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Foundation PSA provides grants for individuals to undertake both short and longer term courses and attendances at study days and conferences.

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Foundation for PSA

The FPSA committee of management have great pleasure in cordially inviting you to

The Elsevier Lecture
on Thursday 21st June 2012 at 18.00hrs

The lecture will be given by Professor Sue Bailey OBE
President of the Royal College of Psychiatrists
Professor at the University of Central Lancashire
Consultant Child and Adolescent Forensic Psychiatrist in the Forensic Adolescent Consultation & Treatment Services at Greater Manchester West NHS Foundation Trust

18.00hrs - Arrivals, Drinks & Canapés
18.30hrs - Lecture Begins
19.30hrs - Lecture Ends
20.00hrs - Dinner
22.30hrs - Depart

at The Radisson Blu Hotel, Meridian Gate, Bute Terrace, Cardiff, Wales, CF10 2FL
RSVP secretariat@foundationpsa.org.uk

This Briefing Paper was prepared for the Foundation for Professionals in Services to Adolescents by Alice Reeves of Quality In Evidence, who also carried out the research on which it is based.
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Quality In Evidence

Foundation for PSA

FPSA Practioner Briefings

No 5 February 2012

Training Needs in Inpatient CAMHS

Introduction

In April 2011, the Foundation for Professionals in Services to Adolescents (FPSA) commissioned Alice Reeves of Quality In Evidence (QIE) to carry out a series of telephone interviews aimed at identifying the key training needs of frontline staff working in inpatient Child and Adolescent Mental Health Services (CAMHS). A total of 12 interviews were carried out with participants based across the UK, with a range of professional perspectives:

- An assistant Children's Services manager and lead nurse for Tier 4 CAMHS;
- A nurse consultant and manager of an inpatient unit;
- Two senior charge nurses in inpatient units;
- Two consultant child and adolescent psychiatrists based in inpatient units;
- A nurse consultant and clinical lead for a 'day service' (intensive outreach) based in a Tier 4 unit;
- A senior practitioner in a short-term residential assessment centre for adolescents with mental health problems;
- A Tier 3 family therapist;
- Manager of a mental health service for looked after children, which provides screening, court assessment, therapeutic and professional support services;
- Clinical lead for the mental health team at a young offender institution;
- A former lecturer in child and adolescent mental health, with experience of working and supervising in inpatient units as well as training staff working in inpatient care.

This briefing paper highlights the key findings from an analysis of these interviews. The full research report is available free of charge on the FPSA's website **www.foundationpsa.org.uk**

Current Training Provision

At the time of the research, there did not exist any kind of standard training suite for staff working in inpatient CAMHS; rather, each individual unit was responsible for compiling a portfolio of courses to meet the needs of its staff and patients. This led to considerable variation between units in terms of the scale and nature of the training provided. Accordingly, views varied widely regarding the sufficiency of current training provision. Some participants felt that staff's needs were generally being met, whilst others described provision as "ad hoc" or "piecemeal".

It was clear from the interviews that nurses and healthcare assistants (HCAs) were commonly working directly with young people in inpatient units having received very little or no CAMHS-specific training. Research participants commented that frontline staff mainly '"learned on their feet" or "fell back on their life experience" in dealing with patients.

Most of the training that could be accessed by staff in inpatient units was provided internally. Short sessions (between one hour and one day) might cover a specific disorder or behaviour such as eating disorders, a treatment approach such as motivational interviewing, or a theoretical topic such as attachment. Training accessed from external sources tended to be focused on developing practical skills, such as the ability to deliver cognitive behavioural therapy (CBT) or dialectical behaviour therapy (DBT).

Funds for Training

Whilst some units had a ring-fenced budget for staff training, others did not, and funding decisions could be somewhat arbitrary and inconsistent. For example, one participant described how funds for training in her unit had to be sourced from the general ward budget, which meant that nursing staff relied on underspend to access training and the success of a funding application could depend on the time of the financial year at which it was submitted. Overall, participants viewed funding for staff training as inadequate and were pessimistic about the chances of this improving over the coming years.

Barriers to Training

Participants identified the three key barriers to staff accessing training as cost, staffing arrangements and availability/ location.

Inpatient units operate a 24-hour shift system, which means that some staff work overnight and are therefore unavailable at the hours when training is provided. Participants mentioned occasions when overnight staff had stayed on in the morning to attend training but been too tired for the training to be truly productive for them. Inpatient units also tend to be leanly staffed, which limits the number of staff who can be released for training at any one time. The nature of the work can also be a barrier: it appeared relatively common that a crisis in the unit would scupper a staff member's plans to attend training, either because a skeleton staff had been put in place to enable the training or because more staff than normal were required to deal with the crisis.

Whilst some kinds of training did not appear to be available at all, there were also cases in which suitable training was available but not locally to the unit. Accessing funds to travel long distances to attend training posed a considerable challenge for staff.

Gaps in Training

The research participants identified a number of areas in which additional training would be beneficial to frontline staff in inpatient CAMHS. The majority of these could be classified as either 'theoretical' or 'practical skill-related'. There was a broad consensus that frontline staff lack a thorough understanding of a range of theoretical topics that are highly relevant to their everyday work and that underpin the ability to interact with young people in the most effective way. Emphasis was placed, however, on the need to integrate theoretical learning with the development of associated skills for use in practice.

Table 1 summarises the specific gaps in training identified.

Table 1: Gaps in Training

Theoretical - general	Child and adolescent development Adolescent psychology, behaviour and experience Attachment, trauma and loss Transference and counter-transference System theory Group dynamics as they pertain to the environment of an inpatient unit
Theoretical – specific disorders	Eating disorders Personality disorders Self-harm
Practical skill-based – general mental health	Young person and family assessment Diagnosis of most common disorders Managing suicidal risk Managing violent or aggressive behaviour Establishing boundaries
Practical skill-based - specialised	Delivering or understanding the most common therapeutic interventions Facilitating group therapy with adolescents Motivational interviewing Solution-focused problem-solving
Practical skill-based - generic	Therapeutic parenting Mindfulness Interviewing young people and families Active listening Observation Meaningful practice reflection Communication – with young people, families and other professionals

Who Needs Training?

One of the clearest messages to emerge from the interviews was the need for **a thorough induction for new staff.** Whilst some units had put together their own substantial induction programmes, in others provision was much more sparse. Participants felt that a good induction would cover all or many of the key topics identified in Table 1 at a fairly basic level so, for example, it would educate staff in the core principles of the most common therapies without going so far as to equip them to lead specialised interventions themselves. The overall aim of the induction would be to provide a strong foundation on which more advanced or specialised training could build at a later stage.

Participants agreed that the induction should certainly be aimed at newly-qualified nurses and HCAs, whilst some felt that it might also be appropriate for more experienced staff who had moved into CAMHS from other backgrounds, or who had simply never received formal training on certain topics. Several participants stressed the specialist nature of the skills required for working on the frontline in inpatient CAMHS and particularly the differences between CAMHS and adult mental health settings.

Continuing professional development post-induction was also seen as important, and training nurses to lead specialised interventions such as CBT and DBT was a high priority in some units. The point was made that this kind of training, which typically requires a large time investment, should be allocated on the basis of the unit's needs: not every staff member necessarily needs to be trained in everything.

Tier 4 or More?

There was a general view among participants that training in many of the areas identified in Table 1 would be highly relevant to staff working in Tier 3 CAMHS, especially those administering 'intensive outreach' services, i.e. services targeted at young people with severe mental health problems either with the aim of keeping them out of inpatient care if possible, or as an initial 'step-down' following a period in an inpatient unit.

Format and Delivery

There was an overall consensus that access to training would be greatly enhanced if it were **delivered locally to the unit.** However, participants were divided on the question of whether it would be preferable to deliver the training in the unit itself or at another venue nearby: whilst some felt that delivering it in the unit would maximise the chances of staff being able to attend, others felt that staff would be able to concentrate better and approach the training with a fresher, more positive attitude if it took place in a different environment from their everyday work. Participants felt it would be important to **repeat key training at regular intervals** to accommodate the fact that not all staff would be able to attend it at once, and to ensure that every new staff member received it within a reasonable time period of starting.

The view was expressed that delivering training in the form of a **series of short sessions** spread over weeks or months could be more effective at "embedding" knowledge in trainees' minds than intensive courses delivered in one day or over a few consecutive days.

Participants emphasised that theoretical teaching should always be clearly related to real-life practice on the frontline. One participant commented:

"You're modelling, bringing to life, something theoretical. I think some of those theories are wonderful but when you're sitting on a landing at two o'clock in the morning with a child who's suicidal or furious it doesn't matter what theories you've got!"

Workshops, working groups, case formulation, practice reflection and knowledge-sharing were all mentioned as potentially effective training approaches and, for this reason, participants felt that it would be necessary to **deliver the training face-to-face.**