

National Workforce Programme
Child and Adolescent Mental Health

Children And Young People's Services Joint Workforce Plan
Northumberland, Tyne and Wear NHS Trust

Children And Young People's Services Joint Workforce Plan

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Children And Young People's Services Workforce Plan Northumberland, Tyne and Wear (NTW) NHS Trust

Introduction

Northumberland, Tyne and Wear NHS Trust was established in April, 2006 and is one of the largest trusts of its kind in the country. It has around 7,500 staff and a budget of more than £250 million a year.

It resulted from the merger of three trusts providing services across the area - Newcastle, North Tyneside and Northumberland Mental Health NHS Trust, Northgate and Prudhoe NHS Trust and South of Tyne and Wearside Mental Health NHS Trust.

The overall aspirations of the Trust are to ensure that people with a disability or mental illness can access consistently good quality care and treatment services that meet their individual needs.

The Trust provides a range of mental health services, learning disabilities, neuro-rehabilitation and substance misuse services for a population of approximately 1.4 million people. The communities served cover the whole of Northumberland, Newcastle, North Tyneside, Gateshead, South Tyneside, Sunderland and parts of North Easington. These areas are a mix of urban conurbation, with some of the countries highest levels of deprivation, and rural populations with Northumberland having some of the most sparsely populated areas of England.

NTW NHS Trust provides CAMH services to Newcastle and Northumberland, with adolescent services being provided to Gateshead, Sunderland and South Tyneside; CAMH services for North Tyneside are provided through Northumbria Health care Trust. Learning Disabilities services for CAMHS are provided by NTW to all areas.

The Trust also provides CAMH services at a Regional level (NTW Fleming Nuffield Unit, Young People's Unit) and a National level (NTW Roycroft (forensic services), NTW Northgate, and Prudhoe; CAMHS Learning Disabilities). The Trust operates from six main sites with a further hundred satellite sites covering a geographical area of approximately 3.500 square miles.

The Trust places a strong emphasis on effective working with their partners to provide consistently good services at a personal, team, operational and strategic level.

The key partners are identified as :

- Service users and carers
- The public, including the Patient and Public Involvement Forums Our staff
- Primary care Trusts and other commissioners
- The strategic Health Authority
- Other NHS providers
- Local Authorities
- Universities
- Voluntary Organisations
- Other statutory agencies
- Independent sector providers ¹

¹ Source: NTW Service Development Plan 2006/7-2010/11

PART1
About this workforce plan

1.1. This workforce plan has been drawn up by the workforce planning team, whose core members are:

Derek Henderson	Service Manager, Children and Young People's Forensic services
Clare Williams	Service Development Officer, Children and Young People's Services
Jane Claxton	Service Manager, Tier 4 In-patients
Jan Cole	Service Manager, Tier 3
Angela Robinson	Divisional Manager, Children and Young People's Services

In addition to the core members there is a wider planning group that meets regularly and includes other service managers, as well as representation of Human Resources, Nursing, Allied Health Professionals and Training and Development.

1.2. The plan covers the period 2007-2012 (in keeping with the Trust workforce strategy) for the geographical service area covered by NTW. Services provided across the NTW footprint include regional and national, as well as local provision.

1.3. This document refers to the workforce employed by NWT, working in the Children and Young People's Service (CYPS). The CYPS represents what is known nationally as a specialist child and adolescent mental health service (CAMHS). References to CAMHS are made within the following commonly used framework.

Tier 1 (Universal Services)

Services that promote mental health and emotional wellbeing for all children and young people, are able to identify problems early in their development, support the needs of children with mild early stage problems. Service Providers: schools, children's services, GP's, health visitors, school nurses

Tier 2

Services that;

- Work with universal service providers to promote mental health and emotional wellbeing and identify and address problems early in their development through training, consultation and support;
- Support children and young people with moderately severe problems through community based and integrated children's provision e.g. extended schools, children's centres

Tier 3

Services supporting children and young people with severe and complex problems that require input from a multidisciplinary team of child and adolescent mental health specialists.

Tier 4

Services supporting children and young people with very serious problems that require specialist treatment that may include inpatient and secure services

1.4.1 This plan addresses the recruitment and retention of staff in specialist CAMHS (Tiers 3 and 4) and includes primary mental health workers (PMHW).

1.4.2 The plan also covers the education and training, as it relates to Children and Young People's Services, of staff working in specialist services (Tiers 3 and 4, including PMHWs).

1.5. This workforce plan is underpinned by national and local policy and directives:

1.5.1 National policy and guidance

Department of Health (2004) *National Standards, Local Action Health and Social Care Standards and Planning Framework 2005/06–2007/08*²

This document sets out the framework for all National Health Service (NHS) organisations and social service authorities to use in planning over the next financial three years. It looks to Primary Care Trusts (PCTs) and Local Authorities (LAs) to lead community partnership by even closer joint working to take forward the NHS Improvement Plan. Building on joint work on Local Strategic Partnerships (LSPs), they will need to work in partnership with other NHS organisations in preparing Local Delivery Plans (LDPs) for the period 2005/06 to 2007/08.

Specifically, meeting the requirements set out under *Local Target Setting*, the workforce planning group will ensure this plan:

- is in line with population needs;
- addresses local service gaps;
- delivers equity;
- is evidence-based;
- is developed in partnership with other NHS bodies and LAs; and
- offers value for money.

CSIP/NIMHE (2007) *Mental Health: New Ways of Working for Everyone*³

Essentially, this work, along with the Creating Capable Teams Approach, will help organisations, providers and commissioners, plus service user and carer groups, to engage with clinicians and other practitioners at a local level in reviewing current working practices, in thinking about how roles can be extended and in considering how new people can be brought into the workforce through new roles.

The outcome we should be seeking is the creation of capable, multidisciplinary teams that are focused clearly on meeting the needs of service users and carers by:

- supporting service users towards recovery and self-management, where possible, with the right level and type of worker with the appropriate competences and skills;
- having specialist mental health professionals to support the voluntary sector and primary care by providing assessment, treatment and the care navigator function for those with more complex problems; and
- making the best use of resources.

NWW should be an explicit strategy and direction for the whole of the mental health workforce. (pages 8-9)

Implications for the workforce planning team include consideration of:

² <http://www.dh.gov.uk/assetRoot/04/08/60/58/04086058.pdf>

³ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074490

- new roles
- role re-design - clear role definition, staff working according to their expertise/specialism, roles designed around skills required
- creating capable teams.

Department of Health (2004) Core Document, National Service Framework for Children, Young People and Maternity Services⁴

The main policy driver for CAMHS and children's health, this document states:

Implementation of the NSF is dependent on having an adequately resourced, trained and motivated workforce, which means having the right numbers in the right place with the right skills. Workforce capacity is currently a significant issue in children's services across health and social care, with shortages and problems with retention being experienced in many of the staff groups providing services to children. These pressures will need to continue to be addressed both centrally, through national workforce planning processes, and locally, through the development of all-agency workforce, recruitment and retention strategies, based on a proper understanding of the needs of local populations, starting with the child and family rather than professional groups, and matching the skills and deployment of staff to the particular needs of each area.

These staffing constraints, along with the need to respond flexibly to rapidly changing demands on services, mean that there is a continuing requirement to look at workforce modernisation and role redesign. A range of new, and amended, roles need to be developed, with staff working in new ways across agencies and within multi-disciplinary teams. (Page 17)

The workforce planning group will address workforce requirements by referring to local evidence of need and demand, correlating this information with evidence of what works.

Department for Education and Skills (2004) Every Child Matters Children's Workforce Strategy⁵

Our vision now is of a world-class children's workforce which:

- strives to achieve the best possible outcomes for all children and young people and reduce inequalities between the most disadvantaged and the rest;
 - is competent, confident and safe to work with children and young people;
 - people aspire to be part of and want to remain in – where they can develop their skills and build satisfying and rewarding careers;
- and
- parents, children and young people trust and respect. (Page 6)

We will:

- support the development of local workforce strategies;
 - strengthen safeguarding and improve outcomes for looked after children;
 - tackle the key strategic challenges. To do this we set out action to:
 - improve recruitment, retention and the quality of practice;
 - bring services together around the needs of children, young people and families;
- and
- strengthen leadership, management and supervision. (Page 17)

The workforce planning group will ensure that this Child and Family Services workforce plan is fully compatible with the children's services workforce planning and development.

⁴ <http://www.dh.gov.uk/assetRoot/04/09/05/66/04090566.pdf>

⁵ <http://www.everychildmatters.gov.uk/files/7D2DD37746721CC8E5F81323AD449DD7.pdf>

Department of Health, (2008) *Valuing People Now. From progress to transformation*⁶

A number of initiatives are helping to change the social care workforce. These include:

- the Secretary of State for Health commissioning work to improve the status of social care – including the development of a skills academy to focus on leadership, management and commissioning;
- the national social care recruitment campaign;
- DH establishing an Adult Social Care Workforce Strategy Board to take forward the Status of Social Care Review;
- Skills for Care taking responsibility for developing the Learning Disability Awards Framework (LDAF) into a new Learning Disability Qualification (LDQ), which is an important tool in improving staff practice for front-line staff; 38,000 staff have achieved the LDAF induction/foundation, but take-up of wider LDAF units has been disappointing for such an excellent qualification.

- Education and training for health professionals working in the learning disability field – nurses, psychologists, psychiatrists, speech and language therapists – faces similar challenges. New guidance from the Chief Nursing Officer will make recommendations about the future of learning disability nurse training. Health professionals in general (health visitors, midwives, GPs and others) also need an understanding of how to make their services accessible to people with learning disabilities. (page 84)

The workforce planning group will investigate the potential for introducing the LDAF and LDQ into areas of CAMHS.

The Children's Commissioner for England, (2007) *Pushed into the Shadows – young people's experience of adult mental health facilities.*⁷

All staff should treat patients with respect, whatever their age. It is of vital importance that staff working with children and young people are appropriately trained and can support the young people throughout their admission and planning for discharge. This is highlighted by the Mental Health Act Commission report which notes:

“If the ward is designated to admit young patients between the ages of 16 and 18 years on a regular basis, ensure at least some of the ward staff are provided with specialist training in the care of adolescents with mental health needs.”

Recommendation 10

All young people admitted to adult wards should have regular access to a named keyworker/lead professional who has received training in working with young people and who has responsibility for liaising with CAMHS and ensuring that young people's care is properly planned and they are fully supported throughout their stay. (pages 96-97)

The workforce planning group will ensure that all staff involved in the care of young people in in-patient units are appropriately trained and skilled.

1.5.2 Local Policy

Based on a series of stakeholder events the Trust has developed a vision to assist in the development of strategic priorities that form the essence of its function:

⁶ http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_081014

⁷ <http://www.teespublichealth.nhs.uk/document.aspx?id=4721&siteID=1012>

- Delivering clinical excellence-providing high quality care and treatment, safe services which are comparable to the best in the country and with national and international best practice
- The preferred provider of specialist services for local people with a mental illness of disability
- Exemplary in the involvement of service users and carers, staff and partner organisations in the planning and delivery of our services
- Achieving and performing better than national and local standards and targets. In addition we will challenge ourselves and the commissioning partners to identify and meet meaningful targets that demonstrate the delivery of the vision for the NHS North East people with mental illness and disabilities
- A centre of excellence in research and development, which uses proven findings to improve our services. We will give further consideration to applying for "Teaching Trust status"
- The employer of choice in the NHS North East
- Financially robust
- Providing care in environments which are safe, which promote well being, rehabilitation and recovery, and which meet or exceed all nationally accepted standards
- An influential organisation in advocating and promoting well-being and social inclusion at a local, regional and national level

In providing care and treatment, and in the management of the Trust, we will operate with the following values:

- We will place users and carers at the centre of everything we do
- We will treat users and carers with dignity and respect
- We will support and show respect to our staff; we will encourage their personal and professional development; we will acknowledge their expertise and professionalism; and we will value the role they fulfil
- We will always look to do things better-encouraging and acknowledging improvement and innovation
- We will promote effective team and partnership working
- We will be honest, show trust, have integrity and be open and transparent in our work
- We will embrace diversity
- We will listen to the views of others

The following statement is drawn from NTW's 2007/8-2011 service development priorities for child & adolescent mental health services and provides the strategic context for this document.

- The top strategic direction for CAMH services in addition to the clinical service objectives applicable to all areas are:
- Progress that current planning underway to develop a new integrated service model and build new accommodation for mental health and learning disability services for young people
- Develop a new adolescent learning disability medium secure unit with capital funding provided by the national Commissioning Group
- Develop services to achieve NHS and National Service Framework of Children, Young People and Maternity Service targets and aspirations
- Improve the commissioning of services and their development by working with the national and regional commissioners on their reviews of children's services
- Continue to work closely and develop our partnership in the five Children's Trusts in our area

Implications for the workforce planning team include consideration of:

- New roles

- Role re-design - clear role definition, staff working according to their expertise/specialism, roles designed around skills required.

1.6. This plan is also linked to NTW Workforce Strategy 2007-2012. *Excellent Staff, Excellent Care* is designed to support and facilitate the achievement of the Trust vision and strategic goals. The strategy comprises a workforce vision and a set of aims that are congruent, integrated and consistent with the Trust's Strategic Plan.

The Workforce Vision is to become:

- the employer of choice in the NHS in the North East
- an employer that makes the best use of all the talents of the workforce to provide excellence in patient care

Our Workforce Aims

- Shape our Culture and Values
- Implement the Staff charter
- Initiate the Ten High HR Impact Changes and the link with other strategies
- Develop HR Practices and Systems
- Become a Model Employer
- Work in Partnership with Trades Unions and Staff Side organisations
- Develop people management skills; clinical, managerial and professional leadership and effective team working
- Ensure appraisal (Joint Development Review) and robust implementation of the Knowledge and Skills Framework
- Develop Recruitment and Retention
- Realise the Benefits of Pay Modernisation
- Improve Workforce Design and Planning
- Support the Management of Organisational Change
- Facilitate new ways of working across professional boundaries and creating new roles to improve services
- Reduce Sickness Absence
- Improve Management of overtime, temporary and agency staff
- Ensure Equality and Diversity
- Support Social Inclusion
- Improve Communications and Staff Involvement
- Improve Information Systems to ensure Productivity and Assurance

**The local labour market
Regional, national and international labour markets.
Local population profile and mental health need of
children and young people
The current specialist children and young people's
services, service description and staffing**

IMPORTANT NOTES:

- THE FOLLOWING TWO SECTIONS CONTAIN GRAPHS THAT NEED TO BE VIEWED IN COLOUR AND IF A COLOUR PAPER COPY IS NOT AVAILABLE IT WILL BE ADVISABLE TO VIEW ON A COMPUTER SCREEN.
- THE SELF ASSESSMENT MATRIX AND THE NATIONAL CAMHS MAPPING ARE THE TWO PRIMARY SOURCES OF NUMERICAL INFORMATION WHEN BENCHMARKING SERVICES. BOTH DATASETS ARE GROWING IN RELIABILITY BUT CARE SHOULD BE TAKEN IN DRAWING FIRM CONCLUSIONS FROM THE DATA.

2.1. The local and regional labour market.

The North East is the poorest of the English regions with GVA per head⁸ at 20% below the UK average. This under-performance of the North East is the result of a complex interaction of economic, social and geographic factors. Over recent years the regional economic base has changed from one based primarily on traditional industries, and diversified into new areas such as microelectronics, the offshore industry, biotechnology and automotives. There has also been significant growth in the service sectors, public administration, education and health.

Despite this diversification the North East is still dealing with economic, social and structural consequences of its past dependence on the traditional industries which is reflected in its poor performance across a range of indicators, including the key drivers of productivity – employment, education and skills, investment, innovation, enterprise and competition. The North East expects to see an increasing proportion of older people and a decreasing proportion of younger people.

Labour supply consists of people who are employed, as well as those people defined as unemployed or economically inactive, who can be considered to be potential labour supply. Most labour supply data comes from the Annual Population Survey (APS).⁹

As APS estimates are based on samples, they are subject to sampling variability. This means that if another sample for the same period were drawn, a different estimate might be produced. In general, the larger the number of people in a sample, the smaller the variation between estimates. Estimates for smaller areas such as local authorities are therefore less reliable than those for larger areas such as regions and it is more accurate to look at figures related to regions and add the local nuances e.g. the difficulties in recruiting locally when competing with a national or regional unit.

⁸ Gross Value Added (GVA) per head is an internationally accepted measure for comparative living standards and for the broadly defined 'productivity' on which living standards depend.

⁹ The APS is the largest regular household survey in the United Kingdom, including data from the Labour Force Survey (LFS), plus further samples from England, Wales and Scotland. The survey includes data from a sample of around 256,000 people aged 16 and over.

Employment rates in the North East are below the national average with wage levels also being low. The unemployment rates of economically active adults are also high compared to the England average.¹⁰

Figure 1 Employment rates of working age adults in the North East

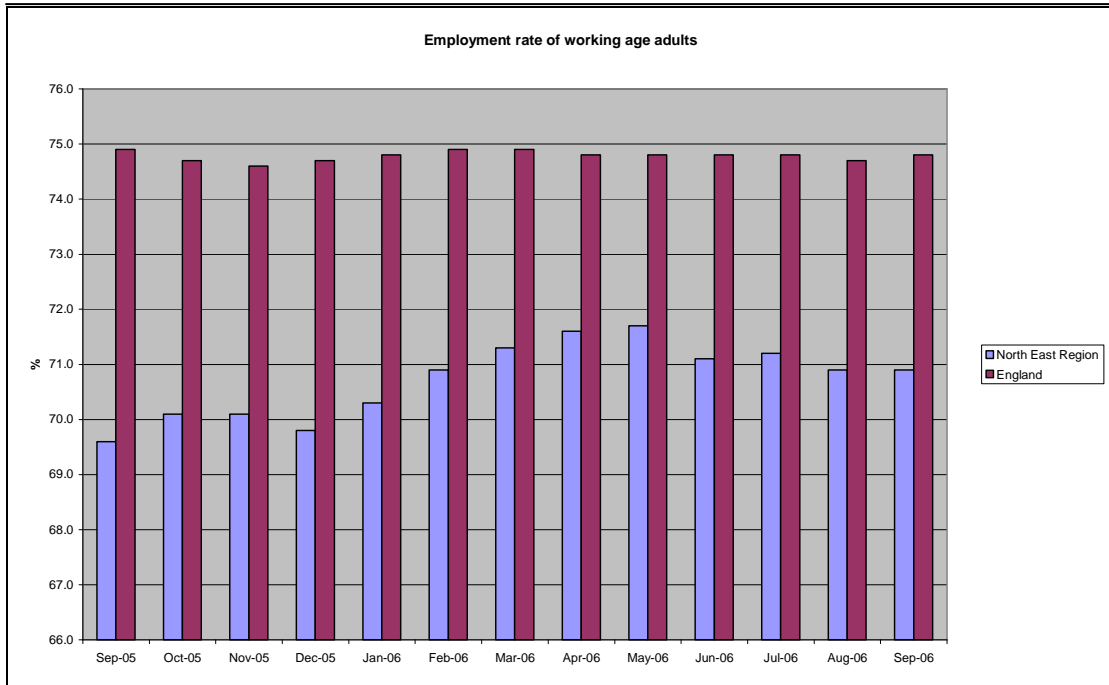
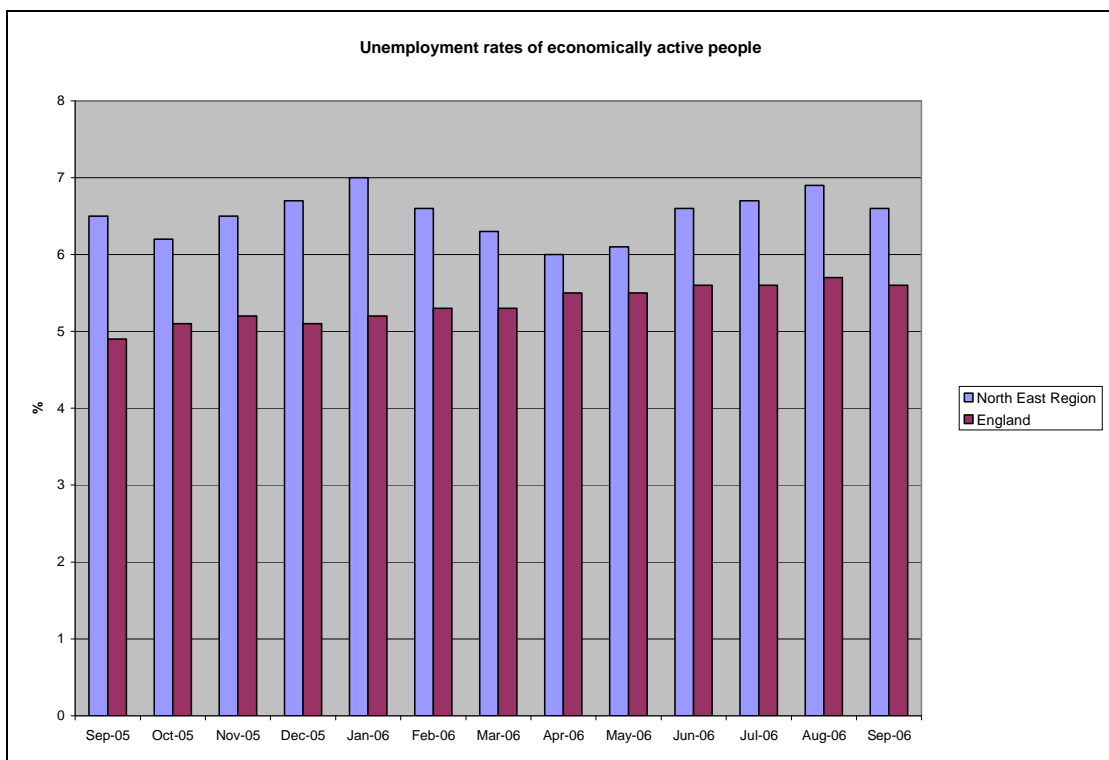


Figure 2 Unemployment rates of working age adults in the North East

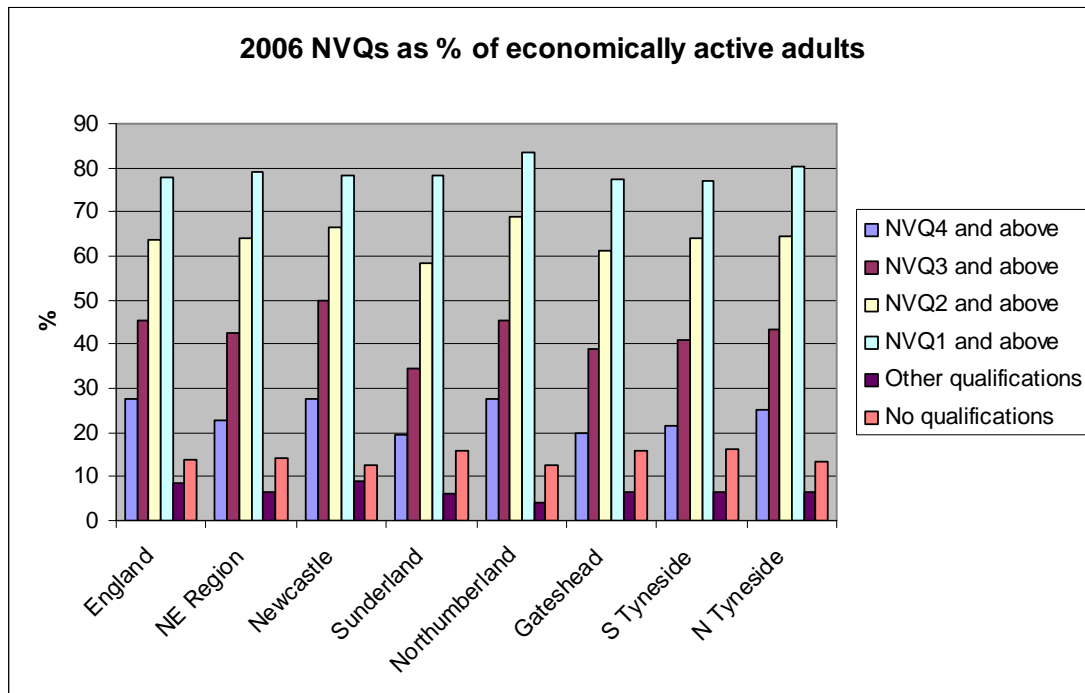


¹⁰ <http://www.dtistats.net/reppsa/200612/tables.htm>

Patterns of change for the region are generally similar to those for the whole of England although an overall decline is expected for numbers of women. Declines are projected in the younger age categories and for prime age workers (35-44) with the fastest growth in the population being in the 60+ age group. The labour force as a whole is projected to grow by just over 2% by 2014. The biggest increases are expected for older workers (45+), with significant declines for prime aged (35-44) workers of both genders.¹¹

Of the economically active adults South Tyneside has the highest proportion of people without a qualification and the work force is relatively unskilled and or mismatched to the job availability. Newcastle and Northumberland are able to attract a larger proportion of people with higher qualifications, which is reflective of England as a whole and above the average for the region. The planning group identified Northumberland as the area in which professional people would prefer to live and noted that with very good transport links across the NTW footprint, many of those living in the more desirable areas may however be travelling into urban centres to work.

Figure 3 Levels of educational attainment across the North East labour market, compared with England as a whole



2.2. The national and international labour markets.

National and international labour markets.

Major concerns for the national workforce are around the training, recruitment and retention of doctors and nurses, although across NTW the numbers for these staff groups are higher than the national average (see Figures ..). Many of the issues raised around recruitment and retention of doctors and nurses apply equally to other professions, however.

¹¹ A. Green, D. Owen and R. 2006 *Regional Profiles of the Workforce by Ethnicity and Migrant Workers*. Learning and Skills Council.

Additionally, 2.2.3 below outlines a rationale for possibly increasing the number of social workers in NTW Children And Young People's Services, given there is a slight shortfall of these and family therapists (who often have social work background) compared with the national average (shown in Figure..).

2.2.1 Psychiatrists

Pidd (2003) offers key messages from senior house officers (SHO) about their training, reporting that they want to:

- receive good, regular supervision
- work in safe, pleasant environments
- have exposure to varied posts in training schemes, including more specialities
- work with enthusiastic, positive consultants
- see a future in do-able jobs at the end of training (page 408)

Pidd also suggests various strategies to attract students and SHOs into psychiatry:

- Getting enthusiastic young psychiatrists to promote the speciality at career fairs
- Developing promotional material targeted at graduate entrants
- Developing recruitment initiatives for those already in mental health
- Ensuring that undergraduate experiences are positive
- Identifying and nurturing interested students through to SHO posts
- Developing special study modules in psychiatry and promoting them to students
- Encouraging more pre-registration house officer posts in psychiatry (page 405)

2.2.2 Nurses

In the 1990s one in ten new nurse registrations were from overseas; by 2000-2001 this had risen to over half of all new registrants. The Royal College of Nursing (2005) has responded to this upsurge by producing good practice guidance for recruiting and employing nurses from overseas. The guidance covers recruitment, retention, continuing professional development and culturally competent practice.

The Royal College of Nursing (2004) has also produced The Future Nurse Project, in which it is made clear that the shortage of registered nurses is not just about increasing numbers entering nursing but also about understanding the exit routes out of the profession. If the number leaving, either early by retiring, exceeds the number joining, then an increase in the workforce cannot be achieved. Retention may therefore be seen as critical to future workforce levels.

The document reports there are relatively few nurses in the NHS at the end of their nursing career and that the challenge for the NHS to retain nurses comes early on in nurse careers, when the vast majority of nurses are NHS employed and form opinions about the suitability of the NHS as a workplace for later in their careers.

Sixty-four percent of nurses employed in the NHS work full-time (around 44 hours per week) and most (51%) of these work internal rotation shift patterns. In contrast 20% of nurses in general practice work full-time. The level of choice and control over working hours also varies between employment sectors. Nurses working in NHS hospitals or independent care homes are less positive about the choice they have over their hours and those who work internal rotation shift patterns particularly dissatisfied. Control over working hours and achievement of a work-life balance will be an important determinant to their choice of employment.

2.2.3 Social workers

Lindsey (2005)¹², in considering the question of multi-disciplinary CAMHS teams, notes that social workers were traditionally part of the team, bringing particular skills capabilities. She further observes that for many years there has been a lack of social workers employed in many CAMHS, because of policy decisions by Local Authorities to withdraw, in part due to resource issues, but also because of conflicting views about the social work role.

Lindsey states, “It is quite clear that there are some CAMHS settings where the contribution of social work remains essential. For example, in hospital paediatric liaison teams and in child and adolescent in-patient units, social work is integral to the service for the users. This includes, but by no means exclusively, a child protection role. In making recommendations for the development of out-of-hours and emergency services, the same considerations about social workers apply. Clearly, the first point of contact for a disturbed young person is frequently emergency duty social workers, who carry out the initial assessment and who need to be appropriately trained to do so.” Two specific areas in which Lindsey regards social workers as pivotal in effective service delivery are given below.

Box 1 Role of social workers in services for children and young people with learning disabilities (Lindsey, 2005)

There has been a dearth of services for children with learning disabilities, despite the fact that 40% of them have a mental health disorder and that the rate is higher amongst those with a severe learning disability. The CAMHS Standard, together with Standard 8 — Disabled Children and Young People and Those with Complex Care Needs, made recommendations that all disabled children, including the learning disabled, should be able to access the range of mental health services they require. This is one of the greatest challenges that the implementation of the NSF creates, since it requires the creation of a workforce that is capable of working with children and their families, who also have the skills and understanding to work with complex, severe and multiple disabilities. In the short term, this is going to need a high level of cooperation between existing specialist services and CAMHS, with services developing in partnership with them, by using consultation, joint working and training. A key recommendation of the Disability Standard is the need for the children and families to receive co-ordinated, high quality services which promote social inclusion. Here is another example where children and families will benefit.

Box 2 Role of social workers in highly specialist services (Lindsey, 2005)

Highly specialist CAMHS (Tier 4) should consist of a network of out- and day-patient, assertive outreach and in-patient services for young people requiring highly specialised provision. The needs of children and young people with severe, challenging and complex problems are best met in each locality by a network of care. This recognises that all agencies but particularly health, social care, youth justice and education, face situations with young people that require collaborative working of a highly specialised nature. This may be provided in residential care and education settings; in secure units and young offenders' institutions; in intensive community settings, for example therapeutic fostering. In these settings, social workers require a sophisticated level of mental health expertise and CAMHS need to be in a position to offer consultation and advice from health, social care and education services working together, since what is often the case for these families is that they have to relate to a myriad of uncoordinated services.

¹² Lindsey, C., (2005) Some Implications of the Children's National Service Framework for Social Work Practice With Regard to Child Mental Health. *Journal of Social Work Practice*, vol.19, 2005, p.225-234

Walker (2005)¹³ suggests additionally that social workers are essential members of the CAMHS multidisciplinary team specifically in the three spheres of cultural competence, social inclusion and young people's participation.

Box 3 Role of social workers in cultural competence (Walker, 2005)

One area where social workers can claim expertise and a strong value base is that of social justice and anti-discriminatory practice. This is what marks out the difference with other professions seeking to practise as PMHWs or in other CAMHS roles. One way of actualising these principles is in the practice of cultural competence. Too little attention is being paid to the needs of black, other ethnic minority, and refugee and asylum seeking children and young people within the organisational and policy changes being made to CAMHS. Social workers in CAMHS have the opportunity to demonstrate skills and knowledge in this area by defining cultural competence in their understanding of the mental health needs of children in an ethnically diverse and culturally rich society.

Box 4 Role of social workers in social inclusion (Walker, 2005)

The unique psychosocial perspective of social work offers a vast reservoir of knowledge and skills to bring to bear on the problems of socially excluded children and families. A depressed black lone parent for example could be seen in deficit pathological terms with poor early attachment requiring a 'parental' figure to explore repressed or ambivalent feelings. A whole person approach however would perceive her as a survivor with resilience and positive characteristics despite a racist infrastructure, within which she can be linked up with others in similar circumstances to learn collective ways of supporting and changing their circumstances. The outcome of being more emotionally available to her child is the same but the process is much more empowering.

Box 5 Role of social workers in participation (Walker, 2005)

Practitioners have built up a repertoire of therapeutic methods in working with children and young people, engaging with them in areas of great sensitivity such as bereavement, parental separation, or sexual abuse. The same repertoire of research techniques is yet to be developed to ensure that children and young people are being given the best possible chance of contributing to service evaluation. By facilitating this, social workers in CAMHS can help build a children's rights perspective into their practice. Evidence of children's desire to be part of therapy (Smith et al., 1996; Strickland Clark et al., 2000; Walker, 2001a) suggests that children's reactions to therapy can be influenced by their attachment style. In families where there are insecure attachments for example, children can feel constrained to speak more freely because of fears of what the consequences might be and the discomfort in exposing painful or difficult feelings. Ways to engage such children have been developed and could be adapted by social workers engaged in CAMHS research.

¹³ Walker, S., (2005) Releasing Potential — The Future of Social Work and CAMHS. *Journal of Social Work Practice*, vol.19, 2005, p.235-250

2.2.4 Attracting people to work in the NHS

Arnold et al (2003) researched the reasons why people join, stay and leave the NHS.

They conclude that:

- The best aspects of working in the NHS are working with patients, job security and availability, a good pension, task variety, team working and learning were also mentioned.
- Understaffing and associated pressures at work were the strongest barriers to working for the NHS. Issues to do with the convenience, flexibility, length of work hours and low pay were also mentioned.
- Working for the NHS as a nurse or associated health professional (AHP) was thought to be a rewarding career.
- The starting pay levels for nursing, physiotherapy and radiography are often underestimated.
- Qualified staff currently working outside the NHS were unlikely to return. Agency staff are slightly more likely to do so, but are still not enthusiastic.
- Unqualified people (students, school pupils, general public) were positive about the NHS.

The report recommends the following:

- Use realistic job previews.
- Emphasise job security and availability, pension provision and career progression prospects in recruitment publicity.
- Further publicise the starting pay levels for qualified staff.
- Further opportunities for senior staff to retain direct patient contact should be made available and publicised.
- Offer all staff (not just those with children) some control over their work hours.
- Effort should be concentrated on attracting new recruits, more than existing qualified staff working outside the NHS.

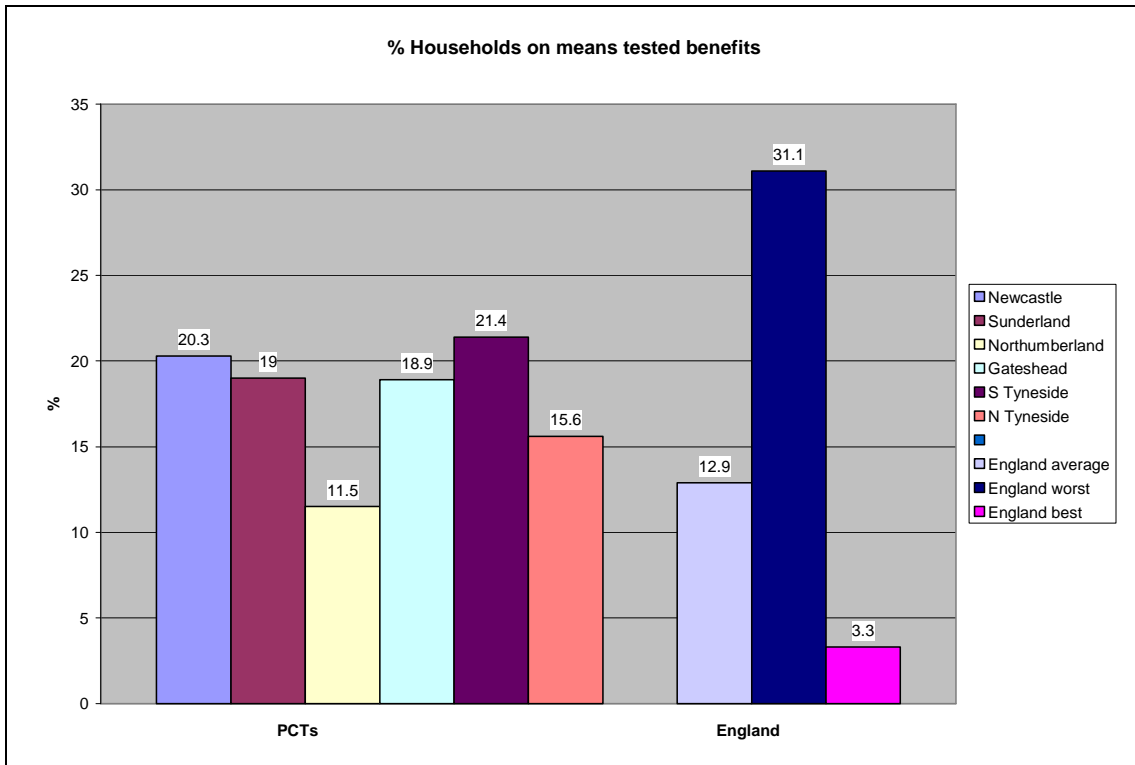
2.3 Local population profile and mental health need of children and young people.

2.3.1 Deprivation/proxy indicators of mental health need

The Figures below provide a snapshot of the deprivation across the NTW footprint, in order to gain an appreciation of the variations of mental health need that might be expected. From a workforce perspective this may inform service location and concentrations of staff, therapeutic skills and training. It is not intended to replace a population needs assessment.¹⁴

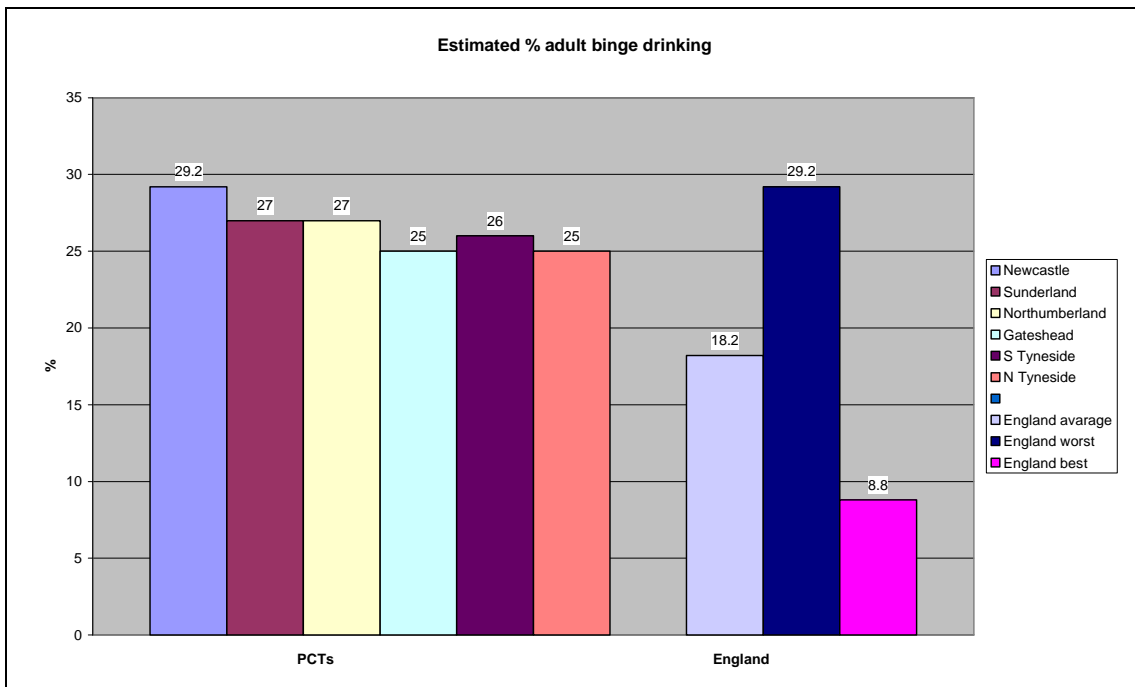
¹⁴Health Profiles provide a snapshot of health for each local council in England using key health indicators which enables comparison locally, regionally and nationally as well as over time. They are designed to help local councils and the NHS decide where to target resources to tackle health inequalities in their local area. Health Profiles are quality assured by APHO, and have clear and explicit methodology, which should eliminate the need for local production of identical indicators. <http://www.communityhealthprofiles.info/>

Figure 4 Households on means tested benefits across NTW, compared with England as a whole



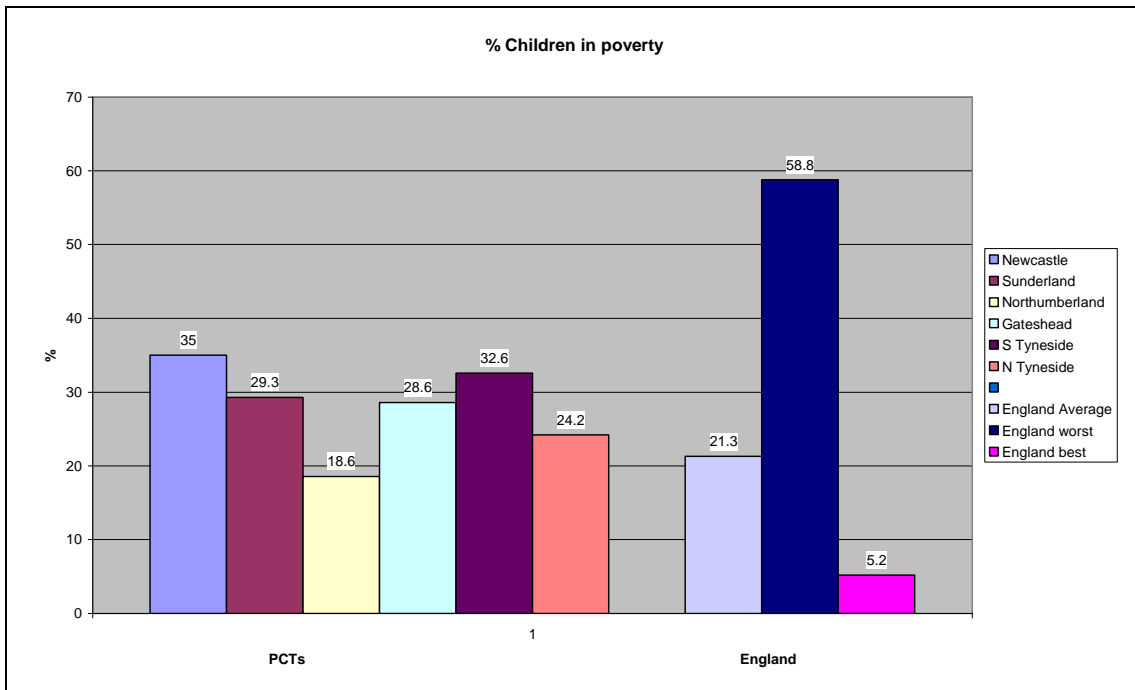
With the exception of Northumberland, all the areas within NTW have higher than average numbers of people on means tested benefits, with Sunderland the highest.

Figure 5 Adult binge drinking across NTW, compared with England as a whole



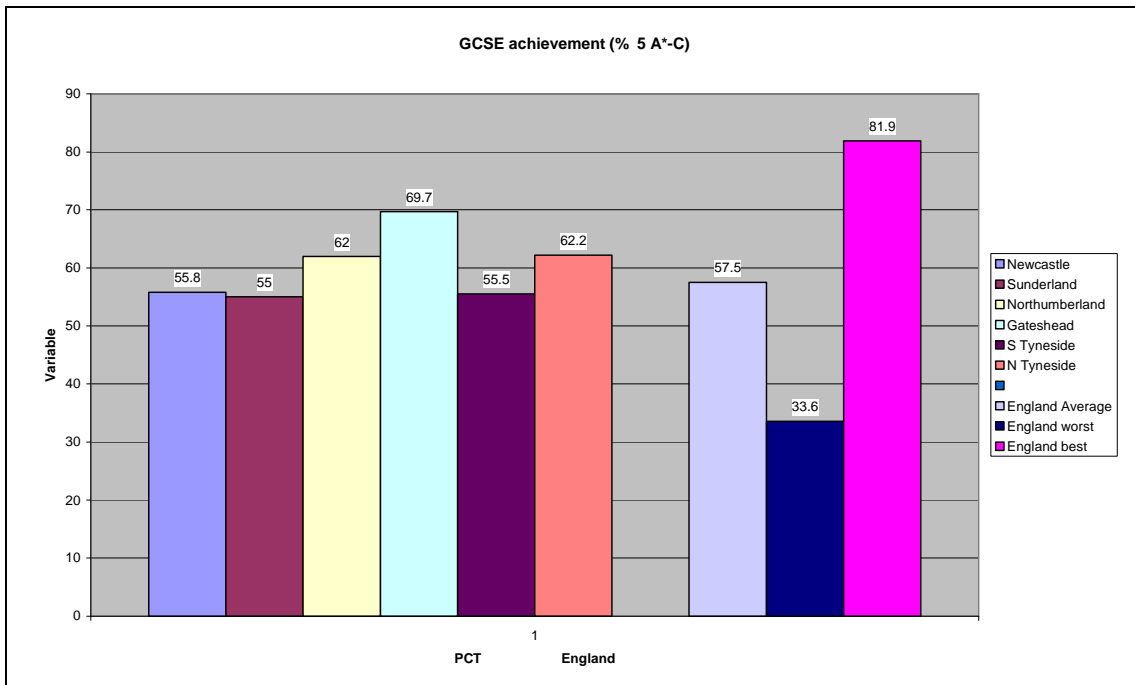
All areas have high levels of adult binge drinking, with Newcastle on a level with England's worst.

Figure 6 Children in poverty across NTW, compared with England as a whole



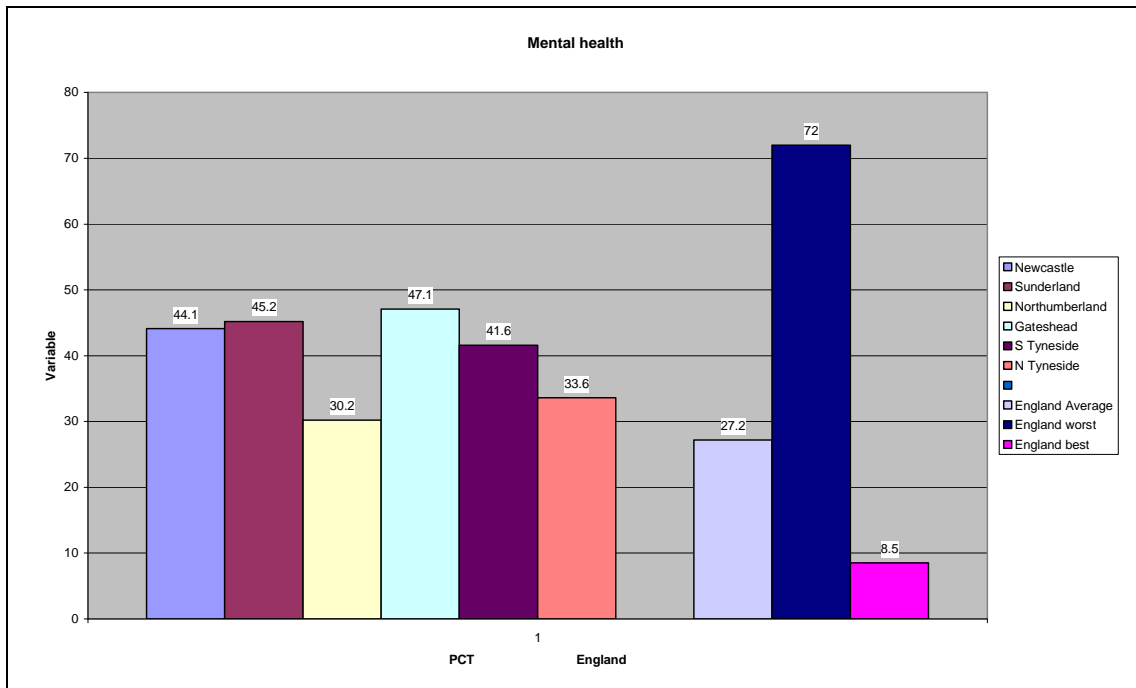
Excepting Northumberland, all areas have higher than average levels of children in poverty (NB this graph reads counter-intuitively).

Figure 7 GCSE achievement across NTW, compared with England as a whole



All areas are near or above the England average for GCSE achievement.

Figure 8 Mental health across NTW, compared with England as a whole

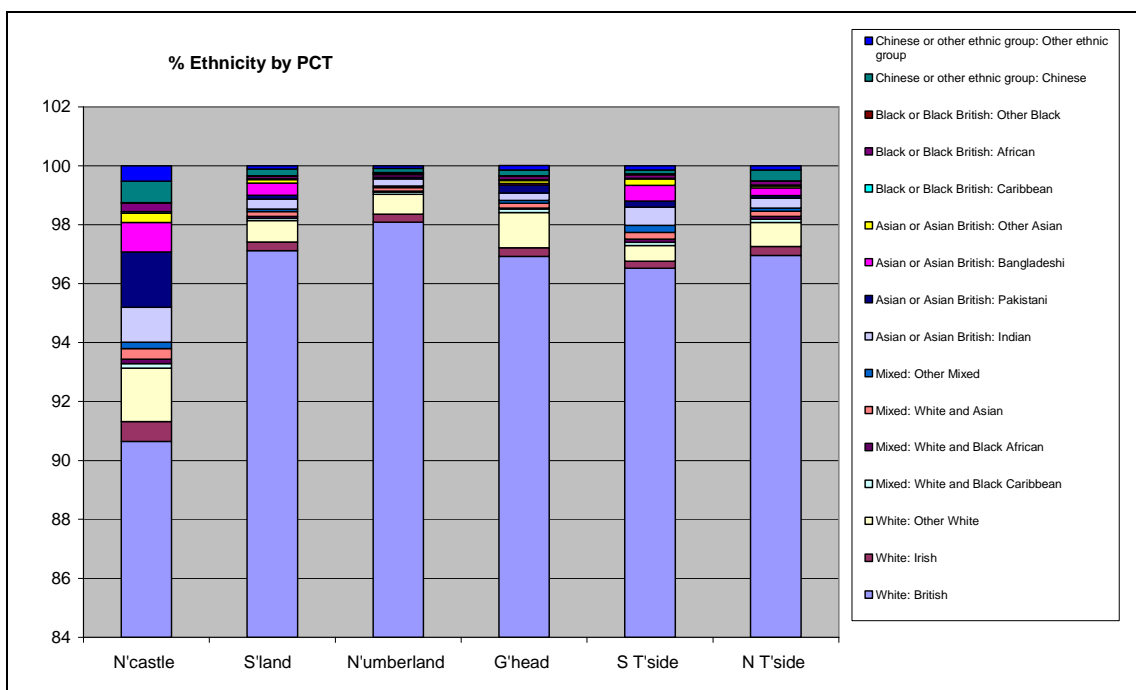


All areas show above average rates of poor mental health in the general population.

2.3.2 Diversity

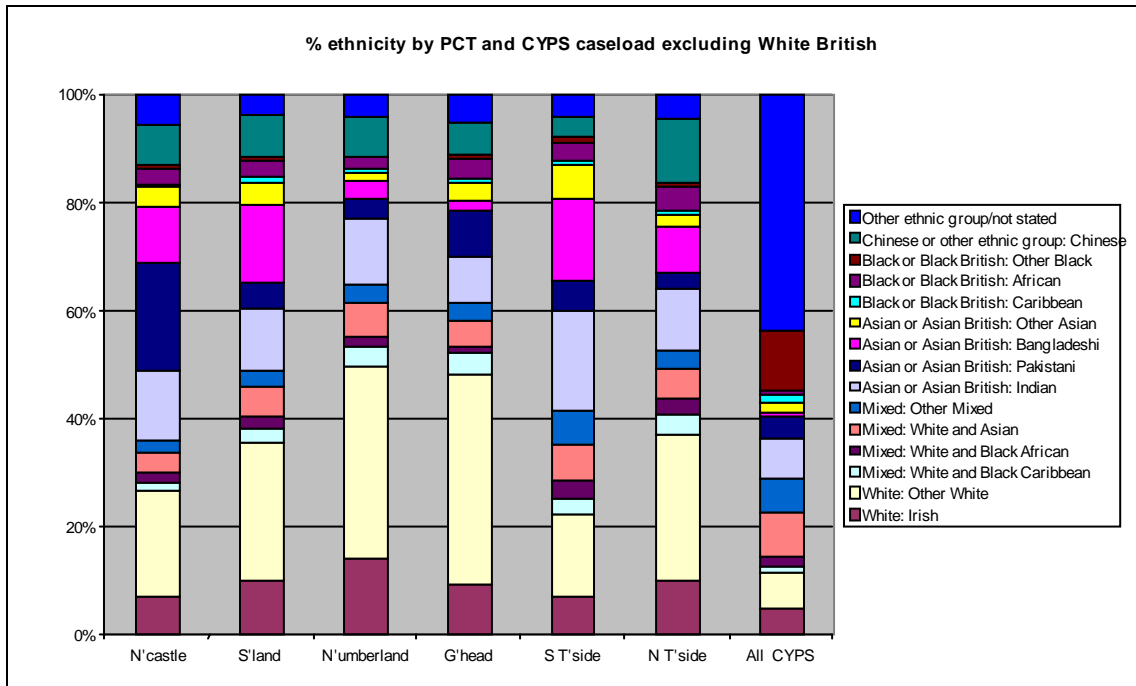
The figures below show the ethnic diversity across the NTW footprint, enabling comparisons between PCT areas and comparison between local populations and total CYPS caseload.

Figure 9 Ethnicity by PCT



This shows clearly the greater diversity in Newcastle than in other areas.

Figure 10 Ethnicity by PCT, excluding White British and including NTW CYPS caseload



The CYPS caseload shows a unexpectedly high proportion of “Other/ethnic group not stated”. This indicates problems in recording ethnicity and means a useful comparison between population and caseload cannot be made.

2.4 The current specialist children and young people’s services

2.4.1 Service description

The current service provision of specialist children and young people’s services is given in Table 1 below:

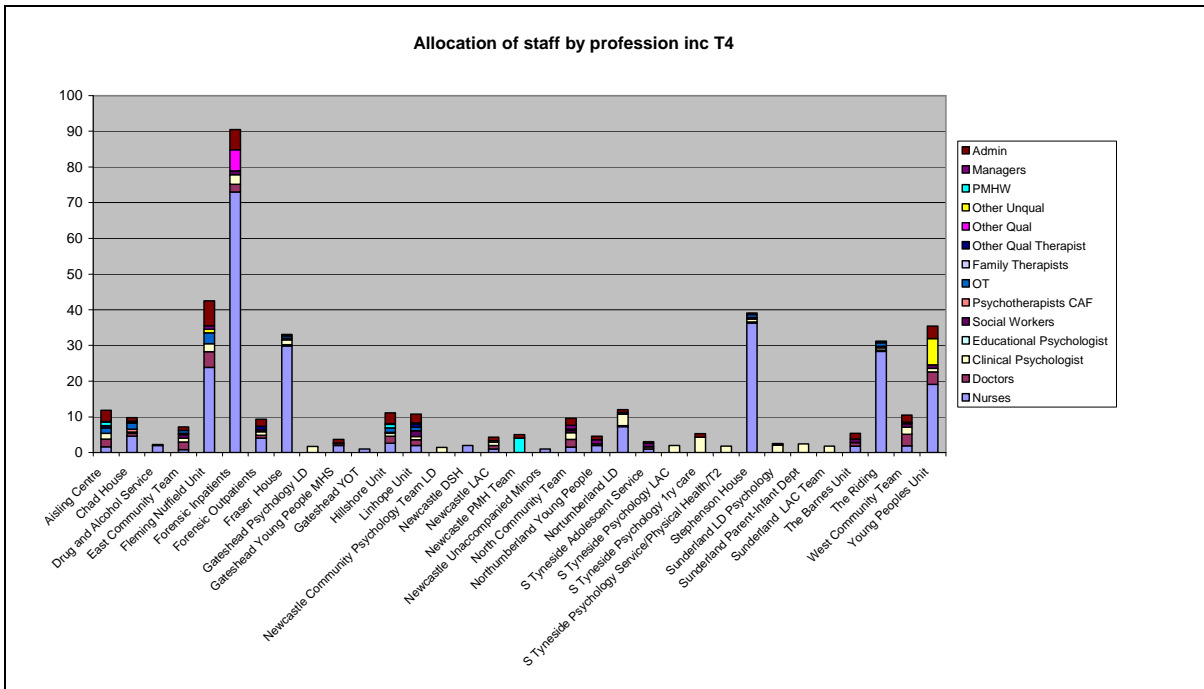
Table 1 Specialist CHILDREN AND YOUNG PEOPLE'S SERVICES provision

Geographical area covered	Name of service/team	Brief description of provision (inc tier)	Age range covered
Gateshead	1. Gateshead community LD Team (psychology) 2. Gateshead Young People's Mental Health Service 3. Gateshead Youth Offending team	1. Single disciplinary generic CAMHS team 2. Multi-disciplinary Generic Canhs Team 3. Dedicated CAMHS worker working in a non-CAMHS team	1. 0-18. 2. 16 -19 3. 13 -18
Newcastle	1. Newcastle North Locality 2. Newcastle West Locality 3. Newcastle East Locality 4. Youth Offending Team 5. Look after Children's Team 6. Deliberate Self Harm Team 7. Drug and Alcohol 8. Newcastle Community LD Team 9. Newcastle unaccompanied minors team	1. Tier 3 multidisciplinary generic CAMHS team 2. Tier 3 multidisciplinary generic CAMHS team 3. Tier 3 multidisciplinary generic CAMHS team 4. Multidisciplinary targeted CAMHS team 5. Tier 3 targeted CAMHS team 6. Tier 3 single disciplinary generic CAMHS team 7. Targeted CAMHS team 8. Multidisciplinary LD team 9. Dedicated CAMHS worker working in a non-CAMHS team	1. 0- 18 2. 0-18 3. 0-18 4. 13-18 5. 0- 18 6. 0-18 7. up to 18 8. 0-18 9. 0-18
Northumberland	1. Aisling Team 2. Chad House 3. Hillshore unit 4. Linhope Unit 5. Northumberland Young Persons team 6. Northumberland child & adolescent LD team	1. Multidisciplinary Tier 3 CAMHS team provision 2. Multidisciplinary Tier 3 CAMHS team provision 3. Multidisciplinary Tier 3 CAMHS provision 4. Multidisciplinary Tier 3 CAMHS provision 5. Targeted CAMHS team 6. Multidisciplinary generic CAMHS team	1. 0-18 2. 0-18 3. 0-18 4. 0-18 5. LAC 0-18 YP 10- 18 6. 0-18
South Tyneside	1. South Tyneside Adolescent mental health service 2. South Tyneside Clinical Psychology Looked After Children Team 3. Clinical Psychology service into physical health and Tier 2 CAMHS 4. Community LD team 5. Primary Care Clinical Psychology team	1. Multidisciplinary generic CAMHS team 2. Single disciplinary generic CAMHS team 3. Single disciplinary generic CAMHS team 4. Targeted CAMHS team 5. Single disciplinary generic CAMHS team	1. 0-19 2. 0- 19 3. 0-19 4. 0-19 5. 0-19
Sunderland	1. Clinical Psychology LAC team 2. Community nursing LD team 3. Psychology LD team 4. Barnes Unit	1. Targeted CAMHS team 2. Single disciplinary generic CAMHS team 3. Single disciplinary generic CAMHS team 4. Multidisciplinary generic CAMHS team	1. 0-19 2. 0- 19 3. 0-19 4. 0-19
Regional/national	1. Fleming Nuffield Unit 2. Young Peoples Unit 3. Roycroft Unit plus forensic out reach 4. LD Medium Secure Unit 5. Riding Unit 6. Fraser House 7. Stephenson House	1. Tier 4 CAMHS unit 2. 14-19 adolescent inpatient service 3. LD/Forensic adolescent inpatient service 4. adolescent national forensic service inpatient 5. Tier 4 CAMHS unit 6. Tier 4 CAMHS unit 7. Tier 4 Low Secure unit	1. To 14½ 2. 14½ - 19 3. 12-18 4. 12 -18 5. up to 18 6. 13 -19 7. 14 -18

2.4.2 Current staffing

The emphasis of the CAMHS workforce plan is on using existing resources more effectively. The NSF however has recommended that numbers of specialist CAMHS practitioners should be 15 WTE per 100,000 population. In order to calculate actual staffing compared with the recommended 15 per 100,000, it is necessary to be able to measure the actual population served by any team or set of teams. Due to complex configurations across the NTW footprint it is only possible to achieve this comparison for local services in Newcastle and Northumberland.

Figure 11 Allocation of the disciplinary mix across the teams – all services



This complex figure demonstrates the wide array of teams comprising the service, some of which are very small. A slightly different picture emerges when Tier 4 is taken out, as seen below.

Figure 12 Allocation of the disciplinary mix across the teams excluding Tier 4

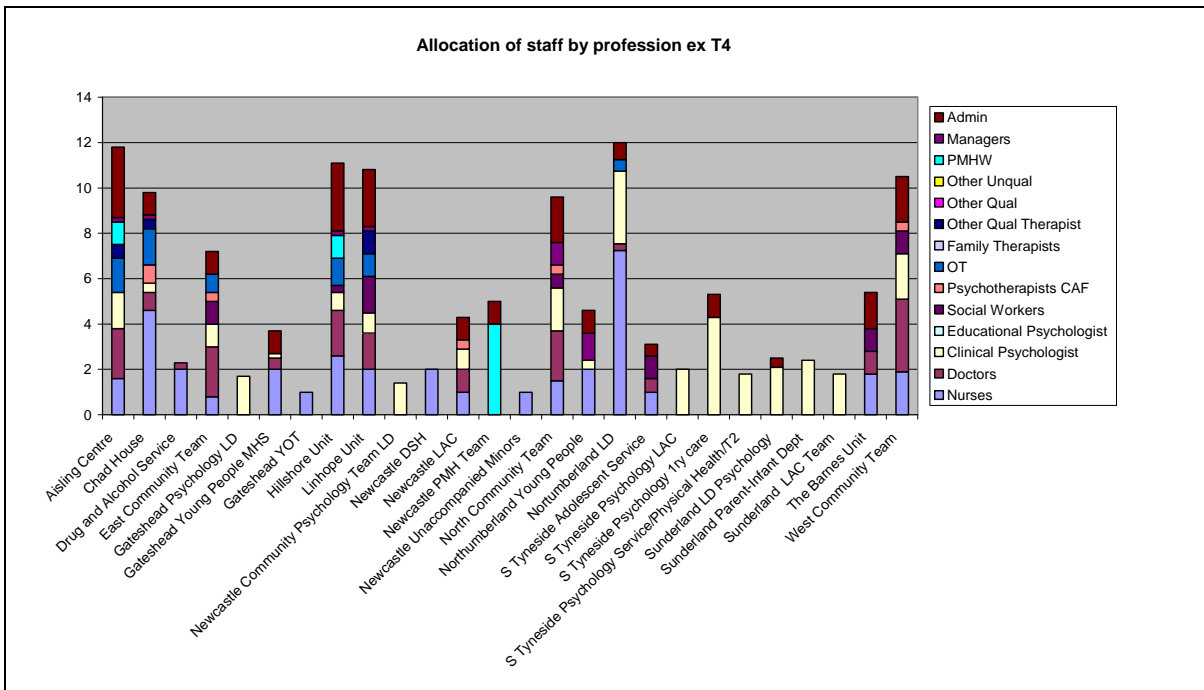
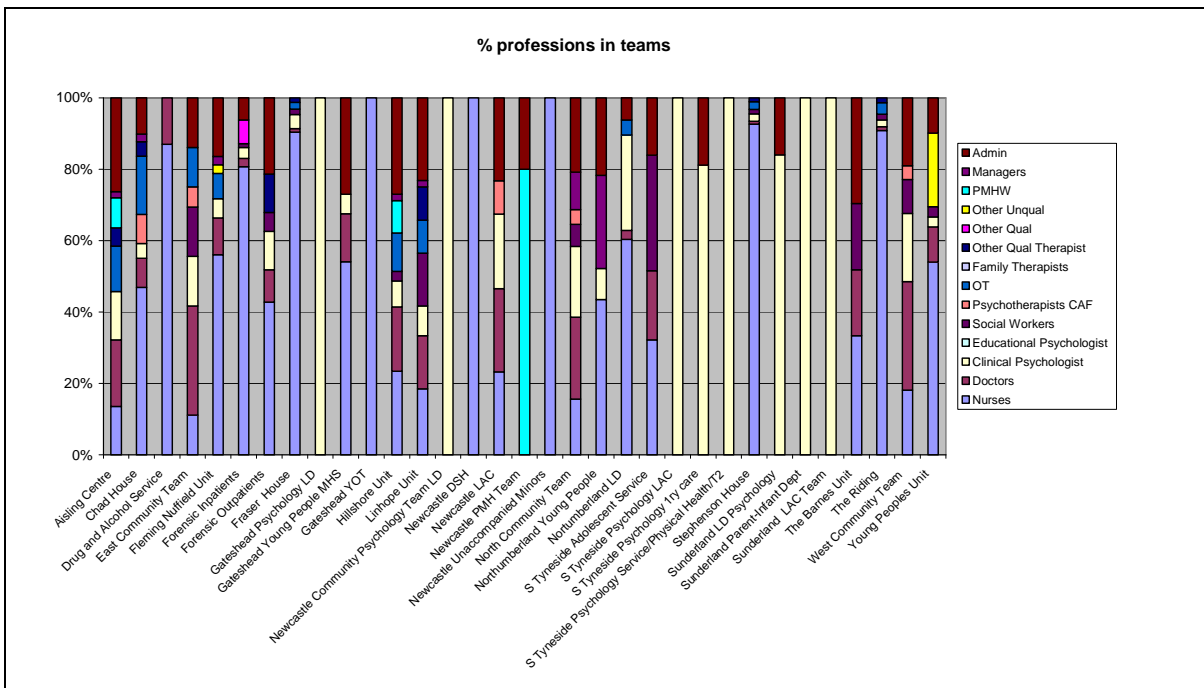
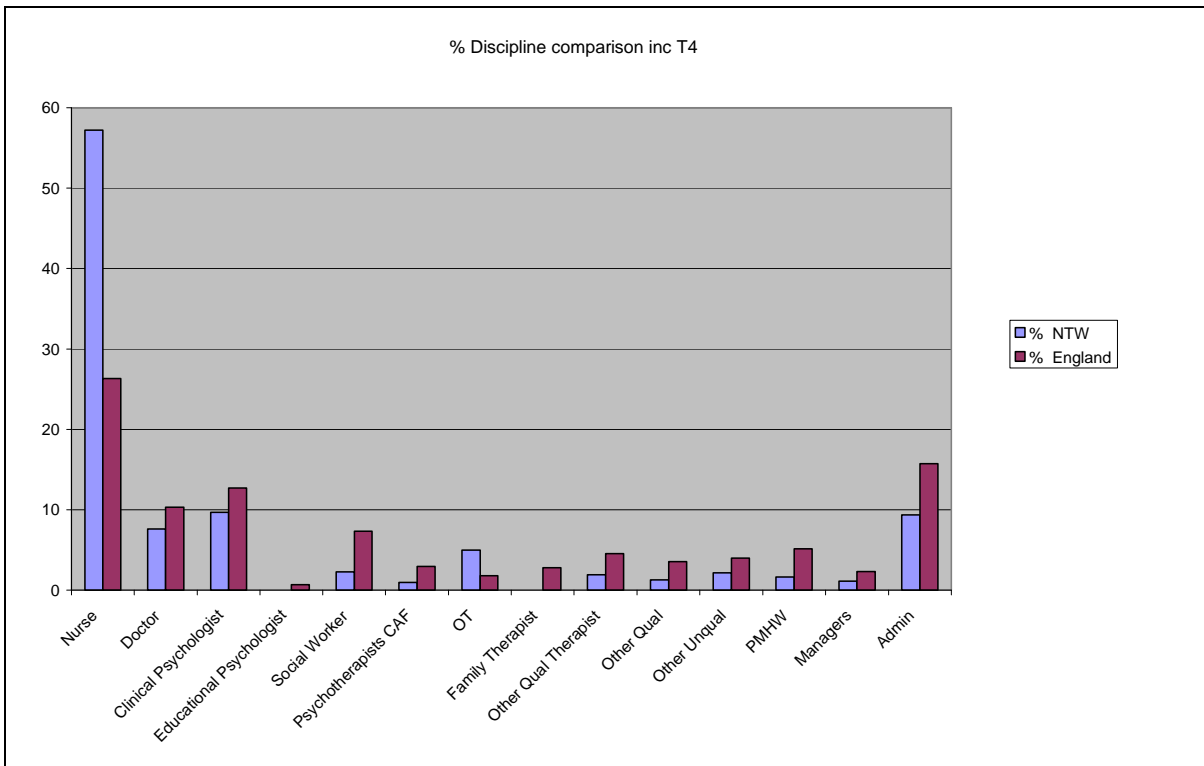


Figure 13 Percentage within each team of each profession – all teams



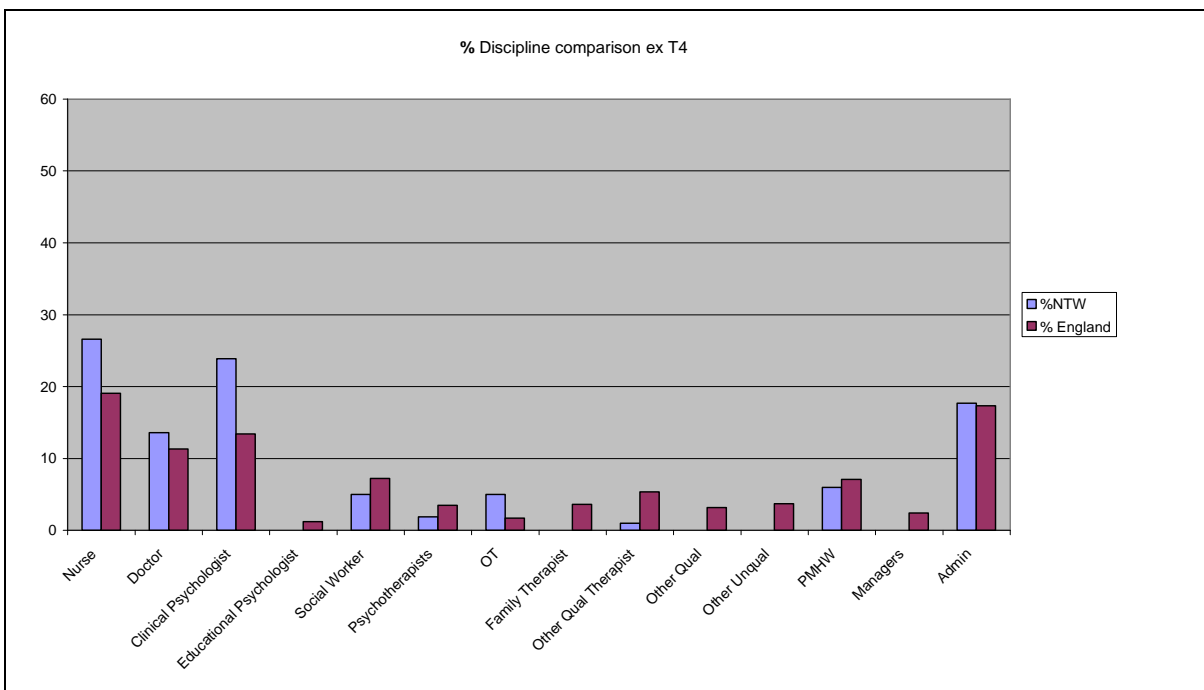
The preponderance of apparently single discipline teams in this figure can be partially explained by the fact that within multi agency teams, the Trust may only contribute one professional into the mix. Family therapists do not appear on the figure – however both social workers and nurses practise family therapy across the teams.

Figure 14 Comparison of disciplinary mix with English average including Tier 4



The figure above shows a much larger number of nursing staff than might be expected. It is possible the figures are skewed by having forensic services staff in NTW, whereas this is not common across England. The picture looks significantly different below, where Tier 4 services are taken out.

Figure 15 Comparison of disciplinary mix with English average excluding Tier 4



2.4.3 Current case mix and indicative skill mix

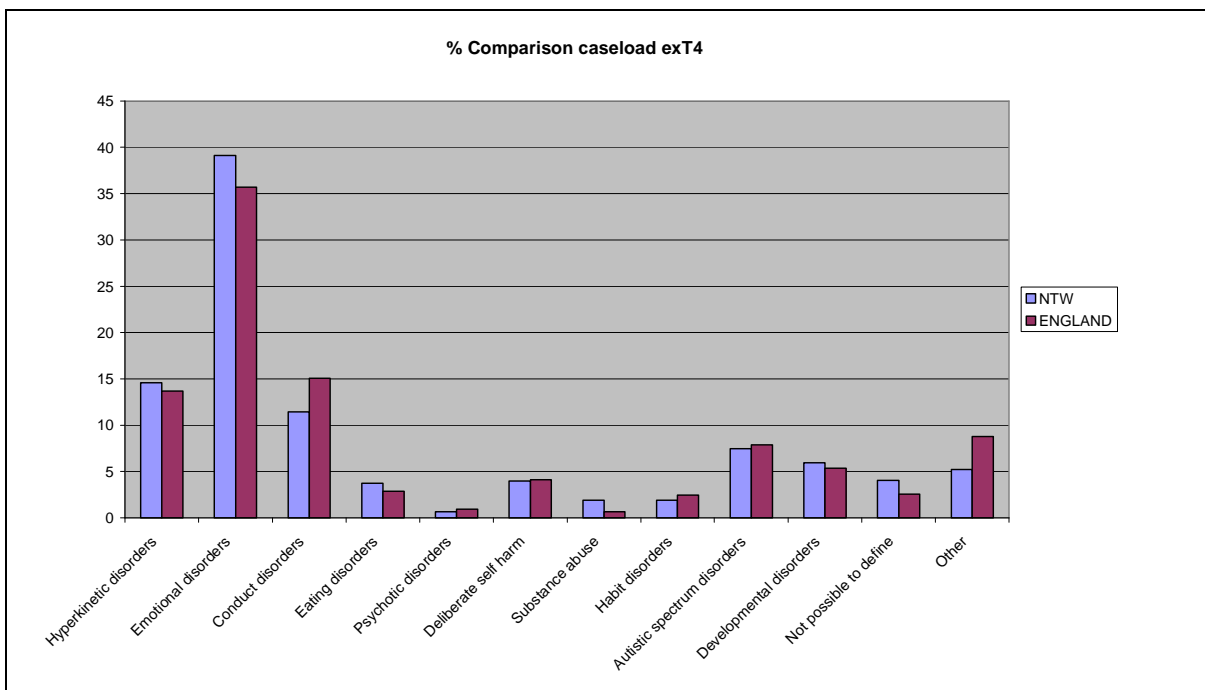
Case mix is an approximate indicator of demand. Additionally, employing the best available evidence it is possible to use case mix as a proxy indicator of the skill mix needed in each service, in order to offer the most effective interventions.

Indicative skill mix has been calculated by taking evidence for effective interventions and isolating the skills required to deliver them.

To see how this process works, please read the full explanation of the evidence for effectiveness, by Wolpert, et al, (2006).¹⁵

To view the process showing how the evidence and skills were summarised for use in this report, examine Appendix 1 – this document is not amenable to printing and should be viewed electronically.

Figure 16 NTW caseload by primary presenting disorder, compared to English average



The case mix does not differ significantly from the English average.

¹⁵ Wolpert, M., et al, (2006) *Drawing on the Evidence*
<http://www.ucl.ac.uk/clinical-health-psychology/pdfFiles/DotEBooklet2006.pdf>

Figure 17 Current case mix

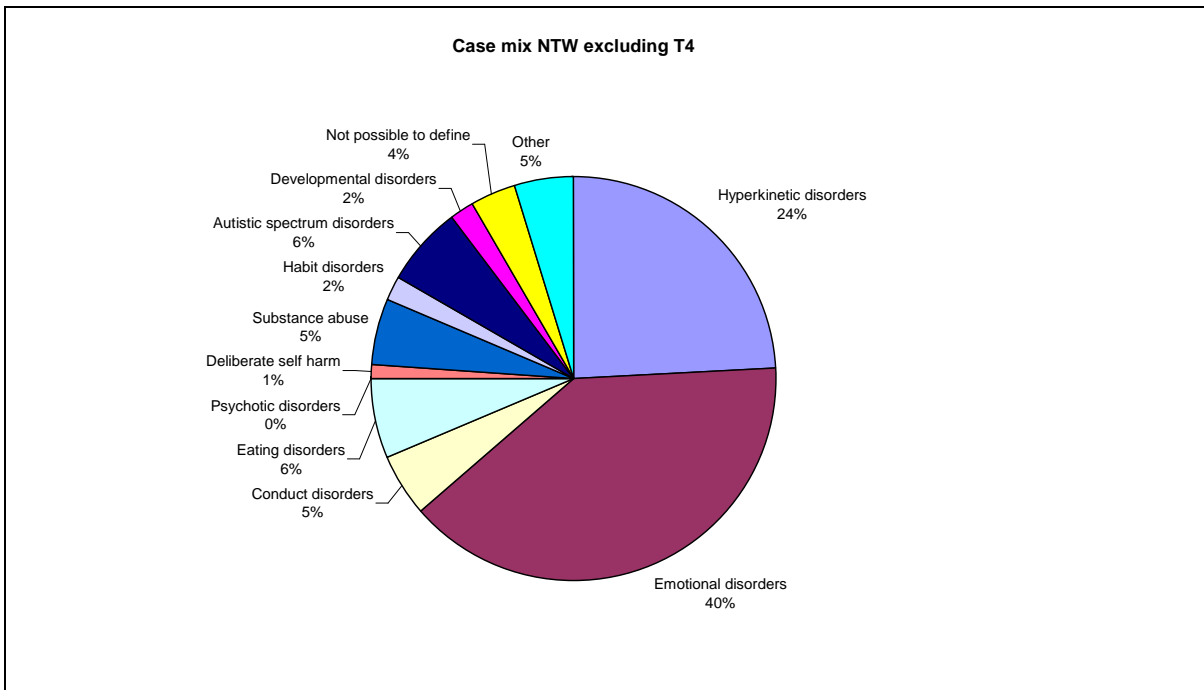
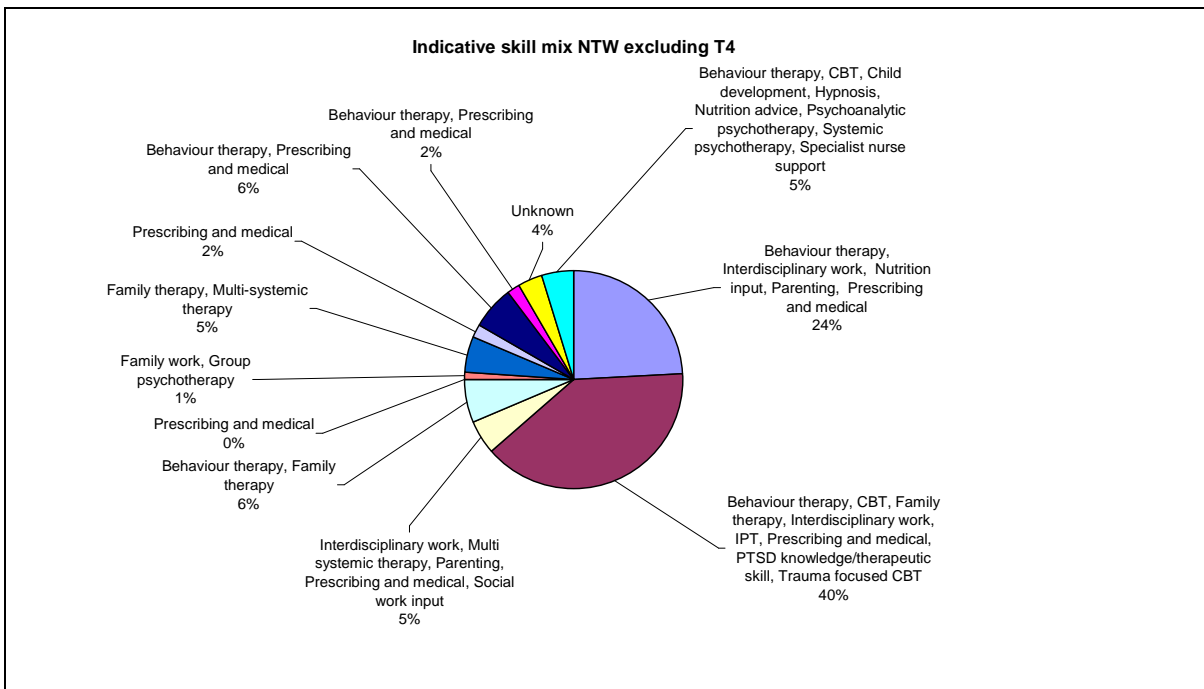


Figure 18 Indicative skill mix



PART 3
Strategic vision for future services
The six principles of CAMHS workforce planning
Increasing capacity and capability

3.1 Strategic vision for future services

NTW aims to be a centre of excellence. The Children and Young people's Services Directorate has a planned programme of service improvement, already incorporating New Ways of Working (NWW) and Creating Capable Teams Approach CCTA).

The Trust vision is to be:

- the employer of choice in the NHS in the North East
- an employer that makes the best use of all the talents of the workforce to provide excellence in patient care (see also page 7).

3.2 This plan addresses the local issues identified within the six principles of CAMHS workforce planning. These have been organised under three headings of:

Statements of value and principle
Broad aims and aspirations
Proposed actions and outcomes

3.2.1 Improve workforce design and planning

Values and principles

We are committed to:

Ensure equitability across localities
Exploit and use to the maximum scarce expertise
Base decisions on what to deliver on evidence

Aims

We aim to:

Promote 10 Shared Capabilities for all
Move from area to county level structure
Promote core delivery organised at locality level and specialist delivery organised at county level
Establish core competencies for all staff
Match needs and resources more effectively
Focus on value for money
Agree essential and non-essential tasks for each role to establish what can be done more cheaply

Actions/outcomes

Our measurables will be to:

Introduce job planning for all staff
Establish the ratio of direct to non direct (including training) clinical time
Initiate succession planning by using specialists to train generalists
Introduce diary exercises to assess time commitments and usage, build data to help capacity planning

3.2.2 Identify and use creative means to recruit and retain

Values and principles

We are committed to:

Develop a strong emphasis on staff well being

Promote healthy teams with managers who help people to grow and develop so that clinicians then feel valued and are creative themselves

Aims

We aim to:

Grow our own from basic training (it is already happening but will soon end)

Improve our processes for validation and equitable remuneration

Produce high quality clinicians who can then pass on skills through in-house training.

Encourage local service based projects – from projects come ideas

Actions/outcomes

Our measurables will be to:

Create roles that are interesting and satisfying through role re-design, for example:

- lecturer/practitioner
- education/clinician
- clinical – researcher

Achieve a positive high profile in local/regional professional community by marketing the service.

3.2.3 Facilitate new ways of working across professional boundaries

Values and principles

We are committed to:

Challenge the medical model

Embrace equality of value, recognising the contribution of each staff member or profession as well as service users

Aims

We aim to:

Facilitate an open/outward looking culture

Develop leadership

Actions/outcomes

Our measurables will be to:

Develop integrated pathways across tiers, including early intervention

Identify core competencies to meet needs

3.2.4 Create new roles

Values and principles

We are committed to:

Create new roles on the basis of evidence of need

Aims

We aim to:

Investigate extended roles – e.g. nurse prescribing

Consider 'support worker' type roles

Identify core training required

Actions/outcomes

Our measurables will be to:

Analyse skills gaps in order to advertise for mental health workers with particular skill sets
Introduce a range of bandings to include newly qualified and unqualified.

3.2.5 Develop leadership and change management skills

Values and principles

We are committed to:

Emphasise that leadership is a real issue and is connected to but separate from change management

Aims

We aim to:

Offer change management skills at 'team managers' level

Actions/outcomes

Our measurables will be to:

Identify knowledge and skills to fill the gap left by WDC and Modernisation agency
Identify and/or develop training which equips us for the speed of change

3.2.6 Develop the workforce through revised education, training and development

Values and principles

We are committed to:

Address the lack of basic input on CAMHS in all basic training (with possible exception of psychology)

Aims

We aim to:

Develop a range of accessible courses at all levels, including distance and open learning, interactive web based learning and facilitated/taught courses.
Encourage research at the coalface by all practitioners

Actions/outcomes

Our measurables will be to:

Develop and run practical skills courses
Validate good quality in-house training courses
Develop local courses to sell to others

PART 4
1. Implementation
2. Goals and milestones
3. Monitoring and review

4.1. Implementing this plan

The aim of the workforce planning group in compiling this action plan is to promote a more corporate approach across the directorate in workforce planning and service improvement. The actions are not in any priority order, as each is linked into the others to form an integrated plan. Given that the actions are not ranked in priority order, completion times have not been added. Instead the group agreed to review progress 6 months after compiling the action plan, with their CAMHS Regional Development Worker (RDW).

4.2 Goals and milestones.

In January 2009 the CAMHS RDW (Sharon Hall) will work with the group to assess progress against the above actions and produce a revised action plan.

4.3 Monitoring and review

Evaluation and review date: January 2009 – exact date to be agreed.

At the action planning meeting it was agreed that service managers will be responsible for disseminating the workforce plan to each service area/team, so that staff can become involved in its implementation.

It was also agreed that a provider-commissioner dialogue needs to take place over the coming months so that commissioners are aware of and can support the implementation of the plan in achieving outcomes for children, young people and families.

4.1.2 Action plan

Task	Rationale	Resources needed	Responsible person
CAREER PATHWAYS AND PERFORMANCE			
Introduce job planning for all staff. Integrate with Joint Development Review (JDR) process – in which Personal Development Plans (PDP) are already established. Add to the core dimensions a forward looking section on job and career planning.	This also links to succession planning, looking at where we are today and where we are going. Helps to target development opportunities better rather than scatter gun approach (energies and resources).	Relies on 100% appraisal target being met. Needs HR support in conjunction with training and development HR presence at local directorate workforce planning group	Service Director (Angela) Coordinated by Local directorate workforce group
Analyse exit data from T4	Discover more about ways in which staff look for career opportunities		Local directorate workforce group
Summarise and analyse PDPs, produce a local training plan and informing wider HR plans	Training development needs are already recorded, but need to be aligned to Trust objectives and priorities. Close the loop on PDPs, be more robust		
Create training framework, linked to core competencies, including mandatory, generic, specialist (may need something different for inpatient – link into national T4 training programme)	Ensure training is aligned to Trust priorities and reflects best practice against the evidence base.		
Introduce work plans to supplement job descriptions	More day to day and achievable than JDs.		Service managers
Initiate succession planning by using specialists to train generalists.			Local directorate workforce group

CAMHS Partnership Facilitation: Workforce Planning

ROLES AND FUNCTIONS			
Introduce e-diary exercises to assess time commitments and usage, build data to help capacity planning. Links to work planning (above).	Need baseline to establish the ratio of direct to non direct (including training) clinical time which in turn informs the provider-commissioner dialogue	Use RIO	Service managers
Introduce a range of bandings to include newly qualified and unqualified Look at parity in responsibility between in patient and community sectors (Use Agenda for Change competencies to bring people to the same level).	Address the current imbalance that leads to large turnover in Tier 4, thought to be due to inequities in responsibility and banding.	HR support	Service management team, HR (Emma)
Continue to implement New Ways of Working (NWW). Identify skill mix, levels of competence (evidence based). Analyse skills gaps in order to advertise for mental health workers with particular skill sets. Audit existing skills – needs a robust measure. Compare and identify gaps Analyse past year's training – does it fit trust/directorate priorities?	Integral to and supportive of improved workforce design and planning.	HR support	Service development officer (Clare) with service management team
Extend Creating Capable Teams Approach (CCTA) to all CYSP staff. Use mapping analysis from this plan to take benchmarking to each team – eg caseload ratio, case mix, productivity.			Service development officer (Clare) with service management team, HR (Emma)
Investigate the potential for creating new roles, (NTW is a pilot for new MHA roles).	To fill skill gaps and may be more cost effective.		Service Director (Angela) and service manager T4 in patient (Jane)

CAMHS Partnership Facilitation: Workforce Planning

TRAINING AND MARKETING			
Internal marketing: Achieve a positive high profile in local/regional professional community by marketing the service eg present to local CAMHS partnerships, CAMHS presence on intra and internet website, good practice event, annual CAMHS conference.	Supports Trust aims to be employer of choice and centre of excellence		Service development officer (Clare) with service management team
Identify and/or develop training which equips us for the speed of change Develop and run practical skills courses Validate good quality in-house training courses Develop local courses to sell to others Investigate whether money saved from efficiency savings can be reinvested in training	Investment in training and development to support better outcomes for children, young people and families	Link into directorate education and training group.	Modern matrons, service managers.
Identify core competencies to meet needs (using the pie charts as the starting point with each team)			Service managers
LEADERSHIP			
Develop leadership skills – aligned to the objectives of the organisation and using the NTW staff charter. Be clear what leadership means (already started)	Support Trust leadership management and development programme		Management team
Establish full representation from all professions of the local workforce group Be explicit about role and function of membership (promote partnership between professional leads and “management”) eg engage SpRs (Two levels – getting participation, then promoting leadership). Set leadership goals via focus groups and awayday programme for all CYPS staff (already established by Service development officer)	Redress the balance from profession-led membership and have clarity about the remit of the group		Local directorate workforce group Service development officer (Clare)
Promote CYPS involvement in the NTW Way 10 year plan – process, improvement and LEAN thinking	Integration of CYPS into wider Trust initiatives		Service Director (Angela)

AUDIT TRAIL EVIDENCE TO SKILLS

This worksheet of source data is based on Wolpert et al (2006) *Drawing on the Evidence* 2nd edition. Its purpose is to identify the skills that most closely match the evidence of effective interventions in CAMHS, in order to assist workforce planning. **Caution: this worksheet is not a substitution for the original document named above.** Much of the contextual and explanatory text in *Drawing on the Evidence* is not reproduced here, where only evidence for practice based on category A and B evidence has been used. Go to:

http://www.acamh.org.uk/site/upload/document/Drawing_on_the_Evidence_-_text.pdf

DISORDERS OF CONDUCT

Level of evidence	A				B	
	Under 12			Adolescent		
Best practice drawn from the evidence	Parent training for children <10	Parent training with individual child skills programme for children 8-12	Multi systemic therapy	Specialist foster placement	Reducing opportunities for delinquent behaviour and increasing skills such as problem solving or coping.	Use of novel antipsychotics with combined dopaminergic and serotonergic action, such as risperidone, may be cautiously considered for children and young people who have not been responsive to a comprehensive trial of psychosocial treatments
Workforce implications ie skill sets/expertise/disciplinary mix	Ability to run individual and group parenting programmes	Ability to run individual and group parenting programmes Expertise in skills training with children	Trained multi systemic therapists	Inter-disciplinary approach and strong links with social care - SW in T3 team?	Inter-disciplinary approach and strong links with schools, YOS, substance misuse services, youth work.	Prescribing, medical monitoring - Psychiatry?
Tier	2	3	3	3	3	3 and 4

AUDIT TRAIL EVIDENCE TO SKILLS

DISTURBANCES OF ATTENTION						
Level of evidence	A				B	
Best practice drawn from the evidence	If diagnostic criteria for ADHD are met following a comprehensive assessment by a suitably qualified professional, and other reasons for the behaviour have been excluded, then a trial of medication is indicated as the first line of intervention. Effective monitoring of children given medication is needed to minimise adverse side effects and optimise treatment benefits. Discontinuous medication (i.e. holiday breaks) may reduce the risk of mild growth suppression.	Children should be started on a short acting preparation of methylphenidate or on dexamphetamine. Atomoxetine is probably the evidence based second line treatment, but although there is relevant RCT evidence to support effectiveness this is a new drug and reports of side effects need to be monitored.	As it is not possible to predict which dose will be effective, dosage should be increased within safe limits until an effect is achieved. If there is insufficient resolution of symptoms with stimulants or atomoxetine, then other medication should be considered. The alternatives include: clonidine, selective serotonin reuptake inhibitors, tricyclic anti-depressants and selective monoamine	If there is insufficient response to medication, then parent training and individual behavioural therapy with the child should be added. Where individual behavioural interventions are used, these need to be provided in the child's school as well as within the home as they do not generalise across settings.	There is some evidence to support the use of omega 3 and 6 dietary supplementation	Behavioural intervention in addition to medication can also be offered as a way of achieving similar outcomes to medication alone but with reduced levels of medication
Workforce implications ie skill sets/expertise/disciplinary mix	Prescribing, medical monitoring - Psychiatry? care with GPs?	Shared	Ability to run individual and group parenting programmes. Expertise in behavioural therapy	Input of expertise on nutrition	Inter-disciplinary and multi-agency working, specifically with schools. Expertise in behavioural therapy	
Tier	3				3	

AUDIT TRAIL EVIDENCE TO SKILLS

ANXIETY DISORDERS

Level of evidence	A	B			
Best practice drawn from the evidence	Behaviour therapy and cognitive behavioural therapy (in group or individual format) first-line treatment for children with specific phobias and children with generalised anxiety.	Behaviour therapy and cognitive behavioural therapy should be considered for children with OCD	Clomipramine and selective serotonin reuptake inhibitors should be considered in the treatment of OCD when cognitive behavioural therapy alone has proved ineffective.	Selective serotonin reuptake inhibitors should be considered in the treatment of social anxieties when cognitive behavioural therapy alone has proved ineffective	'Educational support' should be considered in the management of children with anxiety problems.
Workforce implications ie skill sets/expertise/disciplinary mix	Expertise in behavioural therapy and in CBT	Prescribing, medical monitoring - Psychiatry?	Inter-disciplinary and multi-agency working, specifically with schools		
Tier	2 and 3	3	3		

POST TRAUMATIC STRESS DISORDER

Level of evidence	A	B
Best practice drawn from the evidence	Debriefing should not be offered routinely immediately following a trauma	Children and young people with PTSD, including those who have experienced traumatic events other than sexual abuse, should be offered a course of trauma focused CBT adapted to suit their age circumstances and
Workforce implications ie skill sets/expertise/disciplinary mix	Access to expertise in PTSD	Expertise in trauma focused CBT
Tier	3	3

AUDIT TRAIL EVIDENCE TO SKILLS

DEPRESSIVE DISORDERS

Level of evidence	B	A	B
Best practice drawn from the evidence	Given the high rate of remission in control groups, initial psychological treatment (either CBT, family therapy or Inter-Personal Therapy) for up to three months should be offered as the first line of treatment.	If psychological treatment does not produce improvement in symptoms by six weeks, anti-depressant medication should be offered for adolescents (and cautiously considered for younger children) in combination with longer term psychological treatment using either CBT, psychotherapy or family therapy.	Depression is a condition which is liable to recur. Clinical follow-up and 'booster sessions' may be helpful in reducing relapse.
Workforce implications ie skill sets/expertise/disciplinary mix	Range of therapies: family therapy, CBT, IPT.	Range of therapies plus Prescribing, medical monitoring - Psychiatry?	
Tier	3	3 and 4	

AUDIT TRAIL EVIDENCE TO SKILLS

PSYCHOTIC DISORDERS

Level of evidence	A	B
Best practice drawn from the evidence	Neuroleptics are the treatment of choice for the acute phase of schizophrenia	<p>Clozapine should be cautiously considered in cases of treatment resistant schizophrenia, in line with the nationally agreed protocol</p> <p>Because of the side effects of traditional neuroleptics atypical neuroleptics should normally be used, although caution should be exercised as these too have side effects.</p> <p>Lithium should be considered in the first instance in the acute phase of manic/bipolar disorder.</p>
Workforce implications ie skill sets/expertise/disciplinary mix	Prescribing, medical monitoring - Psychiatry?	
Tier	3 and 4	

AUDIT TRAIL EVIDENCE TO SKILLS

EATING DISORDERS

Level of evidence	A	B
Best practice drawn from the evidence	Family therapy (behavioural/structural) is recommended as the treatment of choice for anorexia nervosa, either as an outpatient or after in-patient treatment.	Behavioural treatment should be considered in hospital in order to increase weight

Workforce implications ie skill sets/expertise/ disciplinary mix	Expertise in family therapy	Expertise in behavioural therapy
Tier	3 and 4	3 and 4

DELIBERATE SELF HARM

Level of evidence	A	B	
Best practice drawn from the evidence	When instituting schools based interventions, selection of material should be made with reference to existing evaluated programmes	Following a suicide attempt by a child or young person, brief interventions involving families should be considered	For young people who have self-harmed several times, consideration should be given to the addition of group psychotherapy

Workforce implications ie skill sets/expertise/ disciplinary mix	Consultancy and support to schools	Expertise in family work	Expertise in group psychotherapy
Tier	2 and 3	3 and 4	3 and 4

AUDIT TRAIL EVIDENCE TO SKILLS

SUBSTANCE MISUSE

Level of evidence	A		B	
Best practice drawn from the evidence	Family therapy should be considered the first line treatment of substance misuse		Multi-systemic therapy should be considered where substance misuse is part of a wider pattern of problems	
Workforce implications ie skill sets/expertise/disciplinary mix	Expertise in family therapy		Trained multi systemic therapists	
Tier	3		3 and 4	

PERVASIVE DEVELOPMENTAL DISORDERS

Level of evidence	B			
Best practice drawn from the evidence	Intensive behavioural interventions, either individual or group, should be considered to help improve the adaptive behaviour of children with autism		Medication is not indicated for the treatment of core symptoms of autism but may be used to reduce specific behaviours associated with autism in children.	
Workforce implications ie skill sets/expertise/disciplinary mix	Expertise in behavioural therapy		Prescribing, medical monitoring - Psychiatry?	
Tier	3 and 4		3 and 4	

AUDIT TRAIL EVIDENCE TO SKILLS

TOURETTES SYNDROME

Level of evidence

	A	B
Best practice drawn from the evidence	Neuroleptics and clonidine should be considered as first choice treatments for Tourette's syndrome. Since the evidence for effectiveness does not differentiate between them, the decision as to which medication to use may be based on the clinician's and family's view of the different side effects. The atypical neuroleptics usually have fewer side effects	The presence of tics is not a contraindication to the use of methylphenidate in the treatment of ADHD Selective serotonin reuptake inhibitors should be considered in Tourette's syndrome with comorbid OCD, but the response may be less favourable than in OCD without comorbidity.

Workforce implications ie skill sets/expertise/disciplinary mix	Prescribing, medical monitoring - Psychiatry?
------------------------------------------------------------------------	-----------------------------------------------

Tier

3

AUDIT TRAIL EVIDENCE TO SKILLS

PHYSICAL SYMPTOMS NO KNOWN CAUSE

Level of evidence

Best practice drawn from the evidence Cognitive behavioural therapy should be considered for recurrent abdominal pain

If attention to diet has not already been considered, trial of a high fibre diet is indicated for recurrent abdominal pain.

Workforce implications ie skill sets/expertise/ disciplinary mix	Expertise in CBT	Input of expertise on nutrition
Tier	2 and 3	2 and 3

COPING WITH PAINFUL PROCEDURES

Level of evidence

A

Best practice drawn from the evidence Cognitive behavioural therapy, behaviour therapy and hypnosis should be used to counter the stress associated with painful procedures and selected according to the particular types or stages of procedure as well as the developmental stage of the individual child.

Workforce implications ie skill sets/expertise/ disciplinary mix	Expertise in child development, behaviour therapy and hypnosis.
Tier	2

AUDIT TRAIL EVIDENCE TO SKILLS

COPING WITH CHRONIC ILLNESS AND DISEASE

Level of evidence

	A	B		
Best practice drawn from the evidence	Cognitive behavioural therapy and behaviour therapy, tailored to specific illnesses, should be considered for children with hard to control physical symptoms.	Psychoanalytic psychotherapy should be considered for the treatment of hard to control diabetes	Systemic family therapy should be considered for the treatment of asthma	Provision of specialist nurse support to families of children newly diagnosed with chronic illness should be considered as a means of improving later physical and psychological outcomes

Workforce implications ie skill sets/expertise/ disciplinary mix	Expertise in behavioural therapy and in CBT	Expertise in psychoanalytic psychotherapy	Expertise in systemic psychotherapy	Specialist nurse support
Tier	2	3	3	2 and 3

AUDIT TRAIL EVIDENCE TO SKILLS

DISORDERS OF CONDUCT	DISTURBANCES OF ATTENTION	ANXIETY DISORDERS	POST TRAUMATIC STRESS DISORDER	DEPRESSIVE DISORDERS
parenting multi systemic therapy social work input interdisciplinary work prescribing, medical	prescribing, medical parenting behaviour therapy interdisciplinary work nutrition input	behaviour therapy prescribing, medical CBT interdisciplinary work	PTSD knowledge/therapeutic skill trauma focused CBT	family therapy IPT CBT prescribing, medical
PSYCHOTIC DISORDERS	EATING DISORDERS	DELIBERATE SELF HARM	SUBSTANCE MISUSE	PERVASIVE DEVELOPMENTAL DISORDERS
prescribing, medical	family therapy behaviour therapy	family work group psychotherapy	family therapy multi-systemic therapy	behaviour therapy prescribing, medical
TOURETTES SYNDROME	PHYSICAL SYMPTOMS NO KNOWN CAUSE	COPING WITH PAINFUL PROCEDURES	COPING WITH CHRONIC ILLNESS AND DISEASE	
prescribing, medical	CBT nutrition advice	child development behaviour therapy hypnosis	behaviour therapy CBT psychoanalytic psychotherapy systemic psychotherapy specialist nurse support	

AUDIT TRAIL EVIDENCE TO SKILLS

This worksheet shows how the categories of mental disorder may be matched, between those used in the National CAMHS mapping and

NATIONAL

**CAMHS
MAPPING
CATEGORIES**
Hyperkinetic disorders

**DRAWING ON THE
EVIDENCE
CATEGORIES**
**DISTURBANCES OF
ATTENTION**

prescribing, medical
parenting
behaviour therapy
interdisciplinary work
nutrition input

**Emotional
disorders**

**DEPRESSIVE
DISORDERS**

family therapy
IPT
CBT
prescribing, medical

**ANXIETY
DISORDER**

behaviour therapy
prescribing, medical
CBT
interdisciplinary
work

PTSD

PTSD
knowledge
/therapeutic skill
trauma focused
CBT

**Conduct
disorders**

**DISORDERS OF
CONDUCT**

parenting
multi systemic therapy
social work input
interdisciplinary work
prescribing, medical

Eating disorders

EATING DISORDERS

family therapy
behaviour therapy

Psychotic disorders

PSYCHOTIC

DISORDERS prescribing,
medical

AUDIT TRAIL EVIDENCE TO SKILLS

Deliberate self harm	DELIBERATE SELF HARM family work group psychotherapy		
Substance abuse	SUBSTANCE MISUSE family therapy multi-systemic therapy		
Habit disorders	TOURETTES SYNDROME prescribing, medical		
Autistic spectrum disorders	PERVASIVE DEVELOPMENTAL DISORDERS behaviour therapy		
Developmental disorders			
Not possible to define			
Other	PHYSICAL SYMPTOMS NO KNOWN CAUSE CBT nutrition advice	COPING WITH PAINFUL PROCEDURES child development behaviour therapy hypnosis	COPING WITH CHRONIC ILLNESS AND DISEASE behaviour therapy CBT psychoanalytic psychotherapy systemic psychotherapy specialist nurse support