A competence framework for multidisciplinary psychological approaches and interventions in paediatric settings

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

www.ucl.ac.uk/CORE/

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Expert Reference Group (ERG)
The work was overseen by an Expert Reference Group* whose invaluable advice, editorial comments and collegial approach contributed enormously to the development of the work.

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Peer Reviewers

We are very grateful to the following reviewers for their comments:

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Contents

A competence framework for psychological interventions in paediatric settings

Executive summary

The report describes a method for identifying competences for all staff working with children and young people[2] in physical health (paediatric) settings. The aim is to ensure that services are delivered in a psychologically informed way that integrates physical health with psychological wellbeing and mental health.

It organises the competences into seven domains.

The first two cover competences that should be demonstrated by all healthcare staff working in paediatric settings:

Core competences for work with children and young people

Core competences for work with children and young people with physical health problems

The next domain - Generic therapeutic competences – identifies the knowledge and skills needed for managing clinical sessions and any form of psychological intervention

The fourth domain identifies competences relevant to assessment, formulation engagement and planning; a subsection of this domain details skills relevant to coordination within and across teams.

The next domain identifies specialist assessments that are pertinent to working in a paediatric context.

The penultimate domain identifies a number of competences that should be demonstrated by all paediatric healthcare staff working with children and young people with specific problems and conditions within paediatric healthcare, subdivided into

a) interventions for common challenges in a paediatric context
b) interventions for specific challenges in a paediatric context and
c) a small set of specific interventions for 'exemplar' presentations.

[2] Throughout the document we refer to 'children', 'young people', 'families', 'parents' and 'carers'. 'Child" refers to the period from birth to adolescence, "young person" refers specifically to adolescence. The terms 'parent' or 'carer' are sometimes used interchangeably for stylistic reasons, but refer to individuals who have a caring and/or parental role in relation to the child or young person.

Also included are a number of competences relating to specific therapies that should be demonstrated by psychotherapeutic staff delivering psychological interventions.

The final domain identifies meta-competences – overarching, higher-order competences which paediatric healthcare and psychosocial staff need to use to guide psychologically informed practice and the implementation of any assessment or intervention.

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

How to use this document

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

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

Scope of the competence framework

The framework is intended to apply to all professions working with children and adolescents in a paediatric context: it defines clinical knowledge and skills relevant to the wide range of professions who may need to apply psychological skills when working with children with physical health conditions in both specialist and community based settings across primary, secondary and tertiary care. As such it is relevant to a range of professions including, but not limited to, nurses and nurse therapists, doctors, physiotherapists, dieticians, clinical psychologists, psychiatrists[3], social workers, child psychotherapists, family therapists, play specialists, occupational therapists, speech and language therapists and those offering religious and spiritual care for patients.

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

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

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

Supporting children and young people who have coexisting mental and physical health conditions

Children and young people with physical health conditions (and particularly those with neurological conditions) may have elevated rates of common childhood mental health conditions. These young people should receive standard mental health assessments, where required leading to an evidence-based intervention; these interventions are detailed in the competence framework for psychological interventions in a CAMHS context (www.core.ac.uk/competenceframeworks).

There is a risk that in a paediatric context mental health problems are seen as the province of CAMHS services, and an equal risk that CAMHS services will be deterred from intervening where there is an evident physical health problem. This can result in the child or young person falling through an organisational net.

There is good reason to assume that the current evidence-base for the treatment of common mental health conditions applies equally to children with physical health conditions (though there may need to be some adaptation to take into account specific aspects of their health condition). As such it would be good practice to offer these interventions to children and young people with a physical health problem seen in any clinical context.

The development of the competence framework

Prior to developing the paediatric framework, the UCL team had completed frameworks for working with children and adolescents in the context of CAMHS, and a framework for working with adults with persistent physical health conditions (both of which can be accessed at www.ucl.ac.uk/CORE/). Clearly the content of both frameworks is relevant to the skills and knowledge required to work in paediatric settings, and while some areas of the paediatric framework were developed *de novo*, others are a melding of the two frameworks, edited to ensure that the content is pertinent and comprehensive.

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

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

Adopting an evidence-based approach to framework development[4]: A guiding principle for the development of previous frameworks (Roth and Pilling 2008) has been a commitment to staying close to the evidence-base for the efficacy of therapies, focussing on those competences for which there is either good research evidence or strong expert professional consensus about their probable efficacy.

While we have applied this principle to this framework, it is important to note several important issues in relation to the evidence-base for work with children and adolescents with physical health conditions (all of which need to be taken into account):

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

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

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

c) Organisation of the evidence base in relation to diagnosis: As is the case across the field of psychotherapy research, the evidence-base for work with children and adolescents in a paediatric context tends to be organised in relation to diagnosis. However, it is well-recognised that most presentations in paediatric context are comorbid, reflect multiple problems or relate to a particular task (rather than a physical or mental health diagnosis), such as promoting adjustment or concordance/adherence with a treatment regimen. This presents a dilemma: organising the framework in relation to diagnosis is one way of keeping it close to the evidence, but this risks making it appear less relevant to clinicians (in the sense that it may be less obvious how to apply it to individual children and families). There is no simple solution to this dilemma, but the clustering of problems and presentations within the framework encompasses both diagnostic categories as well as common clinical challenges in paediatric contexts.

d) Importance of, and evidence for, core, generic therapeutic and assessment skills: There is a clear professional consensus that psychological interventions rest on a set of 'underpinning' skills (core and generic therapeutic competences), as well as a set of assessment skills. Denoting the former as 'underpinning' skills should not be taken to indicate that they are simple or easy to deploy. For example, knowing how to adapt communication to the child's developmental age/stage is far from straightforward, and the process of engaging children and their families can be challenging. Further underpinning competences (such as ability to work with issues of confidentiality, consent and capacity) are a major component of many intervention packages). However, there is often little *direct* evidence of the benefit of these skills from randomised control trials or from other types of study, possibly reflecting researchers' understandable reluctance systematically to manipulate clinician behaviour in this area, and also because

researchers may assume that the inclusion of these elements in an intervention does not need to be explored further. However, although evidence on the causal contribution of underpinning and assessment skills is lacking, correlational studies have established the importance of several of the areas included in the framework (notably the importance of the therapeutic relationship to outcome (e.g. Horvath, Del Re, Flückiger & Symonds,2011; Shirk, Carver & Brown, 2011). Within the assessment field, evidence of the accuracy of the diagnostic process has been gathered through measuring the reliability and validity of standardised tests, scales and interview schedules (both of which are usually accompanied by detailed guidance for their delivery, equivalent to a therapy manual). Nonetheless, in the main the inclusion of specific "underpinning" skills usually rests on expert professional opinion and consensus rather than evidence.

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

These issues all have bearing on the capacity of the framework to stay as close to the evidence base as possible, and in practice research has had to be supplemented by expert professional consensus and practice standards (e.g. Mercer et al, 2015; NICE, 2016), congruent with models of evidence-based practice (e.g. Roth, Parry and Fonagy, 2005; Fonagy 2015), and with the methodology adopted by NICE for clinical guideline development (NICE (2009).

4. Inclusion and exclusion of specific interventions

An initial task for the ERG was to identify those interventions with evidence of efficacy, based on outcomes obtained in clinical controlled trials. This scoping exercise was based on extant clinical guidelines and reviews of the available evidence, in particular:

- Relevant NICE and SIGN clinical guidelines
- "The Matrix" (a guide to delivery of evidence-based therapies commissioned by NHS Education for Scotland and the Scottish Government (NHS Education for Scotland, 2008: www.nes.scot.nhs.uk/media/606133/thematrix-final.pdf)
- 'Bespoke' reviews of the evidence-base in relation to specific conditions and presentations

This exercise identified those interventions for which there was good evidence of efficacy, and which therefore needed to be included. However, it also identified interventions for which evidence was less compelling (for example because of a lack of

controlled studies, a lack of replication or methodological problems that restrict interpretation of outcomes).

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

To some extent this dilemma was addressed in the framework by identifying a set of interventions that reflect challenges in paediatric context, both common and specific. Examples of the former include the ability to promote adherence to a treatment regimen, or the ability to prepare a young person for transition to adult services. Examples of the latter include working with visible difference and body image issues, working with pain or working with paediatric medical traumatic stress. These are not, therefore condition-specific interventions, but areas of focus that the ERG identified as important and often integral to work in this field. It has to be admitted that in nearly all of these areas, research evidence for the efficacy of specific techniques is not strong; the validity of the competences described in these sections is dependent on professional consensus and the process of professional review undertaken by the ERG and external reviewers.

5. Extracting competence descriptions

a) "Underpinning" competences (core competences and generic therapeutic skills) and assessment skills

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

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

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

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

b) Specific interventions for exemplar conditions

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

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

The competence model for psychological interventions in paediatric settings

Organising the competence lists

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

Figure 1 shows the way in which competences have been organised into six domains. The model is intended to:

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

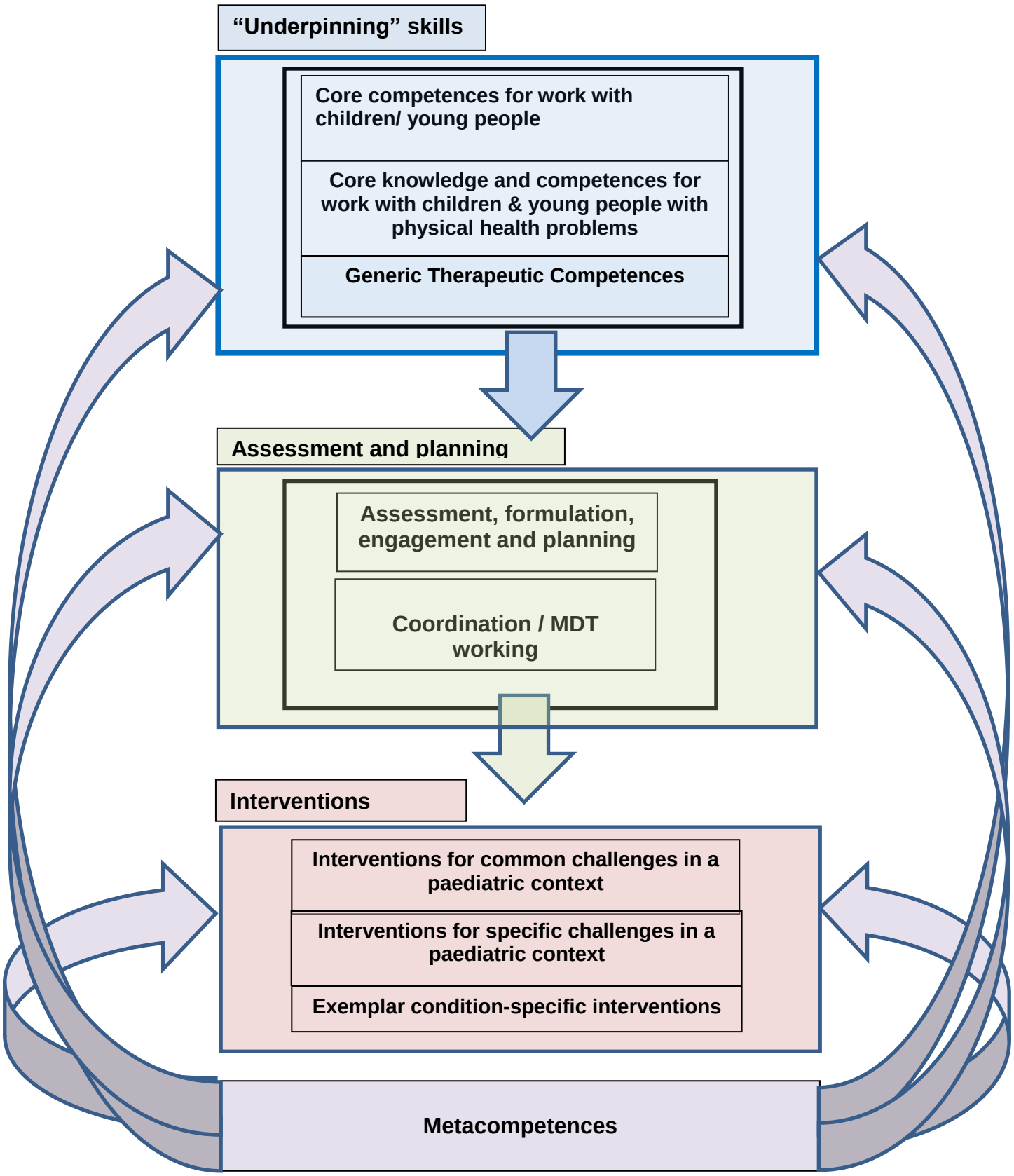


Figure 1 – Outline model for the framework

For all these reasons, the whole framework rests on the domains of 'underpinning' competences. The first is 'Core Competences For Work With Children And Young People', which identifies the knowledge and skills needed by all paediatric staff to

a) orient them to the styles of work which characterise contacts with children, young people and their families
b) liaise with colleagues and other agencies, and
c) apply the professional and legal frameworks which exercise governance over procedures with children and young people.

The second domain identifies 'core knowledge and competences for working with children and young people with physical health problems' needed by all paediatric healthcare staff and includes:

a) knowledge of presenting conditions, and the impact of physical conditions at different developmental stages,
b) Knowledge of models of 'medically unexplained symptoms', 'adjustment', 'behaviour change' and
c) knowledge of the ways in which self-management materials can be developed and employed.

The third domain ('Generic Therapeutic Competences') identifies the competences required to manage clinical sessions and any form of psychological intervention.

Taken together, the skills in the initial three domains should be demonstrated by all workers in paediatric healthcare who are delivering psychologically informed assessment and interventions; their description as "underpinning" skills draws attention to the fact that they secure the integrity of *all* subsequent assessments and interventions.

The fourth domain relates to assessment, formulation, engagement and planning. It identifies the "Assessment and Formulation" skills expected of all caseholders who are delivering psychological therapies. Some of these competences are also relevant to all paediatric healthcare worker because they will aid psychological understanding of the problems presented by children and families in a paediatric context. A sub-domain of this section focuses on skills needed to co-ordinate care within and across teams and is relevant to all paediatric healthcare staff.

The fifth domain identifies a set of 'specialist assessments' conducted by specific staff with relevant roles and prior training; as such there is no expectation that all members of a team will be able to carry them out – each will require some specialist background knowledge and expertise.

The next domain (psychological interventions) contains three sub-domains all of which have relevance across multidisciplinary paediatric healthcare staff but to differing degrees dependent on role. While the knowledge and assessment sections of these sub-domains will be applicable to most paediatric healthcare staff the more specific intervention skills

will only be applicable to those trained to deliver the specific psychological therapy that the competency describes.

The first considers interventions for common challenges that arise in a paediatric context, and will therefore be relevant in almost all physical health conditions. The second focuses on specific challenges that will arise in some, but not all conditions. A final sub-domain considers 'exemplar condition-specific interventions; here there is usually some research evidence of efficacy that points to the benefit of the 'package' of skills being described.

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

Specifying the competences needed to deliver assessments and interventions

Integrating knowledge, skills and attitudes

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

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

The map of competences

Using the map

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

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

Some sections of the map are shaded in order to show which sections apply to all paediatric healthcare workers, and which to workers with specific training, as follows:

Green shading:	Competences in these areas should be demonstrated by all members of a paediatric healthcare team
No shading:	Competences in these areas should be demonstrated by those clinicians who have had the appropriate training and supervision to carry out the assessments and interventions that are listed in these sections.

Layout of the competence lists

Specific competences are set out in boxes.

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

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

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

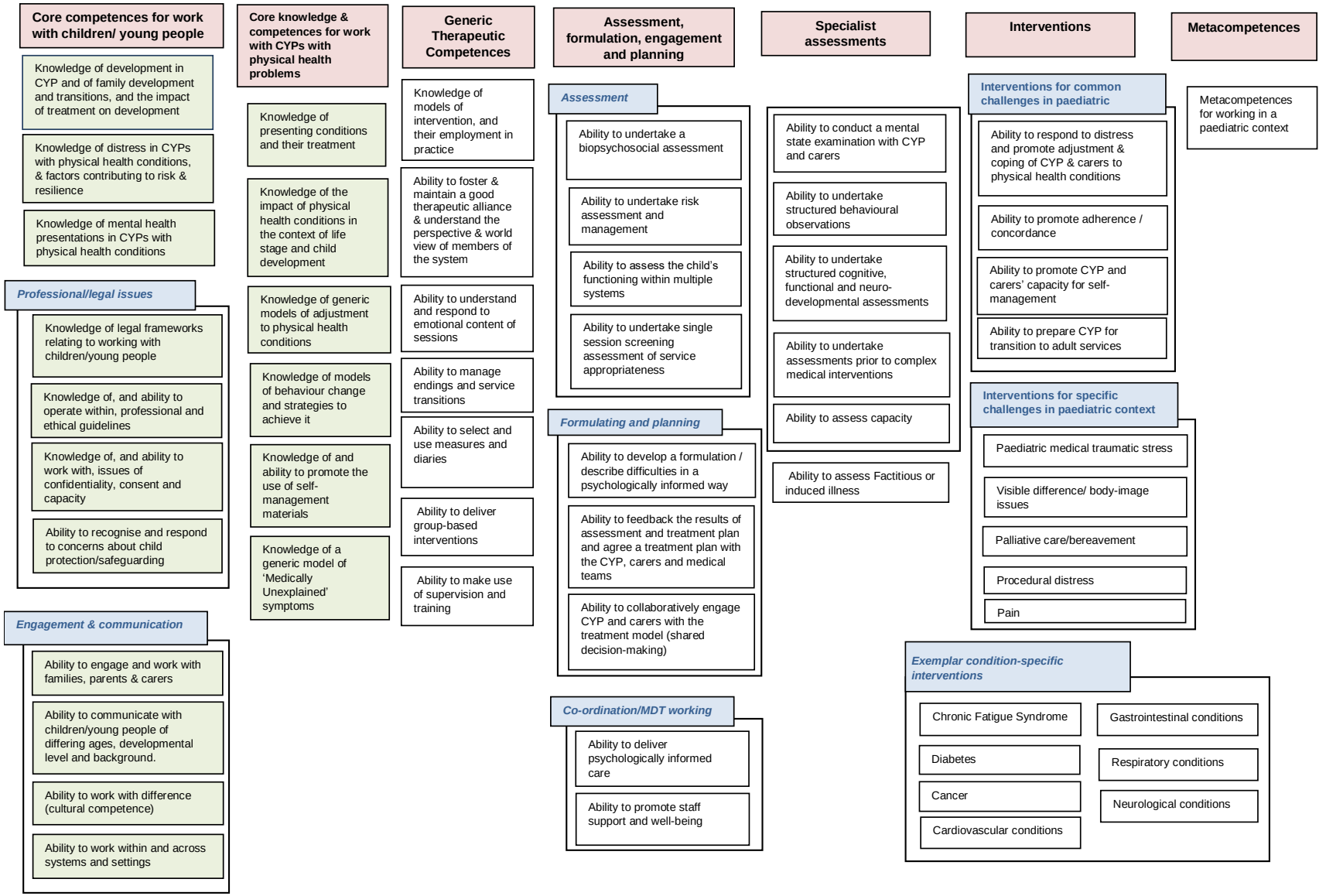
At a number of points the boxes are indented. This usually occurs when a fairly high-level skill is introduced, and needs to be 'unpacked'. In the example below, the high-level

skill is the notion of being “collaborative and empowering”; what follows are concrete examples of the sorts of things a clinician needs to do to achieve this.

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

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

Figure 2 – The map of competences for work in a paediatric context



An outline of the framework

Core competences for work with children/young people

The competences listed in this section describe the knowledge and skills expected of all paediatric healthcare staff irrespective of discipline.

Knowledge of development in children/young people and of family development and transitions and the impact of treatment on development and neurodevelopment
Knowledge of development and factors which impact on development is fundamental to assessment and intervention: it guides the practitioner's understanding of the child/young person's needs, behaviour and attachment relationships, and is critical for the detection of developmental delay. Knowledge of family development is also central; it helps practitioners understand the usual developmental tasks of families and the impact on the family of common transitions. All interventions rely on and refer to the practitioner's knowledge of child/young person development, because of the need to tailor these to the developmental stage of the child/young person and identify whether delays are transient (for example related to environmental factors such as a prolonged hospital admission), or long-term.

Knowledge of distress in children and young people with physical health conditions and factors contributing to risk and resilience
All workers aim to promote well-being and emotional resilience. The ability to recognize understandable signs and levels of distress in children, young people and their parents/carers and implement strategies for supporting them (and distinguish them from mental health difficulties that need specific intervention in their own right) is essential for the promotion of well-being and emotional resilience and in helping children and families to adjust to the demands of their physical health condition and its treatment.

Knowledge of mental health presentations in children and young people with physical health conditions
Understanding how mental health problems present and develop in children, young people and adults (and knowing when and how to refer on for additional interventions) is also central to specialist work. Although the mental health of children/young people is an important focus of assessments and interventions (achieved both through direct sessions with the child/young person and indirect work through the carers), the impact of adult mental health problems in the parent/carer also needs to be recognised and understood by practitioners.

Professional and legal issues

Knowledge of professional and legal issues, and particularly the way in which these apply to clinical practice, is critical to all aspects of assessment, treatment and effective multidisciplinary working. Legislation relating to child protection places a variety of

duties and responsibilities on services and organisations, and all paediatric healthcare workers have a responsibility to follow local procedures for reporting and sharing child protection concerns. Depending on the type of service, their role will range from identifying and sharing concerns about a child/young person to making an active contribution to joint decision-making and/or planning an investigation to support the child/young person and family. Practitioners need knowledge about these issues, but more critically they also need to know how they apply. By way of example, the process of engaging children and their families inevitably involves not only the discussion of confidentiality but also its limits: practitioners need to know when confidentiality can and should be breached, and how this should be managed.

This section of the framework includes four domains of competence:

- **Knowledge of legal frameworks relating to working with children/young people**
- **Knowledge of, and the ability to operate within, professional and ethical guidelines**,
- **Knowledge of, and ability to work with, issues of confidentiality, consent and capacity** and
- **Ability to recognise and respond to concerns about child protection/safeguarding**.

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Engagement and Communication

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

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

Ability to work within and across systems and settings

Staff working in paediatric settings from all professional backgrounds routinely communicate with professionals in different medical specialties and from other agencies such as schools and social work, as well as drawing on the expertise of other disciplines within the clinical team itself. Inter-agency and inter-disciplinary working requires a knowledge of the responsibilities of the other agencies and disciplines, as well as knowledge of relevant policies, procedures and legislation**.** It also demands skills in information sharing and communication as well as the ability to contribute to the co-ordination of case work, and the ability to recognize and manage challenges to effective inter-agency working. Staff also have to be able to conduct their contact with children and families in settings which require additional adaptations to enable engagement and confidentiality.

Core knowledge and competences for working with children/young people with physical health problems

Knowledge of presenting conditions and their treatment
A basic understanding of the physical condition with which the child/young person is presenting is both basic and critical, as is knowledge of treatment options (especially where treatment is potentially onerous and so challenging for the young person and their family).

Knowledge of the impact of physical health conditions in the context of life stage and child development
The ways in which children and young people understand their condition will vary with their developmental age. Alongside this, the impact of both acute and persistent/chronic health problems will differ in relation to life stage, with illness having the potential to challenge developmental transitions, and (in turn) developmental transitions impacting on the young person's relationship to their own illness.

Knowledge of generic models of adjustment to physical health conditions
Adjustment is not an end-point but a process of assimilation that takes place over time, influenced by a large number of factors, some of which promote and some of which inhibit the achievement of an emotional equilibrium and quality of life.

Knowledge of models of behaviour change and strategies to achieve it
Behaviour change is the focus in many consultations, but it is a process that needs to be understood if it is to be achieved. It requires a detailed knowledge of the many factors that influence a person's capacity for change, their motivation to do so, and the probability that they will achieve this. Strategies for promoting change start by engaging children/young people and their families in a collaborative process so that they can identify the changes they wish to make (and have the potential to achieve), set goals and identify target behaviours, implement behavioural change strategies, focus on habit formation and monitor and review change over time.

Knowledge of and the ability to promote the use of self-management materials
Developing skills in self-management requires a collaborative engagement which helps elaborate on the factors that will support or inhibit the capacity for self-management, and which helps children/young people and their families to identify opportunities to practise self-management, applying self-management strategies and ensuring that they can maintain change.

Knowledge of a generic model of 'Medically Unexplained' Symptoms
The generic model of MUS set out here is based (as far as is possible) on empirical evidence, and describes the ways in which biological, psychological and social factors can interact in an iterative, reflexive and self-sustaining manner to produce the symptoms experienced by patients. As such, the model makes it clear that MUS is not a product of any one of these domains, but arises in and through the interactions between them.

Generic Therapeutic competences

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

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

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

Ability to manage endings and service transitions
Endings and service transitions can be a difficult time for children/young people, families, teams and the practitioner. Because disengaging from treatment and therapy is

often as significant as engaging with it, this process is an integral part of the 'management' of the therapeutic relationship. The practitioner has to manage both planned endings and premature or unplanned endings where the family terminates contact with the service earlier than planned. An important consideration in all endings involves the assessment of any risk to the child/young person from terminating contact with the service.

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

Ability to deliver group-based interventions
Interventions are sometimes delivered in a group format, both to children/young people and to their carers. Groups can be based on a range of therapeutic models from CBT to psychodynamic theory. Generic group competences include an ability to plan the group structure and to recruit appropriate service users, as well as a capacity to engage group members and manage group process.

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

Assessment, Formulation, Engagement and Planning

Assessment

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

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

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

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

Formulation and Planning

Ability to develop a formulation (describe difficulties in a psychologically informed way). Interlinked with assessment skills is the ability to create a tailored formulation of the child/young person's difficulties which seeks to understand the child and family's challenges and strengths in a holistic psychologically informed manner from multiple perspectives.

The ability to feedback the results of an assessment and formulation and agree a treatment plan with the CYP, carers and medical teams and the **Ability to collaboratively engage CYP and carers with the treatment model (shared decision making)** are essential skills for promoting successful adaptation and engagement with interventions. Formulations and treatment plans are often constructed in collaboration with the child/young person and family, and the expectation is that they are periodically reviewed in the light of new assessment or intervention information.

Coordination / MDT working

Ability to deliver psychologically informed care
Any worker within healthcare should be able to deliver care in a psychologically informed manner which integrates both physical and psychological health. This goes further than understanding children and families' difficulties within a biopsychosocial framework by emphasising the importance of promoting a general ethos of integration

through psychologically informed team working and promoting the benefits of psychologically informed care across the whole system.

Ability to promote staff support and well-being
Paediatric healthcare workers operate within a demanding and emotionally charged environment and may be dealing with distress and families experiencing threats to their child's survival on a daily basis. This can have a detrimental effect on staff ability to work and support families effectively. This competency promotes the importance of working within a supportive organisation which recognises and prioritises staff health and wellbeing alongside the needs of the children and families that staff care for. Key components of this competency include staff being able to recognise signs of burnout within themselves and other colleagues and to implement strategies and seek appropriate supervision and support to prevent and manage burnout and stress.

Specialist assessments

Specialist mental health assessments
Under the header of "specialist mental health assessments" are a number of assessments usually offered by professionals with specialist training in the relevant area:

- the ability to conduct a mental state examination,
- the ability to undertake structured behavioural observations,
- the ability to undertake structured cognitive, functional and neuro-developmental assessments,
- the ability to undertake assessments prior to complex medical interventions, and
- the ability to assess capacity.
- the ability to assess factitious or induced illness

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

Interventions for common challenges in a paediatric context

The ERG identified areas of challenge which commonly arise in a paediatric context, which apply across presenting conditions, and whose effective management can either be the focus of an intervention in its own right, or be a part of a broader set of interventions. Included in this section is:

- the ability to respond to distress and promote adjustment & coping of CYP and carers to physical health conditions,
- the ability to promote adherence / concordance,
- the ability to promote CYP and carers' capacity for self-management
- the ability to prepare children and young people for transition to adult services.

Interventions for specific challenges in a paediatric context

The ERG identified a further set of 'pan-condition' competences, reflecting a set of specific challenges that arise in some – but not all- paediatric contexts. These include working with and managing:

- paediatric medical traumatic stress
- visible difference/body image issues
- palliative care and bereavement,
- procedural distress, and
- pain

Exemplar condition-specific interventions

This section focuses on condition-specific interventions, where there is some – though sometimes limited – research evidence of efficacy, but a strong professional consensus about the knowledge and skills required for an intervention. They are 'exemplars' in the sense that a list of condition-specific interventions is potentially very long indeed; covering them all would be impractical. In this sense, the conditions included in the map are intended to be illustrative rather than comprehensive.

While some of the areas covered relate to a specific diagnosis (**Chronic Fatigue Syndrome, Diabetes** and **Cancer**), most encompass a range of conditions. Thus, '**Cardiovascular Conditions'** considers interventions for children and young people presenting with a range of cardiac conditions; '**Gastrointestinal conditions**' includes work with a range of presenting conditions, including 'functional' presentations. '**Respiratory conditions**' focuses on work with children with Asthma and Cystic Fibrosis. Finally, '**Neurological conditions**' encompasses work across a broad range of specific presentations, including functional neurological presentations.

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

Metacompetences

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

On the whole, metacompetences are more abstract than those described elsewhere and, as a result, there is less direct evidence for their importance. Nonetheless, there is clear expert consensus that metacompetences are relevant to effective practice. Some of the list has been extracted from manuals, some are based on expert professional consensus[7] and some on research-based evidence (for example, an ability to maintain adherence to a therapy without inappropriate switching between modalities when minor difficulties arise).

Implementing the competence framework

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

Do all clinicians need to be able to do everything specified in the competence list?
As described above, not all clinicians are expected to carry out all the competences in all the domains of the framework. However, all members of a clinical team *would* be expected to be able to demonstrate "underpinning" skills (core and generic psychologically informed competences (shaded green on the map), and all caseholding clinicians would be expected to be able assess clients and use assessment information to develop appropriate treatment plans. Whether or not an individual clinician will demonstrate competence across the unshaded areas of the map will depend on their having had the appropriate training and supervision to work with specific health conditions; to identify and work with specific psychological challenges of having a physical health condition; and to carry out the procedures and interventions that are listed in these sections.

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

Is every competence in a competence list of equal importance?
Many of the lists are quite detailed, and each of the competences are included either because they formed part of an intervention that shows evidence of efficacy, or because expert opinion indicates that these are important and relevant skills. Given that some of these lists are quite long, it is reasonable to ask whether all the skills are of equal value.

This is a hard question to answer, because there is often little research evidence for the mutative value of *specific* skills – most evidence relates to *packages* of skills. This means that we cannot be sure which specific skills are likely to make a difference, and which are potentially neutral in their effect. Until we have more evidence it isn't possible to declare some skills more critical than others, but equally we cannot declare some skills or procedures optional. To that extent, all the competences are of equal value.

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

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

COMPETENCES RELATING TO SPECIFIC PSYCHOLOGICAL THERAPIES

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

When implemented in routine services, treatment formats often deviate from the schedules used in research trials. This can be for a range of reasons, but it is reasonable to ask whether making significant changes to the format may impact on effectiveness. This

is a difficult question to answer because on the whole there is little research evidence on which to draw. However, where research has been conducted it suggests that better outcomes are achieved when therapists show greater fidelity to the procedures set out in the manuals. As such there is much that could be neglected if clinicians deliver bespoke programmes that include some, but not all, areas set out in a manual. This suggests that when clinicians vary a 'standard' treatment procedure they should have a clear rationale for so doing, and that where procedures are varied there should be careful monitoring and benchmarking of clinical outcomes in order to detect whether this has a neutral or an adverse impact.

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

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

Similarly, implementation science models which look at the structures and systems required to maintain ongoing use of skills after training emphasise the importance of coaching and reflective practice at varying "doses" following initial training in new skills.

Applying the competence framework

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

Commissioning: The framework can contribute to the effective use of health care resources by enabling commissioners to specify both the appropriate levels and the range of competences that need to be demonstrated by workers in a paediatric context in order to meet identified local needs. It could also contribute to the development of more evidence-based systems for the quality monitoring of commissioned services by setting

out a framework for competences which is shared by both commissioners and providers, and which services could be expected to adhere to.

Service organisation – the management and delivery of services: The framework represents a set of competences that (wherever possible) are evidence -based, and aims to describe best practice - the activities that individuals and teams should follow to deliver psychologically informed care and psychological interventions.

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

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

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

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

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

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

clients and to improve the performance of practitioners; the framework will support both these through:

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

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

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

- providing a clear set of competences which can guide and refine the structure and curriculum of training programmes[5], including pre and post-qualification professional trainings, across all professions working within paediatric healthcare, as well as the training offered by independent organisations.
- providing a system for the evaluation of the outcome of training programmes

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

Concluding comments

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

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

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

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

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

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