young person and family/carers
An ability to locate problems in the context of an interface between physical and psychological health

Ability to adapt feedback

An ability to adapt the pace, amount of information and level of complexity to:	
	The child/young person and family's level of understanding
	the child/young person and family's emotional readiness to accept the information
An ability to match feedback to the child/young person's level of understanding (e.g. by simplifying the way in which concepts are expressed, or by explicitly and frequently checking their understanding)	
An ability to adapt written information for younger people or children with a disability (e.g. by using pictures, child-friendly booklets or specific communication aids)	

Ability to seek the views of the child and their family/carers

An ability to check regularly that the child/young person and family/carers understand what is being said to them, and whether they agree with the information being conveyed	
An ability to ensure that sessions are structured so as to allow time for the family/carers to ask questions or make comments	
An ability to help the child/young person and family/carers feel comfortable and confident to ask questions when they are uncertain or confused (e.g. by responding positively to questions, validating the appropriateness of questions, or actively prompting them to ask questions)	
An ability to provide answers to questions in an honest and straightforward manner	
	an ability for the therapist to be clear when they need more information in order to answer questions, and to seek this information from an appropriate authority or source

Ability to work towards and negotiate an agreed formulation

An ability to consider the reasons for any significant differences between the family's and the clinician's view of the diagnosis or the formulation, including whether:	
	the assessment has taken into account beliefs about the factors which account for the maintenance of difficulties, especially where there is conflicting opinion on the cause of physical symptoms (e.g. where symptoms are 'medically unexplained')
	information has been clearly explained in a sensitive non-blaming manner that highlights the family's strengths as well as difficulties
	the links between contextual factors and the child's behaviour have been made clear
	the family's reaction to a diagnosis or aspect of a formulation is a normal adjustment reaction to difficult news
	there are factors in the parent/child's presentation and history that may make it hard for them to accept difficult news or specific aspects of the formulation

the assessment fully explored the concerns and/or beliefs of the family (e.g. a parent who strongly believes the child has ADHD and so rejects the idea that behavioural difficulties are inadvertently reinforced by parental reactions)
the assessment and formulation has taken into account the social and cultural context and its influence on the family's belief system

Ability to plan an intervention that draws on the agreed formulation

An ability to draw on the formulation constructed with the child/young person and family/carers which:
includes their ideas about how aspects of themselves, or their environment could change
acknowledges (and accommodates) doubts or uncertainties about the way forward, especially where there are differing opinions about the cause of symptoms

Ability to identify when a psychological intervention is not required and/or not appropriate

An ability to recognise when no further intervention is required, and to discuss the reasons for this with the child, their family and (where appropriate the wider medical team), for example:
when the process of assessment has (in itself) enabled the family to resolve the presenting problem
when the assessment process has helped the family resolve their concerns (e.g. when a child's "problems" are actually recognised to be developmentally appropriate behaviour)
when psychological difficulties are a normal adjustment reaction and are likely to resolve over time without the need for a formal intervention
An ability to recognise and discuss with the child and family that (rather than a psychological intervention) their needs might be best met by other services (e.g. other colleagues within physical health, education, or social services)
Where the child/young person (or carer's) reaction is a normal adjustment reaction an ability to discuss this with them (and the wider medical team) and identify how best to support the child without the need for a formal psychological intervention

Ability to identify when the child and family require more specialist assessment (from within a mental health service or by other agencies)

An ability to recognise when the child and their family require further, more specialist, assessment in order to determine the most appropriate intervention (e.g. referral for language assessment, cognitive assessment, motor skills assessment)

Ability to identify potential psychological interventions

An ability to draw on the formulation and decisions regarding diagnosis to identify the indicated evidence-based psychological intervention
An ability to draw on the formulation and decisions regarding diagnosis to identify when interagency work is required, including:
work with schools

referral and parallel working, for example:	
	joint working with other specialities within the wider medical team
	with adult mental health services
	with social work services
	with counselling services, community projects etc.
referral to and ongoing communication with the legal system (e.g. the Children's Reporter System (Scotland) or Youth Justice System (England))	

Ability to promote informed choice and agree a plan for intervention

An ability to provide the child and family with information on the various options for intervention, including information on their likely efficacy	
An ability to discuss with the child and family any negative effects or side-effects of the intervention(s)	
An ability to seek the child and family's views on each intervention option	
An ability to gauge family members' motivation and preference for particular intervention options	
An ability to discuss any differences in the intervention preferences of various family members, including those of children and young people	
An ability to discuss whether the family anticipates any difficulties with engaging with an intervention(s), including their ability to attend clinic	
	where specific barriers are identified, an ability to address these and to promote attendance (e.g. co-ordinating appointments, involving social work for advice on financial issues)
An ability to reach agreement on an appropriate intervention plan	
An ability to help the child/young person and family identify goals for the intervention(s) that are:	
	shared by all family members, and to identify where family members have different goals in mind
	SMART (specific (explicitly defined), measurable (meaningful and motivational), agreed, realistic (in the sense of being achievable) and time-based)
	appropriately prioritised, usually starting with those areas most likely to be amenable to change
An ability to reach agreement on the sequencing and timing of intervention(s)	
An ability to plan the length of the intervention and/or to set a review date	
Where an external agency is involved in the intervention plan, an ability:	
	to draw on knowledge of consent and confidentiality procedures, and to identify when the safeguarding needs of the child/young person take precedence over obtaining parental/carer consent
	to obtain consent to share information with external agencies e.g. school
	to obtain consent to refer to external agencies (e.g. adult mental health, social work)
	to discuss with the family options for self-referral or access to community resources (e.g. advisors on employment, housing, benefits, debt, recreational activities, etc.)
An ability to include evaluation procedures in the intervention plan, for example:	
	an ability to record the child/young person and family/carer's identified goals for an intervention(s), with the aim of evaluating whether they have been met by review dates or at the end of the intervention
	an ability to identify suitable pre- and post-intervention measures and any arrangements required for their administration

an ability to select measures that are sensitive to changes in the management of the physical condition targeted by the intervention
an ability to identify potential confounds introduced by the physical health condition (e.g. somatic examples of distress in measures of depression)

Ability to Promote Staff Support and Wellbeing

An ability to draw on knowledge that working with children and families with physical health conditions and life limiting conditions can be distressing
An ability to draw on knowledge that there is an association between a culture of compassion and support both towards and within staff groups and better patient care

Recognising stress and burnout

An ability to recognise early signs of stress and burnout in staff, for example:	
	changes in activity level at work and socially
	irritability, anger and frustration
	confusion, lack of attention and difficulty making decisions
	physical reactions (e.g. headaches, stomach aches)
	difficulties with sleeping, or low mood and anxiety
An ability to recognise early signs of vicarious traumatisation in self/staff, for example	
	over-involvement
	over detachment or numbing
	feelings of helplessness
An ability to draw on knowledge of factors that might make it more difficult to manage stress within the workplace (such as feeling isolated/not part of a team; frequent exposure to child death and suffering; high workloads and staff shortages)	
An ability to draw on knowledge that personal experiences of illness and death may impact on a healthworkers' ability to interact with and support children, young people and families	
An ability to recognise more extreme signs of stress and vicarious traumatisation for example:	
	compassion stress (helplessness, confusion, isolation)
	compassion fatigue (demoralisation, alienation, resignation)
	preoccupation with, or re-experiencing of, a traumatic event (e.g. of being involved in a child's resuscitation)
	depression, withdrawal and isolation
	serious difficulties in personal relationships
	significant changes in sleep patterns
	reliance on licit or illicit substances to help manage or prevent feelings
	over pre-occupation with work

Responding to stress and burnout

Promoting a supportive organisation

An ability to draw on knowledge that a staff group whose psychological needs are recognised and met is more likely to provide caring compassionate care that puts children and families first

An ability to draw on knowledge that staff working in busy stressful environments (such as physical health settings) are at risk of developing burnout and should be supported to manage this, by for example:	
	promoting a culture whereby staff are confident of support if they raise concerns and difficulties with supervisors and managers
An ability for managers to respond to stress and burnout in staff using a variety of approaches or interventions appropriate to need (for example supervision, consultation, managerial support, or involvement of occupational health)	

Capacity for staff members to recognise and self-manage stress

An ability for health workers to recognise that taking steps to managing their own emotional health will a positive effect on the families with whom they are working	
An ability to draw on knowledge of strategies to protect psychological functioning and minimise the impact of burnout and traumatisation, for example:	
	accessing strategies that support self-care/resilience (e.g. exercise, social support, maintaining a work-life balance)
	accessing professional support and supervision, including opportunities for reflective practice, “debriefing” and psychosocial meetings
	discussing with supervisor/manager when caseloads have become unbalanced, for example, involve a high proportion of emotionally demanding cases
	setting realistic expectations and being clear about the areas for which the worker carries responsibility
	accessing managerial and organisational support to discuss workplace strategies to minimise stress (e.g. line manager, occupational health)
An ability for the health worker to access support for their own healthcare when self-management strategies prove insufficient	

Ability to undertake a biopsychosocial assessment

This section should be read in conjunction with the other areas of assessment included in this framework (risk assessment and management, and assessing the person's functioning in multiple systems) and the knowledge and skills encompassed in the domains of "core competences for work with children" and "generic therapeutic competences"

Knowledge of the assessment process

An ability to draw on knowledge that the aim of the assessment process is to create a formulation (including a possible diagnosis) which guides the choice of intervention and aims to improve the quality of life of the child and family.
An ability to draw on knowledge of the importance of introducing the concept of the impact of physical difficulties on psychological functioning and vice versa at an early stage in clinical consultations and assessments
An ability to draw on knowledge that the initial assessment generates working hypotheses which may need to be updated or corrected in response to obtaining further information during the course of contact with the family
An ability to draw on knowledge that there are multiple perspectives when assessing a family, and that the child, parents', school and other medical colleague's perspectives on problems and aims for intervention can be significantly different
An ability to draw on knowledge that the assessment process can in itself alter the views of family members towards a problem (e.g. by drawing attention to the links between historical factors or family stresses and the behaviours of the child)

Knowledge of physical health conditions

An ability to draw on knowledge of physical health conditions with which children/young people are presenting, including:	
	the physical symptoms and conditions that children usually experience
	diagnostic criteria (including positive diagnostic criteria for "functional" disorders (such as non-epileptic attack disorder), such that these are not construed as diagnoses of exclusion)
	investigations that are routinely carried out in relation to specific symptoms/conditions
	any physiological mechanisms known to account for the presentation
	the medical interventions commonly employed to manage them (including any adverse impacts, such as side-effects of medications or complications from surgery)
An ability to integrate knowledge of the ways in which both psychological and physiological mechanisms contribute to children/young people's presentations, and how these can interact, e.g.:	
	low mood leading to reduced physical activity, resulting in deconditioning
	low mood or anxiety leading to poor concordance with treatment regimen (and so to poorer health)
	symptom exacerbation being interpreted catastrophically and leading to high levels of anxiety, hopelessness or distress

An ability to draw on knowledge of models of child development and the impact of physical health conditions and treatment on “normal” trajectories, and a capacity to use these models to understand the child’s presentation
An ability to draw on knowledge of relevant models of health and illness behaviour, and a capacity to use these models to understand the child’s presentation
An ability to draw on knowledge of relevant explanatory models of ‘functional’ somatic syndromes, and a capacity to use these models to understand the child’s presentation

Setting up the assessment

Ability to coordinate a multidimensional assessment

An ability to undertake a “multidimensional” assessment of the child or young person which is:	
	multimethod: including information from interviews, observations, and measures as well as any other methods which seem appropriate
	multisource: including information from the child, family, school and other members of the medical team as well as other sources of particular relevance to an individual family
	multilevel: including information about their physical (including sexual), emotional, cognitive, social development, along with cultural and spiritual influences on them and their family

Ability to identify people and agencies who need to be included in the assessment

An ability to identify and involve the individuals and agencies who constitute the child/young person’s network of carers, including:		
	identifying the primary carers (e.g. parents, foster parents, residential childcare staff)	
		identifying who has parental rights and responsibilities (e.g. parent, family member, social work department)
	identifying the professionals and agencies involved with the child/young person (e.g. social work, youth justice, other key medical/nursing/clinical professionals)	
An ability to draw on knowledge of local and national assessment forms including those which can be completed by several different agencies working together		

Drawing on information obtained from other agencies

An ability to identify any agencies and/or key professionals currently or previously involved with the child and family	
An ability to obtain consent from the family prior to seeking information from an agency	
	an ability to draw on knowledge of local policies on confidentiality and information sharing when obtaining (and sharing) information about the child and their family
An ability to obtain relevant records from involved agencies and identify and draw on information likely to be relevant to the present referral	

Ability to focus assessment

An ability to develop initial hypotheses on the basis of information gleaned from the referral, and an ability to use these to plan the assessment
where appropriate, an ability to obtain information from agencies involved with the child prior to an initial appointment in order to determine agency roles and help plan further assessment
An ability to adapt assessments in response to information that emerges and which appears to be of particular significance

The assessment process

Engaging the child/young person and their family in the assessment process

An ability to adapt sessions to take account of any physical or cognitive impairments; or environmental factors (e.g. inpatient admission) that impact on the child's capacity to engage with the assessment process
An ability to draw on knowledge that, for some families, reference to or a referral to psychological services will be experienced as an invalidation of their own account of their problems
An ability to help the child and family feel validated, for example:
by introducing at an early stage in clinical consultations, the impact of physical health difficulties on psychological functioning and vice versa
by focusing upon physical health problems before exploring psychological issues or concerns
by explicitly empathising with their concerns about physical symptoms, and the impact this has on their lives
by conveying a belief in the reality of symptoms
by helping them to discuss symptoms that may be embarrassing to them
by indicating that it is common for physical symptoms to have an adverse impact on mood and on levels of stress
by demonstrating knowledge about the nature of the child's diagnosis, and conveying a sense that addressing psychological factors alongside physical factors can help management of their physical symptoms and other concerns
An ability to monitor and respond to any process issues that threaten the integrity of the assessment – for example, where there is evidence that:
the child/family has negative expectations based on prior experiences with the health system
the child/family perceives the clinician as an authority figure who is judging them
the child/family is unclear or unhappy about reference or referral to psychological interventions, and hence reacts to the questions they are being asked with confusion or hostility
An ability to convey a sense that assessment is a collaborative process, for example by:
ensuring that the structure of the interview is appropriately flexible, and is responsive to emerging content and concerns
actively sharing a developing sense of understanding with the child and family, and inviting their reaction and comment
An ability to identify (with the family/young person/carer) who should attend assessment sessions.
An ability to discuss confidentiality and its limits (e.g. the potential for child protection information which emerges to be shared with other agencies)
An ability to explain the structure of the assessment and the areas that it will cover

An ability to explain the relevance of particular areas of the assessment (e.g. the importance of gathering information about family history)
An ability to respond non-judgmentally to information which emerges during the assessment
An ability to balance problem-focussed questioning with questions that elicit areas of strength and resilience in the family e.g.:
attending to the potential for the language used in assessment to convey a negative connotation, and making appropriate adjustments to counter this (e.g. describing a task as a challenge rather than difficult)
helping the child/young person and family to portray a balanced view of themselves rather than feeling defined by their problems
recognising the potential impact on engagement of “relentless” questioning of problems and difficulties

Ability to adapt the assessment to match the abilities and capacities of the family

An ability to tailor the language used to match the abilities and capacities of the child and their family
An ability to engage families with physical and sensory impairment (for example by offering them a choice in assessment venue, or altering the pace and content of the session)
An ability to make use of interpreters when working with families who do not speak the same language as the interviewer

Making use of direct observations during assessment

An ability to observe the child in relation to domains such as levels of activity and attention, quality of social interaction and communication or emotional state
An ability to observe and consider the impact of the assessment situation on the child’s presentation and behaviour when evaluating the validity and generalisability of the observations
An ability to observe the interactions between the child and caregiver (e.g. during play, during interview sessions, or during separations and reunions that take place in the waiting room)
An ability to observe how family members interact with each other

Areas of assessment

Assessing physical symptoms and medical history

An ability to help the child/family convey their “global” experience of their presenting physical problem(s)
An ability to help the child/family discuss the history of the presenting physical problem(s), including their onset and subsequent development
An ability to gain a detailed picture of the full range of physical symptoms that the child/young person finds troubling, including:
the precise nature of the symptoms (including their frequency, severity and duration)
any fluctuations/ patterns in the symptoms, and their/their family’s perception of factors that influence this

any changes in general health (e.g. appetite, weight, sleep, energy levels)
any changes or difficulties in cognition (such as memory and concentration)
An ability to gain a detailed picture of the history of medical interventions and the child/young person's perception of their outcome

Assessing help-seeking and contact with, and treatment from, health professionals

An ability to identify physical symptoms for which the child or family is currently (or has previously) sought help
An ability to identify the investigations that have been undertaken and to establish:
the significance of any clinical findings and test results (e.g. whether they are normal or abnormal, or rule in or out specific diagnoses)
whether or not further investigations are planned
An ability to discuss with the child/family their experience of contact with health professionals e.g.:
what they have found helpful and what they have found unhelpful
the ways in which information about their health condition has been conveyed
their understanding of the outcomes from investigations and interventions
An ability to identify the medical regimen being followed (both current and in the past), and its impact on the condition for which it has been prescribed
An ability to help the child/family discuss whether and how they follow the medication regimen, and the factors that influence this (e.g.: positive or negative experience of the regimen, or beliefs about its efficacy)

Assessing the impact of the physical condition on functioning / psychological functioning

An ability to help the child identify the ways in their physical health condition adversely impacts on their day-to-day functioning, for example, its impact on:
peer relationships including:
their capacity to engage in activities with peers
the quality of current and past relationships (friendships and romantic)
membership of groups, clubs
any experience and membership of gangs.
any experiences of bullying
family relationships
their capacity to attend and participate in school, work or study
leisure activities
their capacity for self-care
the goals to which they aspire (their 'life-goals')
An ability to gain an overview of the impact of physical health problems on the child/family's psychological functioning (e.g. their mood, or their level of worry and anxiety)

Developmental history

An ability to obtain information on the child's development, including both strengths and interests as well as any delayed or unexpected developmental processes.

Educational history

An ability to obtain details of the strengths and interests shown by the child/young person within the education system as well as any difficulties
An ability to obtain a comprehensive educational history, including:
pattern of attendance including information on absences from school before and after onset of condition/symptoms
academic ability and achievement
emotional/behavioural, concentration or social difficulties displayed in the class or playground.

Family history, resources and coping strategies

An ability to ask about family relationships, extended family, social networks and social support
An ability to identify areas of resilience within the family, as well as any stresses (both related and unrelated to physical health) that may contribute to the presentation, or to difficulties in family relationships
an ability to ask about potential protective factors in the family's social environment (e.g. social support, proximity to extended family or access to community resources)
an ability to ask about any potential stresses in the family's physical or social environment (e.g. overcrowding, poor housing, neighbourhood harassment)
An ability to ask about both recent and past transitions experienced by the family (e.g. new diagnosis or change to treatments, marriage, divorce, loss of family members, new additions to the family)
An ability to identify the resources that the child and family draw on in order to manage, or cope with, their problems, including:
the child/young person's personal resources and coping strategies
the parent/carer's personal resources and coping strategies
interpersonal and community resources including supports within the healthcare system
the family's usual level of functioning (including their belief system and the ways in which they construe and interpret their world)

Assessing the impact of social and cultural context

An ability to draw on knowledge of the family's cultural, racial and religious background when carrying out an assessment of the family's behaviours, beliefs, and the potential impact of this perspective on their views of problems.
An ability to seek out further information about the family's religious, racial and cultural background from the family and other sources
An ability to discuss with the child/family the ways in which the behaviour and reactions of others influences their symptoms, disability and distress
an ability to gauge the beliefs and attitudes of significant others and the ways in which these beliefs influence and interact with those of the child/family
An ability to help the child/family discuss their feelings and beliefs about the impact of their condition(s) on others, and the way in which this influences their responses (e.g. feeling that they are a burden to others, and so making them reluctant to ask for help).

Psychological / mental health history

An ability to gain an overview of any past history of mental health difficulties for the child/ young person and their parents/family (including any help the chid/family has received to manage these, and their experience of this help)
An ability to identify and (where there are indications of its relevance to the intervention) discuss any significant issues in the child's history (e.g. significant loses or separations, exposure to trauma or abuse)
An ability to assess and to respond to indicators of risk of suicide*
An ability to assess and to respond to indicators of risk of harm to self or others*

* risk assessment competences are detailed separately in the relevant section of this competence framework

Helping the child and family to articulate their aims for the intervention

An ability to help the child and their family to articulate the goals they would like to achieve from an intervention	
	an ability to help the child and family identify goals that are specific, realistic and achievable

Discussing the outcome of the assessment with the child and family

An ability to discuss the assessment with the child and their family in a manner which:	
	demonstrates an understanding of the subjective distress experienced by them and their perspective on the issues
	brings a coherence to their symptoms and disparate experiences (e.g. by linking any account to examples from their own experience and history)
	helps them to reflect on the relevance of, and their reactions to, the account that emerges from the assessment
	engenders hope (through indicating the possibility that the intervention can bring about change)
An ability to assess and respond to the child and their family's attitude about, and motivation, for an intervention	
Where assessment indicates that adjunctive or alternative interventions are appropriate, an ability carefully to discuss the rationale for re-referral in order to ensure that the child and their family do not experience this as a rejection, or as a cause for further hopelessness	

Ability to undertake a single-session screening assessment of service appropriateness

Knowledge of the brief/screening assessment process

An ability to draw on knowledge of the aims of a single-session screening assessment session:
to assess presenting problems and risks of harm
to identify resources (such as support networks and adaptive coping strategies) within the child and family
to identify the specific agency/agencies best placed to meet the needs of the child/young person and their family (e.g. Paediatric psychology or liaison psychiatry, CAMHS, other statutory services or non-statutory organisations or community projects)
to identify whether more comprehensive and/or specialist mental health/CAMHS assessments are required
to identify intervention options (if the presenting problems and context are clear, and an evidence based intervention(s) is indicated)
to identify when psychological or CAMHS interventions are *not* required or appropriate
to identify others relevant sources of support (e.g. members of the medical team, or other support systems within physical health care such as chaplaincy or family support)
An ability to draw on knowledge that the time constraint inherent in a single-session screening assessment will mean:
that the extent of any risk assessment will be limited
that because service-users will have little time to build up engagement they may be less likely to disclose sensitive information
that it will be difficult to see the child/young person independently of carers
that direct observations of service users will be restricted to one setting and time and hence have limited generalisability
that background information is likely to be limited to one agency or individual (e.g. if the referral is from the G.P the assessment will need to proceed without information from the school)
that a diagnostic assessment of conditions such as neurodevelopmental disorders will not be feasible (because this is dependent on taking a very detailed history and conducting structured developmental assessments)

Knowledge of other relevant services and external agencies

An ability to draw on knowledge of different services' inclusion and exclusion criteria
An ability to draw on knowledge of the range of assessments and interventions offered within the team and by other statutory and non-statutory agencies including those based within hospital and physical health settings
an ability to draw on knowledge of community resources and projects relevant to the promotion of psychological wellbeing, mental health and coping with physical health difficulties (e.g. youth clubs, drop-in centres, sports facilities, condition-specific support groups and charities)

Ability to structure the interview

An ability to develop initial hypotheses on the basis of information gleaned from the referral, and an ability to use these to plan the assessment
An ability to inform service-users that the interview is a single-session screening which aims to discuss their needs and concerns, and the ways in which these can be met
An ability to explain issues relating to confidentiality with service users
An ability to make appropriate use of basic interview techniques (e.g. appropriate range of questioning formats, facilitation, empathy, clarification, and summary statements)
An ability to help the child/young person and family identify and discuss:
presenting difficulties
areas of risk which may require further assessment by CAMHS and/or other agencies
the strengths of the child/young person and parents/carers to aid intervention planning
the level of family and social support available to the child/young person and family, both within and outside physical health settings
significant interpersonal problems (e.g. at school, with peers, or with family)
concerns about the child/ young person's development
medical history and current physical health condition including plans (or potential future plans) for further investigations, assessments and procedures
the child/young person and family's previous experience of medical services
the child/young person and family's previous experience of mental health services and other statutory services, and to identify whether this has any implication for their engagement with future support/interventions
An ability to make use of observations of the child/young person and the interactions between family members to inform the assessment
An ability to identify any significant areas which need further assessment in order to reach a decision about intervention
An ability to ensure that at the close of the interview service users are clear about the plan for any future contact with mental health services and/or the referral process to other agencies (including any decisions not to pursue further interventions)

Ability to adapt the assessment to match the abilities and capacities of the family

An ability to tailor the language used to match the abilities and capacities of the child/young person and their carer/family
An ability to engage families with physical and sensory impairment (for example by offering them a choice in assessment venue, co-ordinating appointments with other clinic visits, or altering the pace, length and content of the session)
An ability to make use of interpreters when working with families who do not speak the same language as the interviewer

Ability to adapt the interview in response to emerging information

An ability to adapt assessments in response to the emergence of significant information

An ability to draw on knowledge of child and family development*, child and adolescent mental health*, and child protection* in order to:
focus on topics which appear to be problematic or of particular significance for the child/young person and family (e.g. taking a more detailed developmental history if there are indicators of developmental delays)
move away from areas which do not appear problematic for, or salient to, the child/young person and family

* competences for these areas are detailed in the core competences column of this framework

Ability to identify tentative hypotheses and goals for intervention

An ability to identify the child/young person and the family's goals for change
An ability to develop initial tentative hypotheses (in collaboration with the child/young person and family) which may help to explain the presenting difficulties

Ability to feedback the outcomes of the assessment and agree the next steps with service users

On the basis of the assessment, an ability to identify whether the presenting difficulties map to the inclusion criteria for the relevant services
An ability to give the child/young person and their family clear information about the assessment and intervention options open to them
an ability to discuss assessment and intervention options with the child/young person and their family and to help them identify the options they wish to pursue

Ability to undertake risk assessment and management

Competences associated with the assessment of clinical risk are not 'stand alone' competencies and should be read as part of the Paediatric and CAMHS competency frameworks. Effective delivery of competences associated with the assessment of clinical risk depends on their integration with the knowledge and skills set out in the core competency and generic therapeutic competency columns as well as being dependent on comprehensive assessment skills. Risks related to harm from others are described in the child protection section of the competency framework

Knowledge of policies and legislation

An ability to draw on knowledge of national and local strategies standards, policies and procedures regarding clinical risk assessment and risk management
An ability to draw on knowledge of national and local child protection standards, policies and procedures
An ability to draw on knowledge of the principles of the relevant mental health Acts (e.g. Mental Health and Treatment Act/ Mental Heath Act, Mental Capacity Act)
An ability to draw on knowledge of local policies on confidentiality and information sharing
An ability to draw on knowledge of the statutory responsibilities of adults (e.g. parents, carers, school staff) to keep children and young people safe from harm)

Knowledge of risks

An ability to draw on knowledge of the different forms of clinical risk routinely assessed for in clinical practice, including:		
	risk of harm to self:	
		suicide risk
		self-harm without apparent suicidal intent e.g.: deliberate self-poisoning or self-injury, self-harm related to eating disorders or substance abuse, impulsive behaviour, sexual behaviour that puts the individual at risk,
		self-harm through the manipulation of treatment regimes (e.g. manipulating insulin in diabetes or refusing to follow medical advice)
		risk of self-neglect
	risk of harm to others (e.g. violent, and challenging behaviour)	

Knowledge of the risk assessment and management process

An ability to draw on knowledge that the aim of the risk assessment is to develop a formulation and management plan which improves the quality of life of the child and family, and prevents or minimises the risk of negative events or harm

An ability to draw on knowledge that risk assessment is an ongoing process
An ability to draw on knowledge of the benefit of a structured approach to risk assessment which combines clinical and actuarial information so that systemisation and clinical flexibility are included
an ability to draw on knowledge of screening instruments that can contribute to a risk assessment and the assessment of suicide risk
an ability to draw on knowledge of the benefits, limitations and training requirements of risk assessment tools or measures
An ability to draw on knowledge of the limitations of assessing risk and making predictions in relation to an individual because of the multiple and interrelated factors underlying their behaviour
An ability to draw on knowledge of factors that may elevate risk for self-harm, suicide, self-neglect and harm to others
An ability to draw on knowledge that there are different types of risk factor which can be:
static and unchangeable historical events (e.g. a history of child abuse)
dynamic but chronic, with only slow change over time (e.g. social deprivation)
dynamic and acute, and can change rapidly (e.g. access to lethal weapons, conflict with parents and/or peers, acute onset of psychotic symptoms)
An ability to draw on knowledge that risk assessment tools may be a useful part of risk assessment
An ability to draw on knowledge of the benefits, limitations and training requirements of risk assessment tools or measures
An ability to draw on knowledge that there are different stages and forms of risk assessment which may include:
identification of risks during an initial assessment
an in-depth structured risk assessment which includes a systematic evaluation of known risk factors
a highly specialised structured assessment of risk of violence to others (usually conducted in a forensic service, and which may include the use of specialised risk assessment tools)
An ability to draw on knowledge that the different stages and forms of risk assessment can be carried out by different clinicians and agencies

Skills in Risk Assessment and Management

Assessment of clinical risk

In the context of conducting a comprehensive assessment, an ability to carry out an in-depth structured risk assessment which combines information from clinical interviews, measures, observations and other agencies, comprising:
the development of a good working alliance with the child/young person and family and other significant members of the network.
a systematic assessment of the demographic, psychological, social and historical factors known to be risk factors for self harm, self neglect or harm to others
an ability to identify the child/young person and family's view of their experience, including their view of possible trigger factors to harmful events, and ideas about interventions or changes in their environment that might be helpful in reducing the risk of future harm
an ability to consider how the child/young person's developmental stage may

	affect their perception, understanding and behaviours in relation to risk
	an ability to identify the extent to which the adults involved in the child's care (e.g. parents/ carers, school staff) are able to assess and manage risks)
An ability to integrate risk assessment with knowledge of the individual child and family and their social context, including their strengths and any resilience factors	
An ability to identify risk of self-harm or self-neglect directly related to the physical health condition e.g.	
	despair about the long-term outcome
	distress leading to poor self-management
An ability to conduct a risk assessment to gauge:	
	how likely it is that a harmful/negative event will occur
	the types of harmful/negative events
	how soon a harmful/negative event is expected to occur
	how severe the outcome will be if the harmful/negative event does occur
An ability to assess the carer's capacity to take responsibility for their child or other siblings, and to identify the support they may need to continue in this role	
Where there is evidence of risk to children or vulnerable adults, an ability to liaise with relevant services that can offer appropriate support	

Ability to develop a risk management plan

An ability to develop a risk formulation which estimates the risk of harm by:	
	identifying factors which are likely to increase risk (including predisposing, perpetuating and precipitating factors)
	identifying factors which are likely to decrease risk (i.e. protective factors)
An ability to create a risk management plan, in collaboration with the child and family, which:	
	is closely linked to the risk formulation
	takes into account the views of the child and family
	identifies the actions to be taken by the child and family and relevant services, should there be an acute increase in risk factors and/or the family perceives itself to be in crisis
	explicitly weighs up the potential benefits and harms of choosing one action or intervention over another
	details interventions or supports that reduce or eliminate risk factors for the harmful/negative event(s)
	details interventions or supports that encourage the child/young person's strengths and resilience factors
	manages any tensions arising from restrictions the plan places on the lifestyle of the child/young person or family
An ability to identify when it is appropriate to employ interventions that involve an element of risk (usually because the potential positive benefits outweigh the risk)	
An ability to use the risk formulation to judge whether and when to schedule a reassessment with the child and family	
An ability to communicate the risk management plan to children and families, including information on the potential benefits and risks of a decision, and the reasons for a particular plan	

Equality and Diversity

An ability to consider whether any assumptions or stereotypes about particular demographic groups (rather than knowledge of researched risk factors) lead to underestimation or over-estimation of actual risk

Interagency working

An ability to collaborate with all potentially relevant agencies when undertaking a risk assessment
An ability to ensure that there is timely communication with all agencies involved in the case, both verbally and in writing
An ability to communicate the risk management plan to other agencies including information on the potential benefits and risks of a decision, and the reasons for a particular plan
An ability to maintain a clear and detailed record of assessments and of decisions regarding plans for managing risk, in line with local protocols for recording clinical information
an ability to identify and record the actions individuals within each agency will be undertaking
An ability to escalate concerns (within own or other agencies) when the implementation of the risk management plan is problematic
An ability to refer to, and to work with, more specialised agencies (e.g. inpatient units or forensic teams) in line with local referral protocols

Ability to seek advice and supervision

An ability to recognise the limits of one's own expertise and to seek advice from appropriate individuals e.g.:
supervisors and/or other members of the clinical team
specialist forensic teams (e.g. where there are threat of serious violence)
specialist self-harm teams
Caldicott Guardian (regarding complex confidentiality issues)
social workers (e.g. where there are possible child protection issues)