Alice Reeves Independent Research

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An analysis of the training needs of frontline staff in inpatient CAMHS

Foundation for PSA

Prepared for the Foundation for Professionals in Services to Adolescents

Contents

1. Introduction

In April 2011, the Foundation for Professionals in Services to Adolescents (FPSA) commissioned Quality In Evidence (QIE) to carry out a series of telephone interviews aimed at identifying the key training and development needs of frontline staff working in inpatient Child and Adolescent Mental Health Services (CAMHS). Anecdotal evidence suggested that there might be some significant gaps in training for this group; if the research supported this conclusion, a second aim was to provide some broad initial guidance for the development of a training programme to be funded by the FPSA.

This report presents an analysis of 12 telephone interviews with participants based across the UK, with a range of professional perspectives. They are:

- 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.

1.1 Research Methods

The FPSA provided a list of potential research participants, who were initially contacted by email. Telephone interviews were scheduled at the participants' convenience and lasted approximately 30 minutes. Each participant was offered a £50 Amazon voucher as a thank-you for their time.

Interviews were investigative and qualitative in nature. Rather than a structured questionnaire, an 'interview guide' was developed, which identified the key issues to be covered but allowed flexibility for accommodating participants' different perspectives and pursuing points raised spontaneously by them. The interview guide was tweaked during the initial interviews. The final interview guide and the introductory email sent to participants are included in Appendix A.

Interviews were recorded with participants' permission. Detailed notes were written up using the recordings and these provided the material for analysis. Participants were assured that their comments would be kept confidential and reported anonymously, although some gave permission for their names to be passed on to the FPSA for the purposes of further consultation (see Chapter 8).

2. Summary of Key Findings

Below is a summary of the key findings from the research. More details on all of these, plus numerous additional findings, can be found within the body of the report.

Current training provision

- Inpatient units vary considerably in regard to the scale and nature of the training provided to frontline staff;
- It appears to be common for nurses and HCAs to be working directly with young people having received little or no CAMHS-specific training;
- While some units had a ring-fenced budget for training, in other units training was arranged on a much more ad hoc or "piecemeal" basis;
- Participants were pessimistic about the money likely to be available for training over the coming years.

Barriers to training

- A lack of funds is a key barrier to staff accessing training – this includes a lack of funds for travel to training provided at other geographical locations;
- The 24-hour shift system that operates in inpatient units can also make it difficult for staff to attend training;
- Inpatient units tend to be leanly staffed, which presents challenges in terms of arranging cover for staff to attend training – in addition, it was not uncommon for members of staff to be forced to cancel or abandon training due to a crisis in the unit.

Gaps in training

The research participants identified numerous areas where new or additional training for frontline staff would be helpful. These were classified under three headings:

- Theoretical topics – concerning relevant aspects of psychology (e.g. child and adolescent development) or specific disorders (e.g. self-harm);
- Skill-based topics – concerning skills specific to the mental health context (e.g. managing suicidal risk); skills for therapeutic intervention (e.g. family therapy); and more generic skills (e.g. active listening);
- Other topics, such as risk assessment, child protection and managing transitions.

It was clear from the interviews that the main gap in training related to a thorough induction for new staff.

Format and delivery

- There was a consensus among the participants that access to training could be enhanced by delivering it locally to each unit, although views varied regarding whether it was preferable to deliver training within the unit or in a different local venue;
- It was asserted that training would need to be repeated at regular intervals in order to ensure that all staff could attend it and that new staff would not have to wait too long to be trained;
- The view was expressed that training delivered over a series of short sessions, rather than by means of one intensive course, would help trainees absorb and embed the teaching more successfully;
- All participants saw it as important that the training should include interactive elements and relate theory clearly to trainees' everyday working lives. For this reason, face-to-face delivery was considered necessary.

3. Current training provision

Participants working in inpatient units were asked to describe the training currently provided for frontline staff. This encompassed the subject of the training; who provided it; which staff were eligible to access it; how it was arranged and who paid for it.

It seems clear that, at present, there does not exist any kind of standard training suite for staff working in inpatient CAMHS; rather, each individual unit is responsible for compiling a portfolio of courses to meet the needs of its staff and patients. Thus, as we might expect, the nature and scope of training provision varied widely between the units. Some participants saw this variation as problematic in itself; one, for example, mentioned that some years ago there had been a standard one-year child and adolescent nursing course that most nurses specialising in CAMHS attended, and felt that this had guaranteed "a standardised base of knowledge" among all inpatient staff. 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. Participants commented

that frontline staff seemed to receive the least training and support of anyone, and that they mainly '"learned on their feet" or "fell back on their life experience" in dealing with patients.

All the units offered some in-house training in addition to the mandatory courses required by the NHS. Most of this was provided either by staff from within the unit or by staff from other parts of the Trust, although there was also mention of outside trainers coming in. All units also offered opportunities for some staff to access external courses.

3.1 Coverage

The training currently available to staff can be classified under the following headings:

Internal

- Short sessions (between 1 hour and 1 day) on specific disorders or behaviours, e.g. eating disorders, self-harm;
- Short sessions on specific treatment approaches, e.g. motivational interviewing;
- Short sessions on theoretical topics, e.g. attachment theory;
- Case formulations, where the trainer presents a real-life or hypothetical case and the group discusses how they would approach it;
- Induction for new staff – arrangements ranged from nothing specific, through a basic introduction to the workings of the unit, to something much more substantial.

In some units, training was delivered by means of a series of short sessions spread over several weeks or months.

Some units also offered activities aimed at continuing professional development that went beyond formal training, such as personal supervision and reflective practice sessions. These will be discussed further in Chapter 7.

External

External training for nursing staff and HCAs was aimed at developing practical skills within the team through:

- Masters-level courses, e.g. to become a Clinical Nurse Specialist in CAMH or in a specific treatment approach such as cognitive behavioural therapy (CBT) or dialectical behaviour therapy (DBT);
- Other courses on treatment skills not resulting in a formal qualification;
- In one unit, some of the nursing staff had been trained in evidence-based parenting programmes.

3.2 Funding, arrangements and access

While some units had a ring-fenced budget for training and development, others did not. Training budgets, where they existed, tended to be considered too small and participants were understandably pessimistic in regard to the money likely to be available for training over the next few years (see Chapter 4 for further discussion of cost as a barrier to accessing training).

Case example 3.2A: a ring-fenced budget

The Trust has a CAMHS Training Committee, which provides in-house training days and allocates funding for external training. It works closely with the CAMHS Executive that runs the service and has its own training budget of approximately £20,000 a year. Staff have to apply for funds to attend training, and if there's an internal course on the topic they have to attend that before going on an external course.

Case example 3.2B: no ring-fenced budget

Whilst some staff, such as doctors, have a personal budget for training, nurses and HCAs have to apply for funds from the general ward budget. This means that they rely on underspend to access training and the success of an application might be affected by the time of the financial year at which they apply.

Where staff were required to apply for funds for training, the emphasis was on providing evidence that the skills acquired would benefit the everyday work of the unit (this probably explains why all the external training courses mentioned were skill-focused). However, formal applications were not always required. Phrases like "ad hoc" and "piecemeal" were used to describe the way in which training was arranged in some units. One participant commented that, in the past, training in her unit had been arranged in response to the interests of individual staff members but that there was now an effort among the management to move towards a more strategic model whereby training would be arranged to fill gaps in the skill base of the unit as a whole.

It appeared to be relatively rare for inpatient staff to attend training paid for by external funders. Apart from the FPSA, only a couple of external funders were mentioned: central DoH and regional Workforce Development.

HCAs typically had access to in-house but not external training.

3.3 Sufficiency

All participants identified some areas in which additional training would be helpful (see Chapter 5) but views varied widely regarding the extent to which current training provision was sufficient to meet staff's needs:

Case example 3.3A: close to sufficient
The nurses are working their way through a handbook that covers the basic knowledge needed for working in inpatient care: different kinds of cases, boundaries, child development, and so on. They work through a chapter every Wednesday morning. On Friday afternoons, the unit has a CPD slot where guest lecturers come to talk about a very wide range of topics - recent talks have covered eating disorders, the Mental Health Act and safeguarding. There's a special training day on a Saturday every 3 months - upcoming ones will be on handling violent patients and administering the nasal gastric tube. Other training is provided by the Trust. There is also a reflective practice group every week, and all staff receive weekly one-to-one supervision.

Case example 3.3B: far from sufficient
Staff have attended a range of external courses and have internal training every Friday for an hour, but [participant] feels that provision is "piecemeal" and "lacking substance". It can be hard to transfer anything more than superficial knowledge in an hour-long session but the shift system makes it very difficult to get a decent group of staff together for a longer period of time. Recently, the team matron attended a 3 hour training. She then passed on that knowledge to two Band 6 nurses in a 1 hour, 20 minute meeting, and they had to condense it to 1 hour for the rest of the staff. The comments came back that it was too quick and there weren't enough opportunities for questions or discussion. There is no formal induction for HCAs in the unit, they just get paired up with a qualified nurse. [Participant] feels that training is sometimes an exercise in "ticking boxes"; managers like to say you've done it when the audits come around, and cover themselves so that if something goes wrong they can say 'well, you did the training'.

Case example 3.3C: pretty good... but not sufficient
A group of senior staff have put together a basic induction for newly-qualified nurses. It covers aspects of child development, such as attachment and transference, which can pose the biggest challenge for someone who hasn't worked in CAMHS before, and also things like risk assessment, the main therapies and the unit's operational policies. But [participant] feels it's "no way enough". What's needed is a more thorough induction, that really gives staff "a kind of toolkit, if you like, of skills that are enough to allow them to intervene without having to be a qualified specialist". But there's also a need to refresh and develop further the skills required for general CAMHS work, which they don't do at the moment.

4. Barriers to training

Participants were asked to identify the main barriers to staff accessing appropriate training.

Cost

As discussed in Chapter 3, a key barrier was cost or funding, and this situation was not expected to improve in the foreseeable future. One participant said that, in her unit, it had become very rare for staff to attend any off-site training due to what she referred to as "paranoia about the state of the NHS" which had led to "battening down the hatches".

Staffing arrangements

A second major barrier to staff attending training related to staffing arrangements within inpatient units. As they work on a 24-hour shift system, some staff work overnight and are therefore unavailable at the hours when training is provided. There had been 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 can make it difficult to find cover when staff are released for training and limits the number of staff members 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 at the last minute, 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.

The question of how training might best be delivered to accommodate these staffing constraints will be addressed in Chapter 6.

Availability and location

The interviews indicate that appropriate training to address a range of key knowledge and skills gaps among frontline staff is currently unavailable in any location (see Chapter 5). However, participants did also mention cases in which suitable training was available but not locally to the unit. This was essentially a problem of the cost of travel, e.g. one participant said that it had become increasingly difficult for staff in his unit in Scotland to raise money to attend training that was only available in London.

Staff resistance

It was suggested that inpatient units can sometimes be rather "closed" environments, with a tendency to be "self-referential", "institutionalised" or "collusive" in their practices and thinking. This was seen as creating resistance towards externally-provided training or consultancy, which might be perceived by the inpatient staff as insufficiently sensitive to the peculiarities of their particular setting.

One participant also mentioned that individual staff members with a long history of working with young people might resist training due to a perceived lack of need:

"I think there's a fallacy actually that if you've worked in young people's services for long enough you will somehow by osmosis have acquired the skills that you need to work with young people. So you come across people who might consider themselves highly experienced by virtue of the number of years they've done but are not necessarily particularly skilled in interventions with young people or necessarily have the level of understanding of developmental or attachment or systemic issues. So, you know, there's a theory that experience can be a substitute for training – well I don't think it can, any more than training can be a substitute for experience."

5. Gaps in training

Participants identified numerous topics and areas where new or additional training could be beneficial to frontline staff.

5.1 Understanding theory

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. It was felt that an understanding of these theoretical topics would enable staff to interpret a young person's behaviour more accurately, in the context of his or her development, experience and relationships. Emphasis was placed, however, on the need to integrate theoretical learning with the development of associated skills for use in practice (see Section 5.2). The theoretical topics mentioned fell into two broad categories:

General psychological topics

- Child and adolescent development;
- Adolescent psychology, behaviour and experience;
- Attachment, trauma and loss;
- Transference and counter-transference (i.e. the idea that someone's behaviour towards one individual might be 'transferred' from a prior relationship);
- System theory (i.e. viewing the young person in the context of their family and wider networks);
- Group dynamics as they pertain to the environment of an inpatient unit.

Specific disorders

- Eating disorders;
- Personality disorders;
- Self-harm.

Self-harm was viewed as especially burdened with misconception and liable to be seen by staff as "less serious" than other conditions, or as "a cry for help rather than an illness".

5.2 Developing skills

Participants also identified a number of areas in which there was scope to develop the practical skills of frontline staff.

Mental health service skills

- Assessing a young person or a family using current assessment tools (N.B. many of the 'more generic skills' listed below were seen as essential for this);
- Diagnosing the most common mental health disorders (see Section 5.1);
- Managing suicidal risk;
- Managing violent or aggressive behaviour;
- Establishing boundaries.

Specialised intervention or therapeutic skills

- Delivering or understanding the most common therapeutic interventions – CBT, DBT, family therapy;
- Facilitating group therapy with adolescents;
- Motivational interviewing;
- Solution-focused problem-solving.

More generic skills

- Therapeutic parenting;
- Mindfulness;
- Interviewing young people and families;
- Active listening;
- Observation;
- Meaningful practice reflection;
- Communication – with young people, families and other professionals.

Participants who worked outside inpatient units had sometimes found communications with them difficult. One mentioned a "Tier 3 versus Tier 4" attitude among some inpatient staff. Another recounted an experience where an adolescent had moved from the children's home where he was working into an inpatient unit but staff there had seemed unreceptive to input from the workers at the children's home:

"...in terms of 'we know what we're doing, we're a Tier 4 CAMHS, what do you know, you're only a children's home?' [...] My colleagues thought 'well actually we've been working with this young man for years, we know him really well, he sees us as home.'"

5.3 Other topics

A number of topics not falling into the categories specified in Sections 5.1 and 5.2 were also mentioned by participants as potentially important foci for training:

- Child protection;
- Risk assessment;
- Safeguarding;
- Consent;
- Confidentiality;
- Dealing with disclosures of abuse;
- Managing transitions, displacement and culture shock.

5.4 Who needs training?

Having established the areas and topics on which training might be required, it is also important to consider exactly which staff require the training.

Induction level

One of the clearest messages to emerge from the interviews was the need for a thorough induction for new staff. As mentioned earlier, 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 Sections 5.1-5.3 at a fairly basic level so, e.g., it would educate staff in the core principles of the most common therapies to allow them to intervene with these in mind, 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 further, more advanced or specialised, training could build at a later stage. One participant commented:

"I think there is an eagerness within inpatient units to develop training like 'let's get everybody CBT trained or DBT trained' or whatever, but some of them still haven't had the basic knowledge base. That's what worries me."

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:

"CAMHS has a broader well-being remit, less kind of mental illness treatment-driven."

"In say an old-age unit or a medical unit the care may be the most important thing, but here they have to be active therapists themselves."

One participant, however, did caution that the specialised nature of CAMHS work should not be over-stated:

"I think more is made of the speciality of working with children and teenagers than needs to be the case. I sometimes think CAMHS can be a bit precious about it: 'oh no, you couldn't possibly do this without jumping through several rings of fire'."

Post-induction level

Whilst the training gap that most urgently needs addressing was felt to be at the induction level, participants also acknowledged the need for continuing professional development post-induction:

"I mean, induction's fine but once you get a couple of years' experience it's probably quite good to re-visit those things again, which we don't do [...] Even for me, ten years down the line, I'm wondering if there's something I should be doing, because the kids do change. We're seeing a lot more of the serious and significant mental illnesses, a lot more risk, a lot more violence, a lot more suicidality."

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 member of staff necessarily needs to be trained in everything. In some cases, it was felt it might be appropriate for staff who had received intensive training on a topic to pass some of the knowledge gained onto their colleagues.

Tier 4 or more?

There was a general view among participants that training in many of the areas identified in Sections 5.1-5.3 would be highly relevant to CAMHS staff working outside as well as inside inpatient units. This might include all Tier 3 staff, or it might be restricted to those Tier 3 staff administering 'intensive outreach', 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:

"What's happening much more around the country is that Tier 4 is becoming much more integrated into the pathway of care so in some areas – not all – around the country they're moving towards having a step-down... so they're moving towards having urgent response teams, or crisis resolution, or some sort of Tier Three-and-a-half almost."

6. Format and delivery

Participants had a number of valuable thoughts regarding the best way to format and deliver training to staff in inpatient CAMHS.

Location

There was an overall consensus that access to training would be greatly enhanced if it were delivered locally to the unit, especially in view of the cost and practical constraints discussed in Chapter 4, although of course this alone would not overcome the challenges posed by shift system. 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. One participant recalled that when some training had been delivered on-site at her unit, the decision had been taken to leave a skeleton staff on the floor and nominate two trainees who could be recalled to the unit – hopefully for a short time – if required.

Departing from the consensus, one participant put forward the view that training delivered some distance away from the unit might be more "respected" and "protected" than training delivered locally. She felt that unit staff might be inclined to call back colleagues training locally when another option was in fact available but involved more work on their part.

Timing

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. This would be particularly vital for units experiencing high staff turnover. One participant raised the question of whether bank or temporary staff would be eligible for key training, and if so how it could be made possible for them to access this in a timely manner. Approaches other than face-to-face teaching may offer economically-viable opportunities for making training available when needed; these are discussed further in the next sub-section, 'Teaching approaches'.

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. It was suggested that staff might find it easier to implement small amounts of new information delivered in a "drip-drip" fashion into their everyday work; this was contrasted with the potential for a more intensively-delivered course to result in little more than "a folder left on a shelf". One participant highlighted the challenges of applying new learning in highly pressurised conditions, where staff typically spend a lot of their time just "holding the baby".

Teaching approaches

Whilst it was felt that training on many of the topics detailed in Sections 5.1-5.3 would necessarily involve elements of traditional lecturing, participants emphasised that this needed to be clearly related to real-life practice on the frontline:

"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 approaches:

"...a bit of theoretical, a bit of video, a bit of role play, getting them to use case examples, getting them to try things out and think differently, helping them to think about themselves and the work."

Asking trainees to draw on their own experiences was recommended as a way of highlighting the relevance of the training to them, which could be particularly useful for engaging trainees who were sceptical or resistant to the training.

It was suggested that some kind of follow-up after the main training session – perhaps in the form of a test, assessment or supervision - might be helpful for giving the training a clear focus and making the connection with real-life practice. One participant mentioned some of the parenting packages, where trainees aim towards facilitating a supervised parenting group, as exemplifying this kind of approach. It was also suggested that asking trainees to complete some reading or reflection prior to

the course could help focus their minds, although it was acknowledged that inpatient staff do not typically have the time to undertake significant amounts of homework.

There was a consensus among participants that certain teaching approaches, particularly those involving group discussion or practice reflection, could only be delivered effectively face-to-face. The potential of online methods was thus viewed as limited, although online accompaniments to face-to-face courses were viewed positively by some participants, and one suggested that staff on overnight shifts do tend to have time for study. The view was expressed that distance and e-learning might have more potential in relation to advanced rather than basic-level training. One participant suggested that video-conferencing could be a cost- and time-efficient tool for delivering training to staff in disparate locations.

Accreditation

The point was made that some form of accreditation, e.g. a diploma for a Specialist Practitioner in CAMH, which would be available to HCAs as well as nurses, could be both motivating and rewarding for trainees.

7. Beyond training

Participants felt clear that training was the key to addressing knowledge and skills gaps within inpatient CAMHS. In contrast, the provision of paper or online resources was seen as having limited value, mainly due to the time pressures on staff, although some participants did favour providing these as an accompaniment or addition to training. It was commented that there do not seem to be many relevant papers or journals aimed at inpatient staff, and one participant queried whether the FPSA could be doing more to disseminate and promote its training bulletins. Another participant felt that CAMHS staff were typically unaware of practice overseas, and suggested that this might be an area in which the provision of paper or online information could be useful.

Opportunities to meet and network with staff in other inpatients units, to share practice, discuss cases and get new ideas, were seen as very valuable. One participant urged that the FPSA should continue to play a key role in providing such opportunities for staff. Given the cost and time barriers to travelling long distances to attend events, it was also suggested that video-conferencing might be useful for this purpose.

Effective practice reflection was clearly perceived to be important for the provision of consistent, high quality care and the development of staff skills. In Chapter 4 the point was made that an inpatient unit can tend towards operating as a somewhat 'closed' environment, with a culture that does not pre-dispose staff to be open to revision and change. For this reason, it was suggested that bringing in an independent third party to facilitate practice reflection – through, say, a monthly group session - might be helpful. Some consultants with expertise in systems psycho-dynamics provide this sort of service.

8. Resources and recommendations

Over the course of the interviews, some resources were mentioned that appear to be relevant to the issues discussed in this report, and to the potential development of new training for staff in inpatient CAMHS. Perhaps the most key is a 2009 handbook published by the Quality Network for Inpatient CAMHS (QNIC) based in the Royal College of Psychiatry entitled '*Working within child and adolescent mental health inpatient services: a practitioner's handbook'* by Angela Sergeant. Angela Sergeant was one of the participants in this research. She explained that, as a first stage of the handbook's development, a consultative event was held involving approximately 30 staff from inpatient units around the UK. The handbook was edited by Dr Chris Barrett, a senior lecturer in the School of Nursing and Midwifery at the University of Southampton. A draft was also approved by the DoH and the Royal College of Nursing.

Angela specified that the handbook was not intended to train staff to diagnose specific disorders or lead specific therapeutic interventions, but instead focused on:

"...the things that fall in between, the things that if you went to work in an inpatient unit, regardless of your discipline [...] you ought to have an awareness and basic understanding of. It's a broad brush overview, usually for nurses but not necessarily [...] it covers a lot of things but it certainly doesn't cover everything. It's not an exhaustive list, it's more a starter-for-ten really."

In her view, a thorough basic-level training course would need to include components focused on diagnosis and intervention in addition to what is covered in the handbook.

A thousand copies of the handbook were printed and, according to Angela's information, one was sent to every inpatient unit in the country, with the remainder given away at the QNIC conference. Funding was not available for a second print run and the department of QNIC that funded the project has now been disbanded so Angela thought it unlikely that the handbook would be promoted

any further in future. No formal feedback has been sought from unit staff and there has been no evaluation of the handbook's impact, although Angela has received some positive informal feedback and some of the research participants also mentioned that they were either working through it with staff, or were planning to do so.

Angela drew on numerous other texts to inform the handbook, although due to time constraints she did not feel that she had necessarily accessed everything of relevance. It is her view that there is a lot of useful material available but it is fragmented; for this reason, she felt that it would be very helpful for someone to collate and synthesise all the relevant literature out there before developing any new training. This would ensure that any new training drew on the best available information and avoid "reinventing the wheel from scratch".

A further potentially relevant resource mentioned by participants, which is not specifically focused on inpatient care, is the New to CAMHS Training Package developed by NHS Lothian and Edinburgh Napier University. This is due to be updated with the new title Essential CAMHS in Autumn 2011.

A number of the research participants said they would be very happy to be consulted again if the FPSA were to take the decision to begin developing a new training programme. Some were in the position to provide PowerPoint slides or other documentation relating to training they had developed or run within their own units. Their names and more details of what they can offer can be provided on request.

Recommendations

The information collected through this research identifies a clear need for training among staff in inpatient CAMHS units, particularly at the basic level. Therefore, the key recommendation arising is to develop of a programme of work aimed at filling this gap. This report concludes with some further thoughts regarding possible ways forward:

- There may be a case for commissioning a review of the relevant literature and/or consulting with key stakeholders (e.g. QNIC) before beginning to develop any new training in earnest.
- In the short term, consideration might be given as to whether the FPSA could have a role in further promoting the handbook authored by Angela Sergeant, to ensure that all units around the country are getting the most out of this relevant resource.
- If the decision were taken to draw heavily on the handbook in developing a new training programme, it would be advisable to gather feedback from those units who have been using it as a training resource – both about its coverage, and about strategies that have been used to translate it into a teaching tool.
- A number of practical challenges would have to be tackled before launching a new training programme, primarily regarding the location and timing/frequency of courses. There is also the question of whether staff working outside inpatient units (e.g. in 'intensive outreach' services) might require and benefit from (components of) the same training. Of course, all these issues have significant cost implications.

Finally, apart from the development of a basic-level training course, participants highlighted a number of additional ways in which they felt FPSA funds could be used to support staff working in inpatient CAMHS. To summarise, these were:

- Supporting a proportion of staff in getting trained to lead on specific interventions such as family therapy, CBT and DBT;
- Supporting experienced staff in refreshing or extending their knowledge and skills in relation to general CAMH work;
- Providing relevant printed and/or online resources;
- Providing opportunities to network with staff from other inpatient units;
- Funding external consultants to facilitate practice reflection.

Appendix A

Introductory email

Dear [Name],

I am following up on an email sent to you by Katy Thorne of the Foundation for Professionals in Services to Adolescents (FPSA, formerly APSA, the Association for Professionals in Services to Adolescents) on 26th April.

I am an independent researcher who has been commissioned by the FPSA to carry out a series of telephone interviews to explore the training needs of staff working in Tier 4 CAMHS units. I understand that, some time ago, you agreed to take part in an interview and I hope you are still willing! All units that participate in the research will receive a £50 Amazon voucher.

I am available to call you most afternoons from 2pm onwards. I can also interview you in the evening if you prefer. The interview should take about 30 minutes. I would be grateful if you could email me with two or three times over the next few weeks when you will be available.

The purpose of this research is to support the FPSA in developing a programme of training to address the key development needs of frontline staff. Your contribution to this important endeavour will be very much appreciated.

Please don't hesitate to email me any questions you have. I look forward to hearing from you.

Best regards,
Alice Reeves
Independent Researcher

Interview guide

Introduction

- I am an independent researcher who has been commissioned by the Foundation for Professionals in Services to Adolescents (formerly APSA) to collect information about the training needs of staff working in Tier 4 CAMHS units.
- The purpose of the research is to develop a programme of training to be funded by the FPSA and delivered within the unit to multiple staff members. The training will focus on supporting frontline staff to develop the practical skills they need in their everyday work. This programme will be separate from the FPSA's grant-giving programme, of which you may already be aware.
- So that I don't have to write copious notes, I would like to record the interview. The recording will be kept securely on my computer and not passed on to anyone else. Is that OK?
- Although I have been given some information as background, I am not an expert in CAMHS, so please use layman's terms as much as possible and forgive me if I ask what sound like ignorant questions!

Main interview

- Could you begin by giving me your job title and a short description of the work you do in the unit?
  If necessary, prompt: how long have you worked in the unit?
- What other types of staff work in the unit?
  If necessary, prompt: nurses, medics, psychologists, unqualified staff
- How is training usually arranged for staff in the unit?
  If necessary, prompt: who arranges, procedures for arranging?
- Who usually funds this training – the Trust or someone else?
- What would you say are the main barriers to staff attending training?
  If necessary, prompt: cost, time/cover, location, finding suitable training
- To what extent do you feel that the staff in your unit are currently getting the training they need?
- In what areas do you feel that training would be useful for staff in your unit?
  If necessary, prompt for subject areas (eating disorders, depression, ADHD) and skills (communication, group work, leadership, establishing & maintaining boundaries).
  Also explore needs of different types of staff
- Thinking about training you've received in the past, do you have a view on what works best, for example in terms of lectures versus workshops, or short courses versus longer ones?
- Finally, apart from training, are their other ways in which the FPSA might usefully support your professional development and that of your colleagues in the unit?
  If necessary, prompt: books, journals, practitioner magazines, online resources

Closing

Do you have any questions for me? Please feel free to email me if you think of any questions later (if necessary, give my email address).

The FPSA Secretariat will email your Amazon voucher to you (if necessary, confirm email address).

Thank you very much for your time.

The Foundation for Professionals in Services to Adolescents

So what's in a name?

At the start of 2011, the Association for Professionals in Services for Adolescents (APSA) became the Foundation for Professionals in Services for Adolescents, or Foundation PSA.

A rich history

The history behind Foundation PSA stretches back several decades to the inception of the original Association for the Psychiatric Study of Adolescence in 1968. It developed into the second iteration, the Association for Professionals in Services for Adolescents (APSA) in 1992. Its genesis came from the then emerging in-patient units for disturbed adolescents in the 1960's and early 1970's.

A proud legacy

APSA also accelerated the publication and development of its flagship product, the Journal of Adolescence, now the pre-eminent international publication in respect of adolescent needs, issues and interventions. This was joined for 13 years by the practitioner magazine, APSA Rapport and latterly, from 2007, the successor Practitioner Briefing Papers.

The future

Although the charity has changed the name the aims and objectives remain the same. That is supporting professionals to improve their knowledge base and to enhance their clinical expertise. The main focus is on Tier Four services but it will continue to support staff working in other tier services also.

Foundation PSA has provided grants for individuals to undertake both short and longer term courses and attendances at study days and conferences to their members. Of course the charity undertakes many other activities as well. The FPSA will continue to provide these awards. However a significant change is that it is no longer necessary to be a member of the charity to be eligible to apply for a grant. For further information and guidance on applying for a grant please visit our website

If you would like to be updated or kept informed of opportunities please register your email address online at www.foundationpsa.org.uk

This report 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.
Contact alice@qualityinevidence.com. Website: www.qualityinevidence.com