

11. Competences requiring specialist training



11.1. Working with complex needs in a CAMHS inpatient context

- An ability to draw on knowledge that most children/young people admitted to an inpatient unit will have both complex needs and coexisting conditions/presentations, accompanied by a level of severity that warrants an inpatient stay, and:
 - an ability to draw on knowledge of ways of adapting and integrating interventions into a coherent care plan that
 - stays close to the evidence base for specific presentations, but accommodates the needs and preferences of the individual
 - draws on knowledge of evidence-based psychological and pharmacological interventions for specific presentations
- An ability to draw on knowledge that children/young people whose presentations are not comorbid or severe are usually more appropriately treated in the community, and as such may be adversely impacted by an admission (e.g. those with a conduct disorder, substance misuse, trauma, an eating disorder, autism spectrum disorders, mild learning difficulties)

Comprehensive assessment and formulation

- An ability to draw together information from comprehensive assessments to derive a case formulation and a care plan that:
 - reflects both personal meaning and evidence-based understanding
 - reflects shared decision making
 - encompasses risk and all relevant issues
 - pre-empts and attends to potential obstacles to engagement or intervention, such that these can be mitigated
 - flags any priorities for intervention
 - identifies a risk management plan
 - indicates the sequence of interventions
 - indicates who is responsible for each aspect of the intervention
 - promotes the use of appropriate interventions and inhibits those that may be harmful (e.g. starting a psychological therapy when a short-term admission is planned)

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■ 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



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)

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