



- 11.1
- 11.2
- 11.3
- 11.4
- 11.5
- 11.6
- 11.7

■ An ability to ensure that the whole team are agreed on, and own, the formulation, e.g.:

- by making it explicit
- by explaining its rationale
- by being open to debate and discussion of the formulation, such that a formulation is not 'imposed' on team members

■ An ability to recognise that formulations are hypotheses that need to be collaboratively developed with young people and parents/families/carers and tested in the context of intervention plans, and should be subject to iterative review

Applying and reviewing the formulation

■ An ability to apply the formulation such that it organises and drives the sequence of interventions

- an ability to systematically review and reevaluate the formulation in the light of new information, and in relation to what works and, especially, what does not work
- an ability to ensure that the young person and their families/carers can input to the process of review, and where relevant their feedback is integrated into an updated formulation

Setting an achievable care plan

■ An ability to ensure that the care plan realistically reflects

- the resources available in the unit (e.g. available staff, resources of parents/carers)
- the quality of service delivery (e.g. appropriate training of staff who are expected to carry out specific roles)
- the quality of the 'therapeutic milieu' (and therefore the quality of the context into which specific interventions will locate)
- the likely length of an admission
- the readiness of the young person
- the motivation of the young person and indicators of their likely engagement (e.g. an expression of interest in an intervention)

■ An ability to modify the care plan if there are indications that it is unlikely to be achievable (e.g. if unexpected staff absences restrict available resources)

■ An ability to identify how members of the team will contribute to the agreed plan of care



- 11.1
- 11.2
- 11.3
- 11.4
- 11.5
- 11.6
- 11.7

Monitoring progress

- An ability to put in place and make systematic use of systems that track outcomes using:
 - holistic assessment methods (drawing on multiple sources of information (including self-report) and multiple informants)
 - measures that are relevant to the issues and conditions/presentations being addressed
 - indicators of positive behaviour
 - goals that are determined by the child/young person and are meaningful to them (even if not equivalent to those set by the team)
- An ability to monitor and track the effectiveness of the care plan and revise both the formulation and the care plan as required
- An ability to document and record progress in a manner that is accessible to all those who need to access this information
- An ability to review progress against the initial care plan in order to identify and guard against 'therapeutic drift' (e.g. where new [but iatrogenic] difficulties emerge and command attention, and where a continued admission may be against the best interests of the young person)

Planning for discharge and transitions of care

An ability to put in place proactive planning for continuing care and support after the child/young person leaves inpatient care (e.g. maintaining links with services already involved in their care and actively involving community services in the discharge plan)