

# Inpatient CAMHS CYP whole team training specification

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## 1.0 Background

The key aim of this programme is to transform existing inpatient services for children and young people by adopting and adapting where necessary, those elements of the CYP IAPT programme that will help improve outcomes for children and young people, and by providing treatment which is based on best evidence, outcomes focused and client informed. Improving the mental health and well-being of all CYP is a national priority. In most cases, mental health needs can be met through community services however a small number of young people have needs which can only be met through highly specialised inpatient care. Residential psychiatric provision for children and young people has a complicated history spanning 60 years, but notably over the past thirty years there has been a dramatic reduction in inpatient beds, resulting in inpatient psychiatry becoming a low volume, high cost, 'supra district' service (Green & Jacobs, 1998).

A psychiatric inpatient unit is the most acute and arguably the most medicalised mental health environment that a young person with psychiatric difficulties might encounter. The structural and organisational aspect of the unit combined with the acute nature of the symptoms necessitates an intricate relationship at the medical therapeutic and psychotherapeutic interface. Treatment within an inpatient unit carries some unique challenges; whilst removal of a child with severe emotional difficulties from their home into an inpatient unit has potential benefits; (separation from possible negative influences in the family, access to an intensive treatment programme), the benefits must be weighed against the potential harm and negative effects of such a decision (Hersov, 1998).

The adolescent inpatient context is a complex environment, with the unit needing to respond to the extreme and varied needs of young people. Many would consider the unit a therapeutic agent in its own right, and as such, attention is paid to what forms the therapeutic milieu (Green & Burke, 1998). Maskey (1998) describes clinical teams within an inpatient unit as "complex systems, professionally and personally, because of the genuine multi-disciplinary nature of the teams and the intense nature of the clinical work" (p. 157).

The 2008 CAMHS review (DCSF/DH 2008) highlighted that often staff with the least experience of mental health issues are the ones who spend the majority of time with the most vulnerable children and young people (Sergeant, 2013). This is particularly true within inpatient units, which frequently have a heavy reliance on bank and/or agency staff, or a high proportion of Health Care Support workers within their workforce.

Kurtz's (2007) review of Tier 4 CAMHS in the nine regions of England reported on the type, amount and quality of provision and on commissioning arrangements within each region. The findings suggest an implicit notion that the admission criteria in CAMHS inpatient units may often be based upon the perceived capability of the staff working within that setting and their related skill set (Sergeant, 2013). The report raised concerns regarding the lack of staff supervision and access to specialist in-house training during challenging periods. It was apparent that poor staff development, competence and confidence to deal with complex cases had a negative impact upon the retention of staff.

Sergeant (2013) identified that senior healthcare managers, responsible for inpatient 4 units, are acutely aware that recruitment and retention is an ongoing problem. There are increased opportunities for promotion in the community services and a gradual drift of staff members away from inpatient services. This may leave the care of young people, the most complex and challenging client group, being managed by the most inexperienced staff. The Quality Network

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for Inpatient CAMHS (QNIC, 2007), noted an impact on both staff morale and effectiveness and service users and their carers, expressed concern about the over reliance of agency staff and the impact on patient and staff safety. In addition, this QNIC report (2007) highlighted that, whilst provision and ability to attend training had improved somewhat, access to training was still an issue. There appeared to be many potential barriers, notably a lack of training budget and/or a lack of staff cover to enable CAMHS staff members to attend training sessions. The report notes that the individuals who could benefit most from undertaking training sessions, tended to be those that were the most difficult to release from ward duties i.e. unqualified and qualified nursing staff.

There is a range of complex factors that affect the composition and resources of Tier 3 CAMHS and referrals to inpatient treatment are often determined by what can be managed by the community service. The diverse commissioning arrangements may result in the Tier 4 inpatient services being funded by differing organisations, compounding the interface problems. This continues to require the attention of service providers and commissioners to offer better outcomes for people accessing CAMHS services. Green et al (2008) recommended that in order to optimise effectiveness, inpatient services need to change along with the development of new forms of community services.

The South West collaborative and the regional HEI, the University of Exeter, has been delivering a range of CYP IAPT programmes since the start of the initiative in 2011. The University has successfully engaged with local stakeholders and is well respected within the region. In March 2016, the University of Exeter made a successful bid for funding to start preliminary scoping for the development of a CYP inpatient training, engaging key stakeholders, delivering outreach activity and developing a baseline assessment. Information and ideas from the four regional generic inpatient units within the collaborative was fed back into the national curriculum group. Stakeholder engagement at this local level would seem particularly imperative for inpatient training and to date; all four units across the region are signed up for a potential pilot of the programme. During initial engagement activities, clinical staff have been very enthusiastic about being included in the CYP agenda. It was apparent that surprisingly little was known about the CYP programme and staff frequently described a sense that thus far, the CYP agenda had had little impact on inpatient services.

### **Scope of this curriculum**

This curriculum is not designed to replace the need for specific training in children and young people's mental health and does not cover specific treatment modalities in detail such as Cognitive Behaviour Therapy (CBT) and Systemic Family Practice (SFP). The purpose of this document is rather to provide a standardised national curriculum for all teams trained in inpatient services. The course is likely to be provided by, or affiliated to, a university, and run as a 10-day intensive non-credit bearing course. The precise organisation of teaching units will be determined by respective learning collaboratives.

### **Who will be trained?**

All clinical staff working within an inpatient context will be put forward for the training. It is likely that small groups of 4 – 6 staff across the multi-disciplinary team will be put forward at a time, to ameliorate difficulties that inpatient units may face when freeing staff up to be trained. Each unit may make strategic decisions about who is put forward to train and when, emphasising the need for 'service transformation ambassadors' and advocates for change to carry the new training experience back onto their units.

## 1.1 Building on the CYP IAPT principles for inpatient CAMHS

The curriculum builds on the principles of the CYP IAPT service transformation programme, which aims to create a culture of full collaboration between children, young people and/or their parents or carers across staff and services. Key principles underpin the implementation of a CYP IAPT inspired inpatient whole team training:

a) Full partnership and collaboration with children, young people and parents and carers in all aspects of care and service delivery.

Children and young people's participation are mandated not only in the design of individual treatment packages but also in-service design and delivery of care as well as the recruitment, training and appraisal of staff. The curriculum incorporates this as a learning outcome.

b) Regular use of outcome and feedback measurement to guide treatment and service delivery. Participation is further assured using regular feedback through regular outcome monitoring and or outcome monitoring that is adapted appropriately by the inpatient setting to guide intervention for each child or young person, and their parent or carer. This incorporates a mixture of individualised goal and symptom measures suitable for all those admitted to an inpatient CAMHS service.

c) Improve access to evidence-based treatment and services. Supports the training of staff in standardised curricula of NICE approved and draws on the best evidenced therapies for the treatment of children/young people within an inpatient setting where possible. Whole team training is one of the best ways of incorporating and disseminating evidence-based practice and builds on practice-based evidence.

In addition to the principles of CYP IAPT, training staff in an inpatient need to take another core principle into account:

d) Consistency and continuity in the delivery of care. Staff should be trained in the principles that care and interventions should be delivered in consistent way by all team members to reduce the risk of confusion in approach.

As part of implementing this aspect of CYP IAPT, a whole team approach is created which incorporates the best evidenced interventions for children and young people within an inpatient setting. The course will help the team provide 'family friendly' services to the families of children and young people when admitted on an inpatient unit. The family/carer is usually the strongest resource that young people have when they suffer adversity, psychological difficulties and mental ill health and are likely to be dramatically affected by their young person's admission. The family/carer often need help in working out what they can do for their young people, how they can change patterns which affect emotional wellbeing, and how they can build resilience. The structuring of the training, supervision, follow-through support, assessment, and the evaluation of fidelity will be determined by training providers. It is anticipated that trainings will commence across the country during 2017.

Enhancing youth, carer and community participation, and increasing mental health awareness and decreasing stigmatisation are considered to be key strategies for achieving improved access. All these factors are fully integrated into the current document. More needs to be done

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to promote good experiences of care, which requires a full team approach and full involvement of children and young people and their families/carers. Inclusiveness and enhancing the engagement of young people and their family or carer is expected to create a spirit of collaborative care between those receiving care and the practitioner.

In line with the CYP IAPT principles, at the core of this initiative is empowering children, young people and their carers to take an active role in decisions about their care, to engage in shared clinical decision-making, to establish treatment goals appropriate to them, to choose the route to health that's best for them and through this active engagement to strengthen their agency and trust ([www.myapt.org.uk](http://www.myapt.org.uk)). Participating in service design, understanding and modifying treatment progress via patient rated outcome measures (PROMs), patient rated experience measures (PREMs) and participating in the training of practitioners and managers, all serve to enhance a sense of agency.

## **Linked to other training courses delivered through CYP IAPT.**

Through the CYP IAPT service transformation programme and in line with the above principles, staff are trained in standardised curricula of NICE approved and best evidenced therapies. The training of service managers and service leads may be undertaken concurrently with the training of practitioners.

## **1.2 Introduction**

This document outlines the curriculum for Inpatient CYP Whole Team training and should be read in combination with the NHS England access and waiting time standards and commissioning guides. Training is expected to be delivered to all members of the team over time to support the team dynamic, cohesion and consistency of approach. The composition of an inpatient team set out in the guidance is outlined below but it is acknowledged that this will vary between units.

- All members of the multi-disciplinary team may not necessarily acquire all the knowledge and skills outlined here. But it is an over-arching principle that all team members work together to;
- Involve children/young people and their families/carers in developing referral pathways, and every aspect of service provision, service development, training, and the working of the team itself.
- Have sufficient understanding of the concepts and skills of assessment and treatment of children and young people within an inpatient setting to contribute to an integrated multi-disciplinary team capable of delivering effective evidence-based interventions.
- Engage children/young people and families or carers using principles and practice of shared decision making increasing their autonomy and trust.
- Recognise and work with potentially powerful peer group processes.
- Understand the role of quality monitoring and development in service design and delivery and be familiar with local protocols and procedures to participate in these activities.
- Recognise the need to offer evidence-based treatments.
- Regularly use of outcome and feedback measurement to guide treatment and support shared decision making.

## 1.3 Composition of the team

Composition of Inpatient CAMHS teams will vary and are likely to evolve over time in response to specific (local) needs and identified gaps in skills and competencies of the team. In general teams will be multidisciplinary, combining both medical and non-medical staff that will include expert clinicians who are able to ensure safe management of the medical risks associated with inpatient admissions as well as the delivery of psychological evidence based treatments (e.g. family therapy and CBT) and their supervision. In order to achieve the appropriate level of specialist knowledge and skills within the team from medical and non-medical staff; teams will generally include a range of professionals ([See appendix](#)) with the following competencies or backgrounds (this list is not exhaustive).

Teams will also need to develop robust structures to ensure regular collaboration with referrers, service commissioners, children/ young people and their families.

## 1.4 Resources and other guidelines

### Guidelines

MindEd for e-learning sessions relevant to the assessment and treatment of specific disorders, as well as sessions on embedding the regular use of outcome and feed monitoring, and working collaboratively with children, young people and their families

Specifically, for eating disorders: Junior Management of Really Sick Patients with Anorexia Nervosa (MARSIPAN).

### Other resources

Social media and apps – friends or foes: a guide to help to address your concerns about body image, eating disorders and mental health

- Parents Say Toolkit  
[http://www.youngminds.org.uk/training\\_services/vik/children\\_young\\_peoples\\_iapt/parents\\_say\\_toolkit](http://www.youngminds.org.uk/training_services/vik/children_young_peoples_iapt/parents_say_toolkit)
- MyAPT – for guidance on children and young people’s guidance on embedding and evaluating participation.
- National Minimum Standards for Psychiatric Intensive Care Units for Young People  
[http://napicu.org.uk/wp-content/uploads/2014/08/CAMHS\\_PICU\\_NMS\\_final\\_Aug\\_2015\\_cx.pdf](http://napicu.org.uk/wp-content/uploads/2014/08/CAMHS_PICU_NMS_final_Aug_2015_cx.pdf)
- Transition to adult care support – Ready Steady Go
- CAMHS competencies UCL  
[https://www.ucl.ac.uk/pals/research/cehp/research-groups/core/pdfs/CAMHS/CAMHS\\_Clinician\\_Competences\\_Framework\\_V1\\_2\\_.pdf](https://www.ucl.ac.uk/pals/research/cehp/research-groups/core/pdfs/CAMHS/CAMHS_Clinician_Competences_Framework_V1_2_.pdf)
- ‘Keeping in Touch with Home’  
<http://pavingtheway.works/whats-new/keeping-touch-home/>



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- Practitioner Handbook Inpatient  
<http://www.rcpsych.ac.uk/pdf/workingwithinchildandadolescentmentalhealthinpat.pdf>
- QNIC Standards
- NHS E Tier 4 CAMHS Service Specifications

## 1.5 Principles of Delivery

### Teaching and Learning

Some elements of the training require a basic knowledge across trainees so that they can work in a consistent way within their CYP MH services. All trainees will be professionals and so will bring this to the learning experience of the course.

Teaching across the curriculum should comprise the following elements:

- Didactic teaching: Some elements of the training require a basic level of knowledge across trainees so that they can work in a consistent way in their CYP IAPT services. As a result, a small proportion of the curriculum should be delivered in a didactic style to ensure baseline knowledge in particular areas are gained.
- Large and small group discussions: Trainers need to ensure that any didactic teaching is followed by sufficient time to explore the different perspectives of the trainees' group. More intimate, self-exposing, reflective discussion and skills-development should take place in small groups. Trainers should ensure that the aims and competencies for each session are outlined at the beginning of any teaching session and they should consider having a plenary session at the end to consolidate learning.
- Extensive use of case discussion and role-play: This will most likely form the largest part of the training, for two reasons. Firstly, the specific competencies underpinning this training are ones of technique, rather than knowledge. Secondly, this allows trainees to examine their own existing skills and practices in an experimental way.
- Reflective practice sessions: An essential component of working with children/young people within an inpatient setting is embodying an attuned and sensitive interaction in any clinical exchange. Trainees will be supported to reflect on their own practice.
- Action learning sets: Trainees will be set small service transformation task during the training that will be worked on together back in the workplace.

### Trainers and Supervisors

All trainers and supervisors should have knowledge and experience of working clinically with within an inpatient setting as well as the topic being taught.

## 2.0 Key learning outcomes for inpatient CAMHS

### 2.1 Whole team learning outcomes

By the end of this training, members of the team should jointly have knowledge and skills in the following areas in order to support the smooth, safe and effective functioning of inpatient team. It is not expected that any one person would acquire all these competencies, but the team as a whole should be able to fulfil the following functions.

- To manage transfer of care into and between services, to include transition to and from inpatient care with appropriate attention to continuity and consistency of care.
- To integrate pathways of care, to liaise, co-ordinate, create and use effective shared care plans with other service providers, including community CAMHS, voluntary sector services and GP practices.
- To understand group processes, including those between peer and staff and work together therapeutically. To recognise the therapeutic benefits of a therapeutic milieu.
- To recognise how a team and individuals in a team may be affected by clinical presentations, for example high risk patients.

To provide:

- A 'family friendly' service:
  - Responses to referrals in a timely manner
  - Assessment and formulation on admission to be delivered in a timely manner
  - Support (including psychoeducation) for the child/young person and their family/carers and helping them to manage the admission and treatment
  - Motivational support for those in need of treatment who are not yet willing to engage in treatment
  - Risk monitoring throughout the admission
  - Evidence based treatments
  - Accessible educational, occupational and support services for children/young people and their families throughout their contact with the service.
- To implement a quality assurance framework and understand quality standards to support access to high quality care.
- Recognise possible barriers to accessing treatment or the health care system for the child/young person and their family or carer.
- Support children, young people and parents/carers to overcome barriers to implement treatment (including managing reluctance to engage in treatment).
- To develop practices that integrate diverse perspectives of team members with those of children/young people and their families or carers to inform treatment programmes, psychoeducation and service development initiatives, training, and other activities.
- For the team to generate new ideas and problem solve difficulties encountered in delivering clinical services.
- To implement use of robust supervision structures to inform the treatment practices of individual team members on a regular basis and as a part of developing a coherent treatment philosophy across the team.
- To understand and manage dynamics within a team which may influence the functioning of the team in delivering effective treatment.
- To use routine clinical measurement as a team (not just as individual clinicians) to guide and reflect on case management and monitor team treatment outcomes.

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- To monitor and access team training requirements to develop team and individual training plans:
  - Programme training and skills updates
  - Post-training support
- To develop a team culture that enables challenge and confidence of team members to raise concerns/whistle-blow.

### **2.2 Basic whole team learning**

Assumed to take place elsewhere, for example within mandatory training, including:

- Risk assessment
- Manual Handling
- Data protection
- Child Protection – levels 2 and 3
- Conflict Management
- Relevant Legal Frameworks including the Children Act, MHA, MCA etc

### 3.0 Basic knowledge required by the trainee

#### 3.1 The individual child/young person, family and the impact of inpatient admission

- Basic knowledge of the range of mental health and neurodevelopmental disorders usually seen in inpatient CAMHS services. This knowledge is informed by research and includes co-occurring difficulties such as mental illness/disorders, physical illnesses and long-term conditions, learning disabilities and specific learning difficulties, Autism Spectrum Disorders, substance use and vulnerable groups who may have experienced physical, sexual or emotional abuse.
- A basic understanding of the family system and social context affecting the child/young person particularly the impact of parental mental illness, parental substance misuse, exposure to domestic violence and impact of the peer group (both positive and negative).
- Understand the potential risks associated with admission to hospital for child/young people, including harm to relationships within the family and the wider community, potential for institutionalisation and exposure to traumatic events, maladaptive patterns of behaviour and associated “contagion”.
- A basic understanding of the relevant evidence-base for interventions with children, young people and their families for severe and complex mental health presentations.
- A basic understanding of the strengths and limitations of practice-based evidence and the available data in relation to this, including evidence regarding the experience of specific equality groups (within protected characteristics) and those with particular vulnerability such as looked after children.
- To have a basic understanding of the concept of ‘least restrictive practice’ and how this relates to care planning.
- To have an awareness of the critical modifications to clinical practice that are required when assessing and treating children and young people with Autism and Learning Disability.

#### 3.2 Relevant theory including child development and family life cycle

- Basic understanding of the ways in which mental health problems emerge and present in children/young people and the potential impact of these difficulties have on the child/young person and their family.
- Basic knowledge of attachment theory, including development of attachment, coping styles and relational needs.
- Knowledge of the social, psychological, family and biological factors associated with the development and maintenance of mental health problems.
- Roles and responsibilities (of own service and others), in relation to confidentiality and information sharing.
- Recording of consent-confidentiality (particularly with other agencies) but also on admission and in relation to interventions.
- Understanding as to the interface between the inpatient setting and other agencies/ services – A&E, police, social care, criminal justice system etc.
- Understanding structure and responsibilities of agencies or services e.g. adult mental health services; Children and Young Peoples Social Care and processes such as the Common Assessment Framework, Children Act Section 85 responsibilities, schools and

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Local Authority responsibilities and processes linked to education including Education Health and Care Plans.

## 3.3 Group processes and team working

- Each trainee should have a basic understanding of group processes and team working as outlined in section 4.4 below (social systems, groups, team working).
- Demonstrate a basic understanding of the theory of group dynamics, in relation to groups, decision making and how orientations can facilitate or interfere with purpose.

## 3.4 Social systems, inpatient culture and milieu and group processes

- Understand the inpatient service as a social system and how the specific ideology and treatment models used on the unit contribute towards the therapeutic milieu.
- Understand the identity and ethos of the inpatient team, how it relates to the day to day functioning of the unit and how to maximise potential therapeutic daily activities.
- Understand the social systems and working of the team to support effective outcomes and cohesion. This means understanding the purpose of the service and wider system.
- Understand the aims of the service, including the commissioning structure, and the service specification set by commissioners.
- Have an awareness of power imbalances, group dynamics, culture, norms, values, roles, function and responsibilities within the team.
- Understand how the components of care fit together; for example, structures, key clinical meetings, individual services provided by different parts of the MDT.
- Develop an awareness of how personal views may differ from the perceived group norm, and how to be open about one's views to facilitate discussions.

## 3.5 Inpatient work and the self; self-reflection, secondary trauma

- Understand the importance of relationally reflective practice and self-reflection.
- Be self-reflexive in relation to one's own personal and professional responses and use of language in relation to issues such as child protection, challenging behaviour, depression, self-harm, or violence.
- Recognise professional and personal limitations and self-awareness.
- Apply knowledge and understanding of basic unconscious processes such as splitting, projection and transference, and how these impact on interactions with children/young people and families and can influence team dynamics, (internal and external) potentially affecting care and treatment of children/young people and their families.
- Ability to foster resilience within the staff team and resolve conflict.
- Manage interpersonal and group conflict, to reduce distraction from quality and performance.
- Understanding self and interpersonal boundaries related to working within an inpatient setting.
- Have the capacity to effectively use supervision and know the limit of one's own capacity.

## 4.0 Basic knowledge required by the team

The central aim of the following section is to support the team, child/young person and their family/carer in establishing a collaborative, consistent and flexible view and approach, whilst recognising the importance of multiple perspectives across disciplines.

### 4.1 Nature and rationale of an inpatient admission

- A basic understanding of the diagnostic criteria for child and adolescent mental health conditions specified in the main classification systems (i.e. DSM V and ICD-10).
- Knowledge of the incidence and prevalence of mental health presentations across different cultures/ethnicities/social classes and how this may influence care planning.
- Knowledge of problems which commonly co-occur with the mental health presentation
- Link and act as point of contact for children/ young people and families/carers, the agencies and other members of multidisciplinary team.
- Present and discuss the case and the case formulation to the multidisciplinary team in the team meetings, team supervision and individual supervision.
- Take the feedback from team and individual supervision to the child or young person and family/carer and discuss changes in the care plan as a result of the decisions/feedback from the multidisciplinary team meetings and supervision.
- Use the legal framework for consent and confidentiality.
- Communicate complex information to children/young people and families/carers in an accessible and acceptable way for them.
- Assess capacity/competency and consent status and to address these as potential barriers to treatment.

### 4.2 Child/young people and parent/carers' experience and expertise

- Address the experiences of, and tackle and reducing effects of stigma (including self-stigma).
- Identify and understand barriers and levers for change at the individual, team and systems organisational level.
- Understand the effects of team and service change on the wider health, social care and educational systems and the third sector.

### 4.3 Treatment options

- Assess the nature of the mental disorders and presenting difficulties of children/ young people accessing inpatient CAMHS services
- Understanding the definition, core symptoms, common complications/co-occurring complex conditions, epidemiology and treatment of the following mental disorders and presenting difficulties, for example:
  - Depression
  - Social and other specific phobias
  - Separation anxiety disorder
  - Generalized anxiety disorder

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- Obsessive compulsive disorder
- Bipolar disorder
- Post-traumatic stress disorder
- Complex trauma
- Attachment disorders
- Dissociative disorders
- Conduct disorder
- Neurodevelopmental disorders; including Autism spectrum disorders, ADHD, learning disability, specific learning difficulties
- Eating disorders
- Substance use disorders
- Psychosis and related disorders
- Emerging personality disorders
- Chronic fatigue, 'abnormal illness' behaviour or physical conditions with no apparent organic cause (including Pervasive Arousal Withdrawal Syndrome – PAWS)
- Behaviours such as self-harm/suicidality; behaviour that challenges and behaviour that poses a risk to others

### 4.4 Social systems, groups, team working

- Family system and social context affecting the child/young person particularly the impact of parental mental illness, parental substance misuse, exposure to domestic violence, transgenerational trauma and impact of social disadvantage.
- Understanding of factors relating to resilience in staff and children/young people.
- Awareness of the neuropsychological aspects of childhood and adolescence (e.g. brain development) and general processes involved in childhood and adolescent development
- Understanding of role of advocacy relevant charities and self-help e.g. BEAT, Challenging Behaviour Foundation, Young Minds.
- Knowledge of learning theory and how this links to behavioural management and interventions.
- Knowledge of factors that promote well-being and emotional resilience, (e.g. good physical health, high self-esteem, secure attachment to caregiver, higher levels of social support).
- Awareness of normative/non-normative childhood and adolescent behaviour and difficulties across development.
- Knowledge of child and adolescent development across physical, neurodevelopment, psychosocial, emotional, cognitive and moral areas of development.
- Impact of child abuse; neglect, emotional or physical abuse and neglect as well as sexual abuse/exploitation on child/young person's development, relationships and well-being.
- Impact of trauma on brain development, attachment, dissociation and possible re-enactment in relationships.
- Ability to respond to and manage concerns about safeguarding and child protection (in relation to emotional, sexual and physical abuse and indicators of neglect).
- Manage changes in team with new and established team members with different levels of qualification and experience.
- Understand group processes of patient mix, direct care staff, wider multidisciplinary team and interface with external teams and organization.



## 5.0 Skills of the team

These are the skills that are held as essential collectively within the team and represent a shared value system.

### 5.1 Support effective participation of children/young people and parent/carers

- Making a principled commitment to participation.
- Undertake a baseline assessment of current approach to participation, use CYPIAPT Participation Pledges to develop a work plan to address each area.
- Knowing when to adopt each level of participation, from consulting and equal partnership to children and young people and families leading as 'active citizens'.
- Taking children/young people and families seriously, treating them with respect, being authentic, hearing and acting upon what children and young people tell us.
- Addressing specific cultural or environmental needs (e.g. same-sex parents) and understanding these variations.
- Reflect continuously on how provision fits the characteristics of the population, embedding a culture of participation within the service which addresses any adverse impact for particular groups (e.g. LGBT, BME, disabilities) and how services might need to adapt intervention strategies.
- Provide training for staff and children/young people in participation – e.g. involving young people and service users in recruitment and staff training.
- Supporting staff to feel engaged and able to contribute to service design and have their feedback listened to and acted upon.
- Demonstrate how the voices of young people and their families, both through the use of Advocacy and Participation, shape service design.
- Support a day to day 'culture' of participation and person-centred practice.

### 5.2 Communication and engagement with the child/young person and family from first contact

- Encourage the use of information designed by and for young people proceeds first contact. Use of suitable formats and high-quality contact.
- Work towards a shared understanding of/with the child/young person and family.
- Positively engage with children/young people and families from first contact and during admission and manage appropriate boundaries. Provide clarity around decision making and power balance.
- Ability to express confidence in talking with children/ young people, families & carers.
- Provide clear information about the unit's structure, mutual expectations and visiting (including pack).
- Communicate about the long-term consequences of the mental disorder with child/young person and family and other professionals involved in supporting the child/young person alongside recognizing resilience and capabilities.
- Communicate to the child/young person and their family/carer an individualised formulation that considers individual, family and broader contextual factors.
- Explain the principles of the different available treatments to children/young people and their carers including the evidence base and potential strengths and limitations of each approach. Use of shared decision-making tools to support this.



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- Collaboratively develop and organise goal setting with the child/young person and parents/carers, recognizing the different views and opinions of each.

## 5.3 Risk management

There is an expectation that services will already have the following competencies in place and work consistently together using a whole team approach to risk management;

- Understand the use of relevant code of practice guidelines for children and young people and the least restrictive practice - Refer to Practitioners Handbook for Inpatient CAMHS.
- Provide interventions within the least restrictive environment and using least restrictive practice.
- Implement a framework to reduce use of physical intervention e.g. Safewards or no force first approach.
- Therapeutic risk management.
- Assess and manage risks such as neglect, self-harm, suicidal intent/acts, absconion/running away, substance misuse, physical aggression, restricted eating/binge/purge, offending behaviour.
- Recognise the interaction between psychological states and physical risk.
- Risk assessment and positive risk management/harm minimization.
- Demonstrate in relation to secondary trauma.
- Management of difficult/highly expressed emotions.
- Recognise and utilize de-briefs after incidents.
- Recognise and identify appropriate actions following risk assessment.
- Involve the family or carer in risk management.
- Stabilization of risk and supporting self-management/recovery.
- Use a holistic risk assessment within an agreed framework to develop a risk management plan.
- Carry out formal observations as required alongside therapeutic engagement.
- Establish and maintaining therapeutic alliance.
- Set and manage clear interpersonal boundaries.
- Build on and learning skills e.g. Social skills, communication, self-care, daily living skills, self-soothing, relaxation, play, distraction, physical exercise, acceptance, interests.
- Explore motivation to change and negotiate safe ways of managing risk behaviours. associated with the child/young person's mental disorder and ensure that early changes provide steps for further change and re-evaluation of treatment targets.
- Explore and manage risk associated with the use of social media and mobile phones.

## 5.4 Assessment of physical health needs

- Alongside mandatory training, the team has the ability to:
- Consider, and with appropriate consultation exclude, an underlying physical illness that may cause symptoms
- Ability to respond to medical emergencies
- Biological factors including Genetic contributions to psychiatric disorders and other neurobiological factors
- Define and specify physical health needs and use the initial assessment to advise on further monitoring of physical health needs
- Assess physical health status

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- Recognise the therapeutic use of physical exercise
- Assess nutritional needs including any vitamin/mineral deficiencies
- Recognise acute physical symptoms and elicit indicators of change in physical risk
- Recognise symptoms of co-occurring substance and alcohol abuse
- Monitor weight/BP/P, blood tests
- Monitor physical side effects e.g. psychotropic medication

## 5.5 Skills needed to deliver effective treatment

Members of the team will demonstrate generic competency and specialist competency in areas relevant to their team role. The team will maximise the skills and knowledge of individual team members and identify practices required for the delivery of a well-functioning and coherent service, harnessing the multi-disciplinary expertise.

- All staff should be able to convene a meeting (with support if required)
- Work collaboratively.
- Demonstrating the ability to advocate for the patient
- Demonstrate skills in managing conflict within the team
- Demonstrate learning from patient experience to reflect on practice as individual practitioners and as a team
- Deliver practices that integrate diverse perspectives of team members with those of children/young people and their families or carers to ensure consistency of approach and inform treatment programmes, psychoeducation and service development initiatives, training, and other activities.
- Generate new ideas and problem solve difficulties encountered in delivering clinical services.
- Understand the process of transformation within CAMHS both within inpatient and community settings.
- Implement use of robust supervision structures to inform the treatment practices of individual team members on a regular basis and as a part of developing a coherent treatment philosophy across the team.
- Signpost staff to appropriate further training

## 5.6 Clinical and collaborative use of routine outcome monitoring

Use routine clinical measurement as a team (not just as individual clinicians) to guide and reflect on case management and monitor team treatment outcomes.

## 5.7 Consultation and training

- Monitor and access team training requirements to develop team and individual training plans
- Development and agreement on personal and team skills development plans
- Ensure that clinicians meet the standards set by both regulatory and professional bodies.

## 5.8 Supervisory processes and the role of supervision

- Have the capacity to effectively use supervision and know the limit of one's own capacity
- Members of the team with advanced training will provide regular supervision for the team and where appropriate will co-work cases with more complex presentations.

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- Ability to provide model specific expert supervision
- Use of regular outcome and feedback measurement in supervision including peer group supervision
- Deliver post-training support and supervision
- Development and agreement on personal and team skills development plans

### **5.9 Transition, discharge care and liaison with the community MDT**

The team understands the principles of recovery.

- How to develop a relapse prevention plan in the context of a discharge to community services
- Identify indicators for discharge
- Relapse prevention
- Understand psychological problems associated with discharge
- Use effective and timely pathways to discharge
- Communicate and complete joint planning about discharge plans
- Collaboratively support transfer of care between services (e.g. from community-based treatment to inpatient care and back to community, care support in school)

## 6.0 Appendix

In order to achieve the appropriate level of specialist knowledge and skills within the team from medical and non-medical staff; teams will generally include a range of professionals with the following competencies or backgrounds (this list is not exhaustive):

- Health Care Assistant
- Staff nurse
- Charge nurses/ Clinical nurse specialist or Nurse consultant/Ward Manager
- Consultant Child and Adolescent Psychiatrist
- Clinical Psychologist
- Occupational Therapist
- Family Therapist
- Social worker
- Dietician (if treating young people with Eating disorders or PAWS/CFS) otherwise access to Dietetics
- Teacher
- Arts Therapist
- Physiotherapy (if treating psychosomatic/PAWS/CFS etc)
- Access to Pharmacy, Speech and Language Therapist
- Case manager
- Receptionist and administration staff
- Porters and Domestic staff (where appropriate)
- Operational manager
- Experts by experience contributing to the work of the team – representing a range of disorders and diversity (parents/carers and young people)

In addition to the clinical tasks' teams will have to cover a range of administrative and management roles including:

- Operational and service management
- Coordination of training needs
- Coordination at team level of regular data collection