Ability to assess capacity

This section links closely to the section of this framework focused on "Knowledge of, and ability to work with, issues of confidentiality, consent and capacity"

KNOWLEDGE

Knowledge of policies and legislation

An ability to draw on knowledge of the principles of the relevant legislation relating to age of legal capacity
An ability to draw on knowledge of national and local child protection standards, policies and procedures
An ability to draw on knowledge of parental rights and responsibilities in relation to confidentiality and consent

Knowledge of capacity

An ability to draw on knowledge that capacity should be assessed in relation to major decisions that affect peoples' lives (e.g. appraisal of their health needs)	
An ability to draw on knowledge that capacity is not 'all or nothing' and may vary across specific areas of functioning, (e.g. a child's ability to consent may change as their physical health condition improves and/or deteriorates; a child's ability to consent to physical health interventions may change if they develop a serious mental health condition)	
	an ability to draw on knowledge that incapacity can be temporary, indefinite, permanent or fluctuating, and that it is important to consider the likely duration and nature of the incapacity
An ability to draw on knowledge that age or diagnosis alone cannot be used to make assumptions about capacity	

ASSESSMENT

Ability to assess capacity in children, young people and their carers

An ability to ensure that judgments regarding capacity take into account any factors that make it hard for the child/young person, parent/carer to understand or receive communication, or for them to make themselves understood	
	an ability (where possible) to identify ways to overcome barriers to communication

An ability to use an interpreter where the child's or parent's first language is not that used by the practitioner and their language skills indicate that this is necessary
Where children have a disability, an ability to ensure that information is provided in an accessible form (e.g. using an interpreter for children with hearing-impairments)
an ability to determine capacity where the child/young person, parent/carer has significant cognitive impairments and/or memory problems e.g.:
where a child is able to make a decision but is unable to recall it after an interval, asking for the decision to be made again, using the consistency of their response as a guide to capacity
deciding when further formal assessment is required in order to determine the child's capacity and organising this as required
An ability to invite and to actively respond to questions regarding the proposed intervention
An ability to address any concerns or fears regarding the proposed intervention which may be impacting on consent
An ability to draw on knowledge that a child/young person's capacity to give or withhold consent is not absolute, and varies with the complexity of the intervention and perceptions of risks versus benefits (e.g. a young person may be judged able to consent to a blood test but not a transplant)
An ability to draw on knowledge that even where consent has been granted it is usual to revisit this issue when introducing specific aspects of an assessment or intervention
Where a child/young person cannot consent or is deemed to lack capacity to consent, an ability to gain consent from one carer with parental responsibility on behalf of the child/young person ensuring any actions taken should:
be of benefit to the child/young person
be the least restrictive intervention
take account of the child/young person's wishes and feelings
take account of the views of relevant others
encourage independence

Ability to assess the child/young person's capacity to consent to information sharing

An ability to gauge the child/ young person's capacity to give consent by assessing whether they:
have a reasonable understanding of what information might be shared, the main reason(s) for sharing it and the implications of sharing or not sharing the information
can appreciate and consider the alternative courses of action open to them
express a clear personal view on the matter (as distinct from repeating what someone else thinks they should do)
are reasonably consistent in their view on the matter (i.e. are not changing their mind frequently)

Factitious disorder (imposed on another)

- An ability to draw on knowledge that factitious disorder is characterised by:
  - the falsification of physical or psychological signs or symptoms, induction of injury or disease, in another person, associated with identified deception, where;
    - an individual presents another individual [victim] to others as ill, impaired, or injured
    - the deceptive behaviour is evident even in the absence of obvious external rewards
    - the behaviour is not better explained by another mental disorder, such as delusional disorder or another psychotic disorder

- An ability to draw on knowledge that the factitious illness usually represents a way for the carer to use the child to fulfil their own needs, for example:
  - recognition as heroic / suffering carer
  - need for care from health professionals
  - financial or material gain
  - concerned their child has a problem or disability and seeking a diagnosis
  - deflecting blame/responsibility for not coping with parenting challenges
  - maintaining closeness to the child
- An ability to draw on knowledge that factitious illness can also reflect erroneous beliefs, reflecting:
  - concern/anxiety about the child's health
  - misinterpretation
  - delusional beliefs,

- An ability to draw on knowledge that factitious illness requires health professionals to accept the carer's contentions/beliefs about the child's state of health, usually through:
  - erroneous and insistent verbal reports that may (but also may not) be motivated by an intention to deceive. e.g.:
    - exaggerating or inventing history, symptoms or signs
    - persistent insistence on further investigations/referrals
    - reporting that the relevant phenomena only occur in the carer's presence
  - active falsification of the child's state of health by (for example)
    - falsifying reports
    - falsifying or interfering with investigations
    - failing to give medication/food (and so making the child appear ill
    - inducing illness in the child (e.g. by poisoning / over-medicating (laxatives, salt), suffocating

Impact on the child

- An ability to draw on knowledge that there will be the same harmful effects for the child regardless of parental motivation or action
  - direct harm emanating from the actions of the carer, for example:
    - depriving the child of medications or food in order to make them look ill
    - overlooking genuine illness
    - threats to health and life through illness induction
  - iatrogenic harm (albeit inadvertent) from healthcare workers, through repeated (unnecessary) examinations, investigations, procedures and treatments

An ability to draw on knowledge of the impact on the child's development & daily life
limited and/or interrupted school attendance and education
limited normal activities of daily life
adoption of a sick role
social isolation
An ability to draw on knowledge of the impact on the child's wellbeing, for example:
insecure attachment
anxiety or confusion regarding their state of health
the development of a false view of self as being sick and vulnerable

An ability to draw on knowledge of the possible adoption of carer's views as the child reaches adolescence, leading to :
active collusion in 'illness' deception
the development of 'Medically Unexplained Symptoms (MUS) or somatisation

Assessment of factitious illness

An ability to draw on knowledge of alerting signs for factitious illness, such as:
perplexing presentations
discrepancies ('something does not add up)
reported symptoms & signs that are not observed independently of their reported context
reported (or observed) symptoms and signs not explained by child's medical condition
physical examination and results of investigations do not explain reported symptoms or signs
inexplicably poor response to medication or procedures
repeated reporting of new symptoms
repeated presentation to different doctors and failing to attend appointments
a 'quest' for a diagnosis (e.g. carers insistent on more, clinically unwarranted, investigations, referrals, continuation of, or new treatment)
impairment of child's daily life beyond any known disorder

Managing perplexing presentations

If alerting signs are present along with evidence of deception/ illness induction/ falsification of documents and results, then an ability to refer to child protection services
If alerting signs are present but with no evidence of deception then an ability to investigate further by:
consulting relevant medical staff a colleague – named doctor and collating information about all medical/health involvement and diagnoses
verifying the child's current state of physical and mental health, including their physical, educational and social functioning
obtaining the carers' explanations, fears and hopes of and for the child's difficulties
obtaining the child's views regarding their symptoms, illness beliefs, anxieties, and mood
obtaining information about family life and functioning

An ability to work with carers to help to develop an alternative model of healthcare issues, for example, by
indicating that diagnosis may have no implications for functioning
genuine symptoms may have no diagnosis, and ensuring that there is no dispute about the veracity of reported symptoms (e.g. pain)
avoiding the use of diagnostic labels (such as. Chronic Pain Syndrome)
conveying a message that reported symptoms and signs are not life threatening, that further investigations and repeated presentations to doctors may be more harmful than helpful and that the child will not come to harm as a result

An ability to offer a 'rehabilitation' programme that includes:
rationalising and coordinating medical care
reducing or stopping medication for which there is no indication
active multidisciplinary/multiagency rehabilitation which may require may require support from social care
re-establishing full school attendance
graded physical mobilisation

An ability to work with the carers and family, including:
exploring the carers' motivations, anxieties beliefs, needs
exploring the implications/likely changes for carers if their child was functioning optimally
helping carers to 'fill the gap' created in their life by having a well (or better) child
helping the child and family to construct a narrative explanation for improvement in the child
helping the child to adjust to a better state of health by using coping strategies for symptoms, and/or support for loss of gains of being a sick child

Managing challenges to intervention

An ability to identify when carers contest the development of an alternative view of the child's presentation, for example:
disputing the veracity of independent/clinical observations and seek further investigations
declining and/or failing to enact rehabilitation plans
An ability to refer to social services and to discuss the rationale for this with carers (because their behaviour constitutes evidence that they are avoidably impairing the child's functioning)

Ability to conduct a Mental State Examination

Competences for the Mental State Examination are not a 'stand alone' description of competencies, and should be read as part of the CAMHS competency framework.

Effective application of mental state examination competencies depends critically on their integration with the knowledge and skills set out in the core competency column (in particular knowledge of mental health problems, and child and adolescent development), the generic therapeutic competency column as well as comprehensive assessment activities set out in the assessment column

Knowledge of the aims of the Mental State Examination (MSE)

An ability to draw on knowledge that the MSE is an ordered summary of the clinician's observations of the child/young person's mental experiences and behaviour at the time of interview
An ability to draw on knowledge that the purpose of a MSE is to identify evidence for and against a diagnosis of mental illness, and (if present) to record the current type and severity of symptoms
An ability to draw on knowledge that the MSE should be recorded and presented in a standardised format, usually under the headings of: • Appearance and behaviour • Speech • Mood • Thought • Perception • Cognition (orientation, memory and intelligence) • Insight

General skills in undertaking an individual interview with a child

An ability to draw on knowledge of the child/young person's developmental stage and hence to tailor questions to their likely level of understanding
An ability to draw on knowledge that children/young people vary in their ability to introspect and assess their thoughts, perceptions and feelings
An ability to use play materials, art materials or other tools such as diagrams to help with expression and recall (in line with the child's age and ability)
An ability to structure the interview by asking general questions about potential problem areas (such as depressed mood), before asking specific follow-up questions which enquire about potential symptoms
An ability to respond in an empathic manner when asking about the child/young person's internal experiences (i.e. their feelings, thoughts, and perceptions)
An ability to ask questions about symptoms which the child/young person may feel uncomfortable about in a frank, straightforward and unembarrassed manner
An ability to record the child/young person's description of significant symptoms in their words
An ability to avoid colluding with any delusional beliefs by making it clear to the child/young person that the clinician regards the beliefs as a symptom of mental illness
an ability to avoid being drawn into arguments about the truth of a delusion

Appearance and behaviour

An ability to draw on detailed observations of the child/young person to inform judgements of their mental state, including observations of:
their appearance (e.g. standard and style of clothing, physical condition)
their behaviour (e.g. tearfulness, restlessness, distractibility, whether behaviour is socially appropriate)

Speech

An ability to observe and describe the child/young person's form of speech (e.g. quality, rate, volume, rhythm, and use of language, etc.)

Mood and thoughts

An ability to ask about the symptoms characteristic of both uni-polar and bi-polar depression
an ability to notice and enquire about any discrepancy between the child/young person's report of mood and objective signs of mood disturbance (affect)
An ability to ask about thoughts of self-harm
an ability to assess suicidal ideation
an ability to assess suicidal intent
an ability to ask about self-injurious behaviour
An ability to ask about symptoms characteristic of the different anxiety disorders
an ability to ask about the nature, severity and precipitants of any symptoms as well as their impact on the child/young person's functioning

Perception

An ability to ask about abnormal perceptions
an ability to clarify whether any abnormal perceptions are altered perceptions or false perceptions
an ability to explore evidence for the different forms of hallucination
An ability to elicit abnormal beliefs
An ability to interpret the nature of abnormal beliefs in the context of the child/young person's developmental stage, family, social and cultural context
an ability to distinguish between primary delusions, secondary delusions, over-valued ideas and culturally sanctioned beliefs

Cognition

An ability to assess cognitive functioning
an ability to assess level of consciousness
an ability to assess the child/young person's orientation to time, place and person
an ability to carry out basic memory tests
an ability to estimate the child/young person's intellectual level, based on their level of vocabulary and comprehension in the interview, and their educational achievements
an ability to conduct or refer for formal cognitive assessment if there are indications of a learning disability

Insight

An ability to assess the child/young person's insight into their difficulties
an ability to assess attitude towards any illness
an ability to assess attitude towards treatment

Ability to undertake Structured Behavioural Observations

Knowledge

An ability to draw on knowledge of the primary processes involved in shaping behaviour and learning including:
learning theory principles (e.g. reinforcement (positive and negative), contingency, stimulus control, punishment)
social learning theory principles (e.g. imitation/modelling, environmental influence, vicarious learning, predictive function and self efficacy)

Planning the observation

An ability to identify when behavioural observations can make a contribution to the process of assessment and formulation (usually when behavioural issues are relevant to, or are the focus of, the intervention)
An ability to identify a specific focus for observation (for example a particular behaviour interaction or event)
An ability to draw on knowledge of the main strategies used in behavioural observations in order to select the most appropriate method
An ability to draw on information from the assessment to establish when, where and for how long observations should take place (e.g. drawing on information about the settings or circumstances are most likely to elicit particular behaviours or the frequency of a specific behaviour)
An ability to reflect on one's own perceptual or attitudinal biases and maintain an objective, open minded stance
An ability to draw on knowledge of the ways in which subjective judgments can introduce bias (e.g. where the meaning of a behaviour is ambiguous, or where previous observations of the child in other contexts influence the observer's judgments)
An ability to obtain consent from the child and/or their carer(s) to carry out the observation
An ability to gain consent from individuals or services who may provide the location for the observation
Where several people need to be involved (e.g. nurses in a ward setting), an ability to co-ordinate the scheduling of observation and recording, and to ensure that everyone is clear both about what behaviours are being recorded, and how these recordings are made

Gathering data

An ability to draw on knowledge of the main strategies used for naturalistic behavioural observation (including their strengths and weaknesses)
An ability to engage family members, ward based staff, teachers and other observers in the process of collecting and maintaining diary records
An ability to explain the rationale for, and procedures used in, behavioural observation (i.e. the need to gather accurate information about a behaviour in order to plan the intervention)
An ability to make use of diary records (a chronological record of behaviour made after the behaviour occurs, or a way of tracking the child's development over time)
An ability to draw on knowledge of the potential limitations of diary records (e.g.

consistency and accuracy of recording, observer bias, the risk that unstructured recording will result in extraneous detail)
An ability to make use of a “running record” (a sequential record maintained over a given time, made while the behaviour is occurring and which identifies the circumstances surrounding particular events or activities)
An ability to draw on knowledge of the potential limitations of this strategy (e.g. time, quantity of unstructured and undifferentiated data produced and failure to capture relevant detail)
An ability to make use of time sampling (recording the frequency with which behaviours occur within a given period of time)
An ability to make use of event sampling (recording the frequency of behaviours that occur when a particular event or activity takes place)
an ability to draw on knowledge of the potential limitations of this strategy (e.g. the application to covert behaviours, their inefficacy for behaviours that only occur infrequently)
Across all approaches to observation, an ability accurately to record:
the frequency of target behaviours
the content of target behaviours
environmental factors that may be temporally related to target behaviours

Ability to monitor the child’s environment using an “ABC” chart*:*

An ability to draw on knowledge of the use an ‘ABC’ chart to monitor the child’s environment and to identify:
Antecedents: setting conditions and specific triggers for the challenging behaviour
Behaviour: a record of target behaviour and any variations in severity and frequency in different settings and contexts
Consequences: what happens after the challenging behaviour, identifying, possible reinforcers (both positive and negative)
An ability to draw up an ABC chart which includes:
a clear operational definition of the behaviours to be observed
any guidance which may be required in order to obtain reliable recordings (e.g. criteria for defining when one incident ends and another begins)
An ability to select the contexts and situations to be monitored, guided by knowledge of the contexts and individuals associated with a greater likelihood of challenging behaviour
An ability to engage other individuals in completing the chart, where required, offering appropriate training and checking inter-rater reliability

Ability to minimise ‘reactance’

An ability to reduce the risk that the process of observation produces significant changes to behaviour:
where the observer is in close proximity to the subject, an ability to maintain an unobtrusive stance and minimise interaction with them
an ability for the observer to locate themselves in a position that minimises their visibility and their impact on the behaviour being observed (e.g. by sitting at a nurses station or at the back of a classroom)
an ability to discretely redirect children if approached (e.g. to a nurse or the teacher)

Ability to maintain an accurate record

An ability to include a concise summary of the subject, context and purpose of the observation:
an ability to record the scene at the commencement of recording
an ability to record information in the order it occurred
an ability to structure the recording by time (for example break the description into 30 second segments by recording the passing of each 30 seconds in the margin)
An ability to record observations accurately, including:
the exact words spoken, where possible
descriptions of specific behaviours
non-verbal as well as verbal communication
emotional content of behaviour/communication
An ability to identify clearly any inferences or judgements within the description by (for example) using brackets in a transcript

Ability to draw inferences from the observation

An ability to ensure that conclusions about behaviour are based on adequate evidence
An ability to recognise where inferences about the causes of, or relationship between behaviours, are being made and to record this accordingly
An ability to draw on knowledge of cultural differences in the meaning of behaviour and communication when attempting to understand the function of those behaviours
An ability to draw on knowledge of developmental and learning theories to help understand:
how the activities of individuals who are interacting with the target child impact on that child's behaviour
how the activities of the target child impact on their environment
how environmental factors might impact on the child (e.g. the impact of a noisy ward on a child who is fatigued, or who has neurodevelopmental vulnerabilities)
An ability to include an account of the child's perspective when interpreting their behaviours or circumstances (e.g. their capacity to understand the impact of their behaviour, or the impact of being in an unfamiliar environment (such as a hospital ward with reduced scope for activity and distractions)

Ability to assess and manage risk

An ability to assess any risk posed to the child or others during the observation and formulate a plan of action with the aim of maintain the child's safety (e.g. if required, intervening and removing an individual or individuals, recruiting assistance from others present)

Ability to undertake structured cognitive, functional, and neurodevelopmental assessments

The ability to undertake structured cognitive, functional, and developmental assessments focuses on standardised assessment of cognition, language and behaviour. It does not focus on other components/types of developmental assessment, for example, taking a developmental history, obtaining information from other agencies, or conducting observations, which are described under the comprehensive assessment section.

An ability to draw on knowledge of a range of neurodevelopmental disorders and the ways in which these present across the developmental range, including features in the domains of:
cognition
behaviour, and behavioural "phenotypes" associated with neurodevelopmental presentations
emotion
social functioning
An ability to draw on knowledge of current literature relevant to cognitive assessment and underlying cognitive models, and its relevance for assessment approaches and interpretation

Pre-assessment (post referral)

If required, an ability to contact referrers in order to clarify the aims and expected outcome of the assessment process
An ability to gather data from all relevant sources, including medical records and investigations, parents, school social services, GP, in order to:
contribute information to the overall assessment
guide the selection of assessment procedures which are most appropriate/ relevant
identify any confounding factors which may impact on the administration of testing (such as anxiety, and physical or sensory impairments)
An ability to identify any inconsistencies across respondents and consider their likely relevance to the assessment process
An ability to locate and interpret previously-conducted structured and/or medical assessments in order to inform the current assessment process, specifically to:
inform the selection of testing and assessment procedures used
provide a baseline measure/measure of comparison
compile a developmental profile of strengths and weaknesses

Ability to develop an assessment plan relevant to the referral issues

An ability to generate multiple hypotheses that might account for the impairment (or presenting concerns) based on information gleaned pre-assessment
to draw on knowledge of the background information and psychometric principles to select an appropriate assessment approach
an ability to develop hypotheses dynamically, where necessary, based on emerging findings and observations

An ability to draw on knowledge of assessment procedures to select those relevant to the assessment question
An ability to draw on knowledge of the populations on which tests have been standardised, and any implications this will have for the validity of assessing individual children or young people in relation to their:
age
gender
socio-economic status
country of origin
ethnicity
level of functioning

Test administration

An ability for the clinician to administer only those assessment procedures for which they are appropriately qualified and skilled
An ability to recognise that all aspects of the initial encounter may provide important data for the assessment (including, for example, the initial meeting in the waiting room, or the ways in which those present interact with each other)
An ability to provide a testing environment which promotes optimal performance from the child/young person (e.g. using age appropriate language and being friendly rather than distant/clinical, or minimising potential distractions in the room)
Where appropriate, an ability to encourage parents to allow the child/young person to come into the testing environment by themselves (to reduce the chances that they will be distracted), and to recognise where this separation impacts on test performance
where parents remain in the testing situation, an ability to help parents understand the assessment approach and the importance of allowing the child to complete the testing independently
An ability to monitor the child or young person's behaviour and interactions throughout the assessment, including:
their level of motivation/engagement with the assessment process
their activity levels
their level of concentration or distractibility
their social/communication skills
their specific areas of difficulty/competence and their strategic approach to tasks
their reaction to failure/success
their persistence
any reassurance seeking
their receptivity to encouragement/reinforcement
An ability to document these observations systematically and to identify whether they are consistent with reports from other sources
An ability to draw on knowledge of child development to gauge when behaviour is within "normal" limits (e.g. knowing how the ability to concentrate varies with age)
An ability to draw on knowledge of common reactions to assessment (such as anxiety) and to take into account their impact on the child's functioning (so as to minimise the impact of these factors on the validity of assessment)

An ability to engage the child/young person throughout the testing process, alternating periods of rest, “fun activity” and testing to maintain motivation and concentration
An ability to draw on knowledge of the ways in which specific (neuro)developmental disorders may influence the assessment process (e.g. the structured non-distracting testing environment may improve the functioning of children with Autistic Spectrum Disorder)
An ability to adhere to standardised testing structure and protocol, as described in the relevant manual:
implementing any variations in “rules” in line with the procedures specified in the manual (e.g., the criteria for discontinuing a test, or for prompting the child)
applying the criteria for scoring to the responses made by the child in order that results remain relevant to norms and standardisation
recording responses accurately
following scoring procedures
An ability to establish whether additional non clinic-based assessment is required (e.g. behavioural observation in the school or home)
An ability to draw on knowledge of test reliability to ensure that test interpretation is not confounded with practice or interference effects (i.e. because administration of the same or similar tests in close proximity may invalidate any results)
An ability to identify where a child being assessed differs from the research population on which standardisation is based, and to interpret and report their results in the context of this limitation
Where it is not possible to follow the standardised testing procedure (e.g. because the child is uncooperative, or has profound/specific difficulties), an ability to adapt testing (and to record the adaptations that have been made):
an ability to recognise that while adapting tests has practical value (in terms of identifying the child’s strengths and weaknesses) the resulting scores may not be psychometrically sound
An ability to select and/or adapt tests in order to match them to the needs of children with sensory difficulties or physical limitations

Ability to interpret test results

An ability to hold in mind that before assuming that deficits are attributable to cognitive factors (e.g. general intellectual functioning, attention, memory and executive functioning), account should be taken of developmental or acquired difficulties in visual perception, sensory integration, motor skills and communication
An ability to integrate data from testing with behavioural observations and information from other assessment sources to produce a coherent account of the child’s functioning
An ability to interpret results in terms of:
the child’s level of functioning (across the domains assessed)
their relationship to functioning in the standardised sample for the test
the pattern or profile of results, across the domains tested
the significance of individual test results in the context of their overall functioning

An ability to apply the findings to:	
	describe/explain the child's functioning
	describe/explain the ways in which their current environment may be impacting on the child/young person's functioning
	describe how the interaction of the two may result in particular behaviours, strategies or patterns of impairment (e.g. apparent underperformance)

Ability to use the assessment to identify an intervention plan

An ability to adopt a strength based approach to the development of intervention strategies	
An ability to use findings from assessment to suggest strategies which:	
	are aimed at enhancing the child/young person's skill and abilities
	alter the child's environment, with the aim of enhancing/maximising their functioning
An ability to communicate intervention strategies to those delivering them, using language and concepts which are clear and adapted to the context	
An ability to support individuals who are carrying out interventions based on the assessment outcome, ensuring that they understand and can carry-through the intervention plan	

Ability to report on the assessment

Ability to report the results of the assessment in writing using clear, concise and appropriate language, including:	
	the reasons for assessment
	sources of information utilised
	materials used (including what each test measures)
	testing procedure (including relevant behavioural information)
	any adaptations
An ability to communicate findings verbally to parents/carers, and where appropriate children/young people, including discussion of:	
	their experience of the testing process
	the meaning of the findings for the child and for the family
	any areas that the child and family need clarifying
	their expectations for the distribution and use of the report

Ability to undertake assessments (of suitability) prior to complex medical interventions

This section focuses on assessment of readiness for medical procedures that have the potential to result in life-changing short or long-term consequences, and/or where the child will require significant support in the post-operative period

Knowledge

An ability to draw on knowledge that a psychological assessment prior to a complex procedure aims to identify psychological issues that may challenge the child and their family's readiness for a complex medical procedure, and the support they may need to manage this
An ability to draw on knowledge that premorbid functioning is predictive of postoperative coping
An ability to draw on knowledge that informed decision-making prior to surgery will impact on post-operative functioning
An ability to draw on knowledge that focussing on the best interest of the child should be at the heart of the decision-making process

Engagement

An ability to actively include the child/young person as well as their carers/parents, in the assessment and consequent to this in a collaborative decision-making process (so ensuring that all views are considered)
An ability to ensure that the child and family are aware that the assessor is not the 'gatekeeper' to the procedure but is working as part of a wider decision-making team (so as to guard against the family withholding relevant information)
An ability to ensure that the child and their family have a clear, realistic sense and understanding of the treatment options open to them and the possible sequelae of these interventions

Assessment

An ability to ensure that the child or young person is encouraged (in ways appropriate to their developmental capacity) to share their views and that these views are taken into consideration in any decisions about treatment	
Ability to gauge the child and their family's understanding of the medical options open to them, and the postoperative implications of any procedure	
Ability to assess whether the child and their family's expectations of outcomes are realistic and congruent with medical expectations	
	where the expectations of child and/or family are unrealistically high, an ability to identify the reasons for this (e.g. lack of understanding of information that has been supplied, or difficult accepting the likely limitations of the procedure)
An ability to gauge the child and family's capacity to cope with the psychological consequences of the procedure	
	an ability to gauge whether psychological factors will impact on the family's capacity to cope with practical issues (e.g. expressions of revulsion at the idea of helping to change dressings, or of dealing with a stoma)

An ability to assess psychological difficulties or issues that would contra-indicate a complex intervention (e.g. severe depression, substance misuse, eating disorders, psychotic disorders involving somatic delusions, evidence of coercion to undergo procedures)
An ability to undertake a multimodal assessment of the child and family's strengths and weaknesses in relation to the likely demands they will face postoperatively (including practical resources (e.g. whether their house is suitable for a child in a wheelchair))
An ability to assess the ways in which the child and family have managed the illness to date and to identify any implications for post-procedural functioning (e.g. where a young person has struggled with adherence in the past and is may find it difficult to cope with the demands of the treatment regimen)
An ability to identify how the child/young person's developmental stage will influence their capacity to manage the demands of the procedure and their likely post-operative role (e.g. their capacity for self-management)
An ability to identify the likely impact of the procedure on family dynamics (e.g. the impact on siblings or on the parental relationship)
While holding in mind medical need, an ability to identify whether it is the family's best interest to delay an intervention (e.g. so as to allow them time to make the changes that will be required to cope)
An ability to assess the family's ability to work collaboratively with the medical team (e.g. whether they are engaged with and trusting the team), and to identify any factors that may be undermining this relationship

INTERVENTION

Working with the clinical team

An ability to communicate a summary and conclusions from the assessment to the healthcare team and to work with them to achieve a professional consensus about both suitability for treatment and any barriers to treatment
An ability to work as a team to identify, plan and implement appropriate intervention strategies that may overcome obstacles and support the child and family's readiness for treatment

Working with the family

An ability to ensure that the team's decision about treatment options are presented to both the child/young person and family in a balanced and clear manner		
	an ability openly to discuss any differences of opinion between the medical team and the child, young person or family	
		an ability to identify where differences of opinion have implications for safeguarding or child protection issues
An ability to communicate a clear plan of the monitoring and support that will be put in place post-operatively to maximise a successful outcome		
Where there is a decision to delay treatment, an ability to communicate a clear plan of action		
	an ability to acknowledge and discuss any feelings of disappointment and/or concerned about any delay	