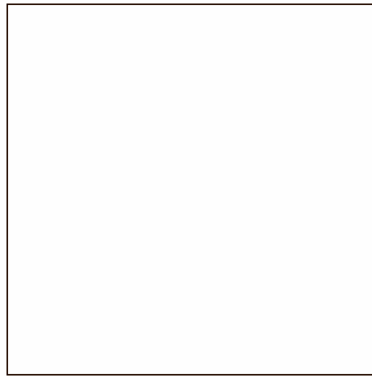
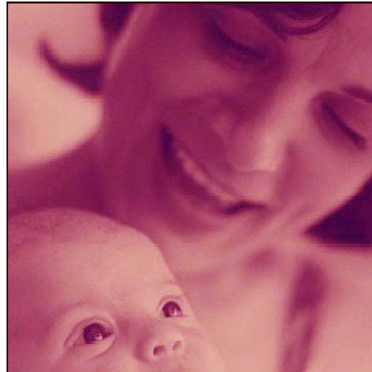
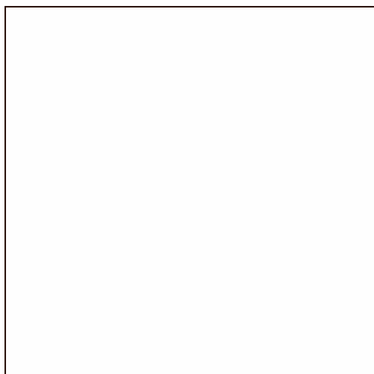
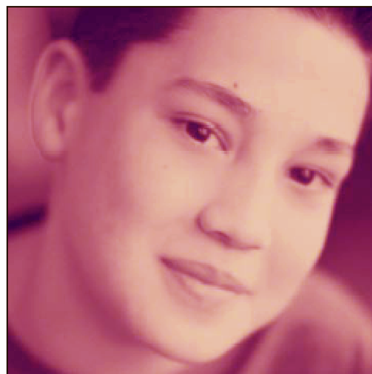
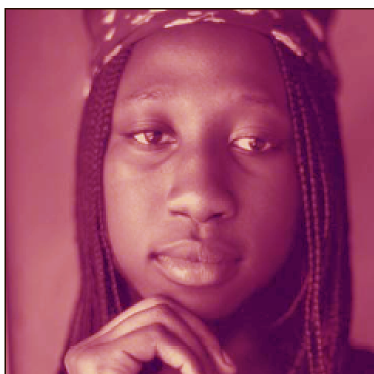
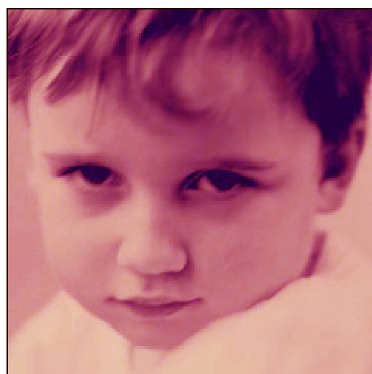
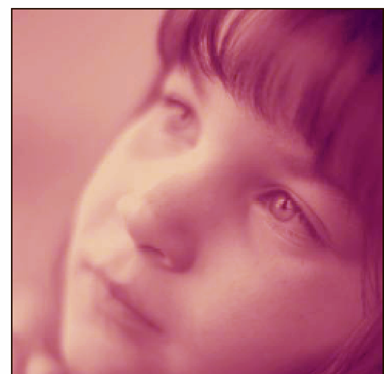




Getting the Right Workforce Getting the Workforce Right

A strategic review of the Child and Adolescent Mental Health Workforce

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Executive summary

1. The Scottish Executive has recently published a number of important policy initiatives designed to support and improve the mental health of children and young people. This report considers the workforce necessary to translate these initiatives into practice.

2. Successful implementation requires that, within the workforce in Scotland, there are skills in promoting mental health, skills in preventing mental health problems and skills in providing appropriate care and treatment for those with emerging and established mental health problems.

3. The workforce which can make a difference to the mental health of children and young people extends from informal and voluntary workers, through those who work in universal services of education and health, to the specialist services provided by local authority, voluntary and independent sectors and the NHS.

4. This report endorses the importance of a clear understanding of the needs which are being addressed and the availability of clearly articulated and negotiated models of care. The picture of the necessary workforce follows from these and this report describes that workforce, the steps necessary to build that workforce and the infrastructure required to sustain it.

5. With few exceptions, the necessary skills can already be found amongst the current workforce but there is a significant lack of capacity in relation to each of these activities.

6. Scottish Executive policy, described in *The Mental Health of Children and Young People: A Framework for Promotion, Prevention and Care* (FPPC), envisages mental health services with greatly expanded capacity for primary mental health work and early intervention but also for work with children and young people with complex and severe mental health problems.

7. The workforce for the community based CAMHS and for in-patient and intensive CAMHS, across Scotland, is established at levels well below that necessary to the kind of improvements in the mental health of children and young people which are anticipated in current policy documents. It will need to expand substantially.

8. Increasing the capacity to improve the mental health of children and young people requires a range of activities. In particular it will involve both increasing numbers, through new investment in posts and improved retention of current workforce *and* increased efficiency, through training and supervision, better infrastructure and improvements in health in the workplace.

Workforce planning

9. The approach to workforce planning described in this report looks across the “tiers” of service and across the sectors and disciplines involved to identify the skills required to address the needs of the “care group”. The report highlights the activities necessary to develop and sustain these skills within the workforce. The experience of preparing this report suggests that there are likely to be significant benefits in

adopting an approach to these workforce challenges which extends beyond planning in terms of single professions.

10. This report has identified three arenas for workforce development activity: building the "mental health capacity" of the network of children's services, addressing the workforce requirements of the community based CAMHS and building the workforce associated with in-patient and intensive CAMHS

11. Workforce planners should note the part played by the local authority, voluntary and independent sectors in delivering specialist mental health services.

12. A contemporary comprehensive CAMH services will typically include child psychiatrists, clinical child psychologists, CAMHS trained nurses, occupational therapists, speech and language therapists, social workers, child psychotherapists, family therapists, specialist teachers, a range of creative therapists and other allied health professionals.

13. There remains a need to expand the number of formal academic posts, in a range of disciplines, as the CAMH SNAP report recommended. But there is also a need for academic skills to become more widely distributed within the clinical community.

14. It is also important, particularly in light of plans to develop roles and re-focus services, that specialist CAMH services have the competencies and the capacity to evaluate these developments.

15. Workforce planning for the CAMH workforce should focus on skills and roles as well as on profession specific developments.

16. The limited information available about the workforce constrained this process significantly. The Scottish CAMHS Mapping, recently initiated by NHS Information and Statistics Division provides the first clear, comprehensive picture of the NHS CAMHS workforce in Scotland.

17. This report includes a benchmarking exercise which relates the size of CAMHS teams to population numbers. Future work should be based on the number of children and young people in the population, with further work required in the short term to adapt available models accordingly.

18. The extent to which particular areas fall short of what is required varies. Information now becoming available through the CAMHS mapping exercise allows these discrepancies to be studied more closely and should lead to them being addressed more systematically.

19. It would be timely to convene discussion at NHS regional level about CAMH services to remote, rural and island communities, to allow workforce plans to develop in a way that supports the optimum configuration of services.

20. Regional planners are taking forward the plans to increase the capacity of the CAMH inpatient sector. This report sets out the workforce implications of those plans which include substantial increases in numbers of staff.

21. The information derived from the ISD Scottish CAMHS Mapping should become an integral part of annual workforce planning cycle for children's services and mental health services in Scotland. Collection of this information should complement information regarding this workforce that will be collected through the SWISS development.

22. The workforce supply is already under pressure and is likely to remain so within this sector. With the Scottish Executive's clear expectation that FPPC will be implemented in full, there will be a need to review the numbers of those entering training of all of the relevant professions.

23. Agencies with a role to play in workforce planning arrangements should identify, at the earliest opportunity, the implications for their workplan raised by this review.

Education and training

24. Each individual who works with children and young people should be aware of the importance of mental health. There should therefore be a specific focus on the mental health of children and young people in the pre-service and under-graduate training and education of all those who work with children and young people. There is room for further clarification of the skills needed to deliver a comprehensive CAMH service. The Development Framework produced by NHS Education for Scotland offers a sound foundation for this work.

26. CAMH services need to have the appropriate range of therapeutic skills available. These will include behavioural, cognitive, interpersonal/psychodynamic, pharmacological and systemic approaches. Some of these skills are appropriately delivered in individual, dyadic, group and family settings.

27. The training routes for many of the professional groups who work in CAMHS in Scotland are such that, despite the range of core professional skills they bring, they cannot be presumed to bring the full range of skills necessary for their CAMHS role. There is a need for "new-to-CAMHS" training which can be accessed by every CAMHS team across Scotland.

28. There is a need for a clear strategic focus on systems for education and training in relation to the skills of the specialist CAMHS workforce. NHS Education for Scotland should continue their important work in driving forward this educational and training agenda, ensuring that the care group perspective is maintained. This will include training for those who are "new to CAMHS" and the range of "advanced CAMHS" skills, including primary mental health work, therapeutic skills and the other specialist skills described in this report. The FPPC indicates that extending the availability of primary mental health work should be an important priority for NHS CAMH services across Scotland. There is, therefore, a particular need to make available appropriate training for those who develop and deliver these services.

30. As CAMH services develop to reflect the FPPC, there will be an increasing need for practitioners who are competent in working with children and young people whose mental health difficulties co-exist with learning disability or with forensic problems.

Training programmes therefore need to adapt to ensure the supply of practitioners who are appropriately qualified in these areas.

31. There is wide disparity in the arrangements for commissioning and delivering the training of the CAMHS specialist workforce. In particular, the arrangements for commissioning the training of child psychotherapists and family therapists for the specialist CAMHS workforce are precarious. These arrangements should be within the remit of NHS Education for Scotland; steps should be taken, including addressing funding arrangements, to allow this to happen as a matter of urgency.

32. Local arrangements to meet the requirements of the new mental health legislation may vary, but the implications for the training of mental health staff who work in general psychiatric wards which admit young people will be similar across Scotland. Addressing these training requirements should form part of the arrangements made to comply with the new legislation.

33. Substantial investment is needed in both infrastructure and new posts. The £1M investment over 2004 – 2006 has allowed the successful piloting of a wide range of new training initiatives and the preparation of training infrastructure. **Implementation**

34. Building the "mental health capacity" of the network of children's services is a shared responsibility. Many of those working in tier 1 services already make an important contribution to the mental health and well being of children and young people. There are clear indicators that there is significant potential for developing these roles. Agencies working with children and young people will need to support their staff with this development. Specialist mental health agencies will also contribute support to this development through liaison, consultation and training.

35. Those working in the wider workforce have a particularly important role promoting resilience amongst children and young people. This is important for all children and young people, but particularly so amongst those who are at risk of developing mental health problems

36. Specialist CAMHS practitioners will have an important part to play in delivering training and supervision. This has important implications for their own training and development needs.

37. These developments, and the associated re-shaping of services, will present important challenges for those working in specialist CAMH services. Support will be required for organisational development and leading the process of change.

38. Creating the CAMH Workforce Development Manager post has significantly enhanced the process of CAMH workforce development by providing dedicated capacity to address a range of critical developmental tasks.

39. The Scottish Executive has now given a clear commitment to prioritising the improvement of the mental health of children and young people, in the full knowledge that this will need to be sustained for a period of years to develop the necessary capacity. NHS agencies and their partners now need to develop workforce plans which detail how these expectations can be delivered.

40. The National Workforce Unit should continue to support and ensure the implementation of the workforce recommendations for children's mental health.

41. Regional workforce planners will take the leading role in implementing the recommendations of this report.

42. The Framework for Promotion, Prevention and Care requires that mental health be consistently addressed in Children's Services Plans; these plans should also address the associated workforce development issues.

43. The arrangements for monitoring the developments in relation to the CAMH workforce should be incorporated within the Scottish Executive's plans for monitoring the implementation of the Framework for Promotion, Prevention and Care.

44. A plan for phased investment in workforce should be developed in conjunction with plans for implementation of the Framework for Promotion, Prevention and Care, with the aim of doubling the size of the NHS based CAMHS workforce within ten years.

Introduction

In 2003 the Health Minister gave an undertaking, in *Partnership for Care*, that building the workforce of those dealing with the mental health of children and young people would be a priority. This document sets out the implications which arise from the work undertaken to realise that commitment.

This report is an important first step and provides a foundation for further work to be developed. It describes the *context* in which this issue has been considered. It then discusses the *tasks* which face the workforce. After a discussion of the *methods* used, the report *reviews* the current workforce in light of those tasks. This is followed by consideration of the *implications* of the assessment and the steps which will be required to take this forward.

Drawing from a wide range of sources, including publishing some newly available workforce information, the report seeks to bring clarity to the complex issues involved and to outline ways forward for those planning workforce at local, regional and national levels.

1. Context

The strategic context for this work derives from the *Child and Adolescent Mental Health Needs Assessment Report* of May 2003[1]. Key elements are:

- the importance of promotion and prevention as well as treatment and care approaches in any mental health strategy
- the importance of the whole network of children's services, as well as the specialist mental health services, to the mental health and wellbeing of children and young people
- the importance of the availability of a full range of mental health services, delivered by a workforce trained for purpose.

The Health Department's response to the report spoke of Child and Adolescent Mental Health Services as "*one of the first priorities for the Mental Health pathfinder client group for integrated workforce development."* The Mental Health Division, in collaboration with the Child Health Support Group and the National Workforce Unit, set up the *Child and Adolescent Mental Health Workforce Group* (CAMHWG), chaired by Dr Graham Bryce. This document summarises the work of that group.

1.1. The follow on to the needs assessment

A numbers of streams of work have followed from this needs assessment process:

1.1.1. The arrangements for implementing the "SNAP recommendations" have been published in the Scottish Executive document *The Mental Health of Children and Young People – A Framework for Promotion, Prevention and Care*[2] (FPPC)

1.1.2. NHS Education for Scotland has published a *Development Framework*[3] (NESDF) which sets out many of the competencies required to deliver this vision of mental health.

1.1.3. The Child Health Support Group published the report of *Inpatient Working Group - Psychiatry Inpatient Services.*[4]

1.1.4. *HeadsUpScotland* – the National Project for Children and Young People's Mental Health – was established in 2004. Under the directorship of Anne Clarke, this project has the task of championing and co-ordinating the delivery of these strands of work.

1.1.5. The post of *Child and Adolescent Mental Health Workforce Development Manager* was created with the principle aim of giving capacity to develop and support the delivery of the agenda emerging from the CAMHWG. Maria Dale took up this 12-month post in April 2005.

1.2. Other relevant policy and strategy issues

1.2.1. New mental health legislation

The *Mental Health (Care and Treatment)(Scotland) Act, 2003*[5] seeks, as its main objective, to underpin effective mental health care and treatment. The new act, whose main provisions came into force on 1st October 2005, introduces a number of requirements specifically designed to improve the experience of children or young people involved with mental health services. These requirements raise a number of implications for the NHS mental health and local authority workforce.

1.2.2. *The National Programme for Improving the Mental Health and Wellbeing of Scotland.*

The work of the programme, set out in its Action Plan[6] for 2003 – 2006, has a number of strands which hold specific implications for those working with children and young people, in particular:

- SeeMe – the anti-stigma campaign *and*
- Choose Life – Scotland's suicide prevention strategy

The National Programme also works in partnership with the Scottish Health Promoting Schools Unit. As is discussed later, that unit's work[7] also has important workforce implications.

1.2.3. NHS Workforce Planning

The workforce agenda is one of the key challenges currently facing NHS Scotland. The *Scottish Health Workforce Plan 2004 Baseline*[8] began the process by setting out the national picture of the NHS workforce. It set out the need for a more strategic approach to workforce development with the NHS as well as proposing ways of developing workforce planning processes, including the use of care groups. Since then, all NHS Boards have produced individual baseline reports as their starting point.

The *National Workforce Planning Framework 2005*[9] takes this work forward by enabling action at National, Regional and NHS Board level. In doing so it connects up workforce planning to service planning, financial planning, education and training support as well as regulatory requirements.

Building a Health Service Fit for the Future[10]*- A National Framework for Service Change in the NHS in Scotland* sets out a challenging vision that will shape healthcare in Scotland over the next 20 years. This agenda will be pivotal to identifying the services required and the size and shape of the workforce in NHS Scotland.

In the Scottish Executive's response *Delivering for Health* sets out the main actions to implement the recommendations of the National Framework for Service Change.

1.2.4. Other important initiatives

Finally there are initiatives currently evolving which will hold a range of implications for the workforce considered in this report. They fall into four main groups:

- those addressing particular populations of children and young people, for example, the *Education (Additional Support for Learning)(Scotland) Act, 2004*[11] and the *Intensive Support and Monitoring*[12] proposals
- those addressing the ways in which services are organised and delivered, in particular the reorganisation of NHS with the development of *Community Health Partnerships*

- those which will directly affect roles within the workforce, such as *Agenda for Change* or, within the education sector, the changing roles and responsibilities of teachers in relation to guidance *and*
- those which will directly affect workforce supply, whether through changing career paths, as with *Modernising Medical Careers*[1], or by modifying working practices, as with the *European Working Time Directive.*

It will already be clear that workforce development is taking place against a background which is changing rapidly. It follows that workforce plans have to adapt and evolve to reflect this.

1.3. Content and purpose of this report

The multi-agency CAMHWG[2], which began its work in spring 2004, has focused on improving capacity in three areas:

1. the network of children's services
2. the community based specialist mental health services for children and young people *and*
3. in-patient and intensive mental health services for children and young people.

The word "capacity" is used throughout report to indicate the ability which a group, team, or agency has to deliver work. The term is used in relation to both the work of clinical services and the wide range of health improvement activities considered. This particular usage follows directly from the CAMH SNAP report[1] which further noted, "*capacity is clearly dependent on the available resources and, in particular the range and level of skill within an agency or team. But it is not solely determined by them. These resources exist in a dynamic balance with a range of contextual and environmental actors which can operate to enhance or reduce effective capacity." (p.67).*

Based firmly on the Framework for Promotion, Prevention and Care, this report provides a review of the workforce challenges. Following an analysis of the present situation, it describes a clear direction for workforce development. The authors acknowledge the complexity of the challenges involved and recognise that much further work will be required to translate these proposals into the practicalities such as detailed workforce plans and education programmes which will be needed to bring the aspirations of the Framework to fruition.

[1] See http://www.mmc.scot.nhs.uk/ for information
[2] See Appendix A for membership

2. Tasks

In this section, the subjects which the group addressed are described.

2.1. The "mental health capacity" of the network of children's services

The SNAP report envisaged a future in which there will be greater capacity for mental health work across the network of children's services. Both the Framework for Promotion, Prevention and Care (FPPC) and the NHS Education for Scotland Development Framework (NESDF) make it clear that those who work in children's services *and* children, young people and families themselves play a part in improving mental health. The FPPC sets out the activities involved in developing and delivering that greater capacity, while the NESDF sets out the competencies required.

This paper mainly addresses itself to the professional workforce issues impacting on all disciplines and professional groups and considers options for further development.

2.2. Community based specialist mental health services for children and young people

The task here has been to consider the implications of the FPPC for workforce. The Framework is a very detailed document, whose most important implications for this workforce process arise from the Framework's implementation of this section from the original needs assessment report:

> *"when it proves possible to enhance the capacity of this sector, it will be important to reshape and refocus. ……..practitioners from these specialists services will have an important part to play in enhancing the wider network……….they are already involved in liaison, consultation and training, but this will occupy a larger percentage of their time and will increasingly lead to joint working with colleagues in schools, primary care, social services, child health teams and others.*
>
> *The effect of this will be to move the centre of gravity for specialist CAMH input increasingly towards the universal services, enhancing the capacity of that network for earlier intervention. This also has the potential to change the pattern of demand on the specialist services, allowing them to develop their role more fully for children with more complex and severe mental health problems."*
>
> *(p. 77)*

Within the Framework account this adapted, developed and extended role for specialist CAMHS becomes clear and, with it, significant implications in terms both of capacity and professional roles. The Framework also has clear implications for training, with the expectation of new learning going on across the network, with specialist CAMHS workers playing an active part in that activity. Such new roles, as well as the increase in capacity, mean that there will also need to be increased training activity *within* specialist CAMHS.

2.3. In-patient and intensive mental health services for children and young people

A range of services fall under this heading and the report considers the overall picture. But the main task has been to look at the recommendations in the report of the Child Health Support Group's (CHSG) Inpatient Working Group on Psychiatry Inpatient Services. That report addressed itself primarily to specialist inpatient services for young people. This report considers how the workforce implications of this earlier piece of work might be distilled and implemented. Two particular aspects of this report have important implications for workforce.

The first is the conclusion that the current level of provision of inpatient places is significantly short of the number actually needed. An increase in the number of beds, from the 35 currently available, to 60, in the first instance, clearly has significant implications for staffing.

The second is that the report proposes a particular model of care for these units and discusses the staffing requirements in that light. Few of the units are currently staffed in line with that model and so, even without increasing bed numbers, the report holds significant implications for workforce.

The Chair of the Child Health Support Group asked the NHS Regional Planning Groups to consider the feasibility of implementing the recommendations for young people's inpatient services. A short-life working group was established to do this. The group has developed proposals to provide 47 places by 2008 and 56 places by 2010. These proposals were approved by the NHS Chief Executives in August 2005 and remitted to the NHS Regional Planning Groups for implementation.

The present report considers these workforce implications and therefore has clear salience for this planning process.

3. Methods

The *National Workforce Planning Framework 2005* acknowledges the developing status of workforce planning in NHS Scotland. The section “A Framework for Workforce Planning” sets out the kinds of processes in place and envisages the maturation of the workforce planning system, with a shift from more “simple” and “static” models of planning to increasing availability and use of “sophisticated” and “dynamic” models of planning. Working with the National Workforce Unit, the CAMHWG have had the opportunity to pilot the use of these more dynamic methods:

3.1. A care group approach

This workforce process has followed very directly from the earlier needs assessment work described in the CAMH SNAP report. That report sought to orientate service responses to the needs of Scotland’s young population, and highlighted the importance of adapting organisational and professional priorities to that focus.

That *care group* orientation, established in the work already undertaken has complemented the National Workforce Unit interest in promoting the maturation of planning processes.

3.2. Flexible use of service and workforce modelling

The CAMH workforce process has also had the opportunity to make use of the evolving methodologies for linking service and workforce modelling. This has been done in relation to **inpatient services for young people**, where the availability, within the CHSG Inpatient Working Group report, of detailed guidance about model of care, professional roles and workforce numbers, made this feasible.

The model, which is summarised in section 5, essentially considers current and predicted demand, examines the issues affecting supply and sets out a range of options in that light.

The level of detail necessary for linked service and workforce modelling has not been available in relation to the **community CAMHS teams** and so that discussion, largely conducted using principles of service planning, indicates the scale and direction of development required, rather than providing definitive guidance. However, this is a rapidly evolving area and information has become available in the course of 2005 which should facilitate more detailed modelling of options for development of that section of the CAMH workforce.

By contrast, the discussion about “**building the mental health capacity of the children’s network**” is based on tasks, roles and relationships, rather than numbers at this stage. Here the main aim is a *developmental* one – namely how to realise an approach to mental health whereby all of those working with children and young people – both individual workers and agencies - are able to consider and plan how to develop their role in maintaining good mental health for all young people and in addressing the needs of those with identified mental health problems.

3.3. Level of integration

It has been possible to consider implications across all of the dimensions proposed in the workforce report – professions, health and social care, and primary through to tertiary care. Many professional groups are involved in the delivery of these services and numbers of them work across sector boundaries.

This approach of integrated care group planning has a number of advantages. It means that a whole range of professional groups is being considered in relation to this single strategic aim and it requires an attention to each of the disciplines which are contributing to meeting this aim.

It also presents some particular challenges, in that it requires an engagement with a substantial range of disciplines: we suggest, for example, that there are around 15 professional groups routinely involved in the delivery of NHS specialist CAMHS. Furthermore, not all of these are NHS employees: local authority teachers and social workers are routinely deployed alongside their NHS colleagues within these services. In other words, a comprehensive picture is gained, but is attended by significant complexity.

It has also been possible to consider some skill mix questions, for example, how best to achieve the availability of “primary mental health work”, which is discussed in FPPC as a central component of mental health service.

3.4. Feasibility

The National Workforce Planning Framework offers guidance about how to establish the feasibility of a workforce plan. It highlights three key issues:

- Affordability: that is the need to ensure that workforce planning projections are affordable and offer value for money
- Availability: that is the need to ensure adequate sources of supply for the planned workforce
- Adaptability: that is the need to ensure the planned workforce is trained and supported and that workforce plans are aligned to those for service redesign.

This report concludes by reviewing its findings in this light. Further work will be required, particularly within workforce planning structures, to take this forward.

3.5. Workforce information

The importance of good workforce information was illustrated by the feasibility of modelling the inpatient workforce. A further illustration emerges from work which has been underway in England since 2002 at Durham University where an initiative funded by the Department of Health has created a fully functional mapping service for CAMHS[3].

The workforce group sought the advice of NHS Education for Scotland (NES) and NHS Information and Statistics Division (ISD) on this matter. Under the leadership of

[3] See http://www.camhsmapping.org.uk/

Dr Liz Jamieson and in consultation with the CAMHWG, ISD developed a CAMHS mapping system for Scotland. This was launched in summer 2005 and the first results are reported in section 6.

4. The "mental health capacity" of the network of children's services

The SNAP report envisaged a future in which there will be greater capacity for mental health work within communities and across the network of children's services. Both the Framework for Promotion, Prevention and Care (FPPC) and the NHS Education for Scotland Development Framework (NESDF) make it clear that this would involve all those who work with children, young people and families. The FPPC sets out the activities involved in developing and delivering that greater capacity, while the NESDF sets out the competencies required.

This section addresses itself, in particular, to the professional workforce issues and considers options for further development. Preliminary ideas for those who are involved in working with children in an informal capacity are also described.

4.1. Defining the "Wider Workforce"

The FPPC is clear that all those who work with children on a day-to-day basis have a role in promoting good mental health amongst children and young people. Being mentally healthy is not simply the absence of illness, but a positive state of "well-being" or feeling good.

The wider workforce also plays a crucial role in identifying mental health problems and seeking specialist assistance for children, young people and their families. More commonly, they support and assist them to address and adjust to difficulties within the community. It is important that we give careful consideration to how we nurture our young people's mental health.

The approach which adults adopt towards children and young people is important. Encouraging children and young people, providing authentic feedback, listening to and respecting the views and opinions and respecting their rights to make decisions about issues which affect them, are all components of promoting well-being.

When those working with children and young people have the skill to help them develop emotional resilience, they offer an additional support for those children and young people who have experienced adversity, focusing specifically on those well-documented elements which build resilience and strengthen those aspects of a young person. Many groups of staff working with vulnerable young people already adopt this approach and the voluntary sector, in particular, make a major contribution to building resilience in vulnerable children and young people.

This work is important both amongst young people who have experienced adversity and amongst the wider population of children and young people.

The wider workforce has several component parts and these can be loosely grouped as follows:

4.1.1. Informal/voluntary workers

There are those who work on a regular but relatively infrequent basis with children and young people and who generally meet with them in an informal, community-based capacity, for example in a sporting, cultural or youth organisational context. Although

members of this group have less face-to-face contact with children and young people than some other parts of the wider workforce, their potential contribution to children and young people's mental health can, nonetheless, be significant.

Relationships within families, for example between parents and with siblings, play an important part in shaping mental health. As well as promoting well-being, voluntary organisations can provide constructive respite for children, young people and families under stress. Through the promotion of skills and the development of talents, many children and young people, including those less successful in academic environments, can gain self-esteem and develop confidence. The response and encouragement of those who work in this way - young volunteers and adults alike - can therefore serve to promote resilience, an important contribution to the mental health of the young person and, potentially, to their family relationships.

4.1.2. *Staff who work with children and young people on a regular basis*

This is the largest group of staff who can have the biggest impact on the mental health of children and young people and can be further subdivided:

Staff working in universal services: such as nursery & childcare staff, all school staff, community learning staff (youth work), and staff in voluntary organisations. Accordingly, the large numbers of people involved in delivering universal services to children and young people play a central role in providing positive environments that nurture the development of good mental health. Teaching and nursery staff, in particular, have sustained periods of contact with children and young people and can be sensitive to developing mental health problems – or to wider circumstances which make it difficult to develop and sustain good mental health.

4.1.3. *Staff who work with children and young people in difficulty*

Secondly, there are other professionals working specifically with children and young people in need who make a significant contribution to the prevention of mental health problems and in the early recognition and intervention where problems are emerging. Staff within social care organisations, such as social workers working with Children and Families fieldwork teams, Youth Justice or Throughcare teams, foster carers or those working within residential settings are often the main source of assistance for children and young people whose difficulties include complex mental health issues[13].

Social services staff also help to sustain treatment outcomes through their knowledge of how wider familial, community and environmental issues impact upon a child or young person. Drawing on an approach which is holistic and socially inclusive, they work to identify and develop a framework of support. By promoting positive parenting experiences for children in need, practitioners in social work services have an important role in preventing mental health problems.

Lastly, there are staff who sometimes work with children and young people in the general course of their work when they (and their families) require particular services. Staff in this group would include most NHS staff such as midwives, Health Visitors, paramedical staff, primary care teams, healthy living centres and community health project staff, child health and paediatric teams, social workers and child protection committees

4.2. Potential roles of the wider workforce

The first and most important role of the wider workforce is to recognise their potential role in supporting the mental health of children and young people. Many of them are already committed to this agenda, especially those who are more likely to come into contact with vulnerable children and young people and who have some experience of their mental health difficulties.

For the majority who work in universal services, however, thinking of their potential role in this arena demands a shift from current thinking. Protecting and promoting positive mental health remains an area to which the majority of people pay little attention. The aim is to encourage more adults who work with children and young people to become aware of the potential that they have to make a difference to children and young people's mental health. For example, actively introducing developmentally appropriate programmes or activities which give children and young people an opportunity to explore the components of good mental health and to build skills that may be required such as assertiveness or problem-solving.

This requires mental health to be raised as an agenda issue and there are a number of processes underway to support that, for example discussion with Scottish Education and Enterprise Department to consider how education staff might have the opportunity to explore further their role in this agenda. A recent mapping exercise commissioned by the Scottish Health Promoting Schools Unit provides detail on the extent of this work in Scottish schools[4]:

It's also important that more people in universal services become more competent both to deal with children and young people who may be having some difficulties and to know when more specialist help might be needed. One of a number of examples of work designed to achieve this is the *Child in Mind* initiative of the Royal College of Paediatrics and Child Health[5].

The FPPC indicates a model of greater involvement by specialist CAMHS in outreach services, providing more support for front-line staff, and providing training and development. These are essential elements which would provide more support to the wider workforce and increase their confidence in addressing such issues. This has important implications for CAMHS staff and this is considered later in this document.

4.3. Workforce issues raised by this model

4.3.1. A healthy workforce

While this should not be a barrier to doing more planned and systematic work with children and young people in relation to mental health, there is no doubt that raising this as an issue can bring challenges for the adults. For some workers this raised awareness can be troubling, sometimes reflecting personal experience, sometimes because of concern or even distress elicited by the young person's circumstances.

[4] see http://www.healthpromotingschools.co.uk/
[5] see http://www.rcpch.ac.uk/education/projects/child_in_mind.html

Work on children and young people's mental health is one part of a wider movement to increase mental health understanding in the Scottish general public. Therefore as well as opportunities to deal with these matters through training and supervision, staff will also have the opportunity to explore this further in their workplaces through SHAW (Scotland's Health at Work) or in specific workplaces such as The Health Promoting School. This would therefore be available either as an "opportunistic" issue within a workplace or part of a CPD/In-service programme, such as that carried out by NHS Greater Glasgow and the Education Department.

4.3.2. *Shift in thinking*

For many staff, there is a requirement to change their thinking to consider mental health as an issue in its own right, in the absence of illness and to become more emotionally literate. This task, which extends well beyond the workforce for children and young people, is one which the National Programme for Mental Health and Wellbeing will be addressing in the next few years. One of the most effective means of supporting this would be to introduce the concept of positive mental health within the under-graduate syllabus of many of the professions who work with children and young people.

4.3.3. *Training and development*

For current staff, there is a need for significant development and training on the issue of children and young people's mental health. Good mental health affects every area of activity for children and young people from learning, to playing, to making relationships. It is therefore crucial and requires to be addressed with some urgency.

It is proposed that the issue of positive mental health and awareness of its importance should be addressed in the same way as child protection issues i.e. that there is a significant input to each individual who works with children and young people and this is addressed in a systematic way across Scotland. This requires considerable investment.

4.3.4. *More developed skills*

To feel competent to deal with the distressed young person, there needs to be a sizeable section of this workforce identifying themselves as willing to have a more detailed training on some of the more common issues which are relevant to children and young people. Practitioners with particular experience in mental health - in the NHS CAMHS, in local authority psychological services and in the voluntary sector - have an important part to play in working with these colleagues to support such learning and development. This would be related to another type of in-service training or within the context of a Personal Development Plan.

5. Specialist CAMHS workforce demand

In this section, the report considers the specialist CAMHS workforce as a whole, particularly in light of recent work on this subject.

Specialist mental health services are delivered by a range of providers: as well as the NHS, local authority psychological services, specialist teams in the voluntary sector and those in the independent sector play an important part. While reference will be made to those agencies, particularly in relation to training, this section focuses on addressing the significant workforce issues associated with NHS based mental health services.

The role and purpose of these services is discussed in detail in *The Mental Health of Children and Young People: A Framework for Promotion, Prevention and Care* and in the Child Health Support Group's report on inpatient psychiatric services[4]. This will therefore only be briefly discussed in this report.

The planning and commissioning of CAMH services is now commonly discussed in terms of a tiered model of service. This model distinguishes those services provided by designated child mental health workers from other services for children and young people with mental health needs. The latter group, which is designated "tier 1" in this model, has been discussed in detail in the previous section. The specialist mental health services are designated tiers 2, 3 and 4, essentially according to the complexity of their service organisation. Tiers 2 and 3 are, typically, community based and delivered services and should be available across Scotland. Tier 4 services are, typically, high complexity, low volume services, with highly specified teams, designed according to task. Such services will usually be offered on a regional or national basis, such as inpatient units.

NHS based teams mainly deliver tier 2, 3 and 4 services. But it is important to note the part played by the local authority, voluntary and independent sectors in delivering specialist mental health services. The phrase *mental health* is used here, as in the other pieces of work which have followed the CAMH SNAP Report, in a broad way. Here its use denotes the work carried out by a local authority based educational psychologist, by a family therapist in a voluntary agency, by a child psychotherapist in an independent agency, as well as that carried out by someone working in a health based CAMH service.

The importance of this network of specialists should be clear to those who plan and deliver services, so that the contribution of this whole network is taken into account. And for the purposes of education and training, this network again becomes vitally important. However, for the purposes of the workforce planning, the remainder of this section focuses on the NHS based CAMH services.

What can this report contribute to the current and future considerations of these services? While there are many possibilities, this report distils current guidance and current evidence, weighed up in light of the experience of the membership of the group, into a series of options, with associated risks, benefits and recommendations.

5.1. Specialist community based mental health services for children and young people

5.1.1. The purpose of these services

The CAMH SNAP report discussed the contribution that specialist CAMHS can make across the continuum of mental health promotion, prevention, treatment and care, and the Framework has now described this in some detail.

Community based CAMH services offer a range of services which the CAMH SNAP report described under four headings: consultation, liaison, training and (direct) service delivery. These services should therefore become able to provide:

- specialist assessment and treatment services
- multi-disciplinary assessment and treatment services
- specialist consultation and liaison services
- teaching
- research
- support, training, consultation and face-to-face work within tier 1 settings
- support, training, consultation to other agencies providing services to children and young people who may be experiencing, or at risk of, significant mental health problems as part of a constellation of difficulties.

The CAMH SNAP report made it clear that additional capacity would be required to allow this, and this report goes on to look at this in more detail. That report also considered the findings of the nationally co-ordinated Australian project to re-orientate mental health services for children and young people[14] (p. 70) towards earlier intervention. Those findings highlighted the importance of resource allocation and partnership issues, but also emphasised organisational development and workforce development. In particular, the authors noted that many of the practitioners involved in the re-orientation projects "had backgrounds in mental health but for many of them early intervention and re-orientation were new concepts." The CAMH SNAP report concluded that the organisational development involved in this reshaping and refocusing presented significant opportunities for shared learning and exchange of skills between those in specialist CAMH services and those already working in the wider network for services for children and young people.

5.1.2. Roles and skills

Skill mix in teams must ensure a range of clinical professionals who are able to deliver cognitive, behavioural, psychodynamic and systemic skills, complemented by psychiatric medical skills. Exact proportions of each skill will vary according to local need and commissioning arrangements[15].

5.1.2.1. Basic skills

The NESDF has set out the range of competencies required by those working in a specialist mental health setting with children and young people. These include:

- Skills in talking to children and young people
- Skills in talking with parents and carers
- Skills in talking with families
- Knowledge of child and adolescent development

- Knowledge of the range of mental health problems affecting children and young people
- Knowledge of child protection principles and practice
- Knowledge of key legislation in relation to children and young people and to mental health

The training routes for many of the professional groups who work in CAMHS in Scotland are such that, despite the range of core professional skills they bring, whether in occupational therapy, mental health nursing or social work, they cannot be presumed to bring the full range of foundation CAMH skills. The exceptions to this rule include child and adolescent psychiatrists, clinical psychologists and child and adolescent psychotherapists, each of whose professional training requires that they address the foundation CAMH issues.

This highlights a training and development issue: unless they come from particular professional groups, or have previous experience in CAMHS, most staff recruited to work in CAMHS will require further training. This is no reflection on the quality of those practitioners; and the various implications which follow are discussed later.

5.1.2.2. Changing roles

There has been substantial change in the way that community CAMH teams have been staffed since the time when these services were largely provided by a psychiatrist, a clinical psychologist and a social worker working together. In particular:

- *Registered Nurse: Mental Health*
  Nurses have become established members of community CAMHS teams in most parts of Scotland. Their role[6] typically involves carrying a caseload and providing therapeutic input, reflecting the widespread uptake of additional training in an area of therapeutic practice within this group[13].
- *Psychotherapists*
  Child psychotherapists and family therapists have become established in NHS posts, with appointments commonplace across England and now taking place in some Scottish NHS Boards
- *Allied health professionals (AHP)*
  Many services, and particularly those with day and inpatient services, have employed AHPs for many years. So, for example, occupational therapists have a small but long established presence within CAMHS. As CAMH services have become more involved with children and young people with developmental delays and disorders such as autistic spectrum disorders, learning disability and attention deficit hyperactivity disorder, the involvement of AHPs has increased. In some services this has been reflected in speech and language therapists joining occupational therapists as members of CAMHS teams.
- *Social workers*
  The role of social workers within CAMH services has been a changing one. In some areas, social workers have withdrawn altogether from community CAMH teams. In some areas, CAMH based social workers have increasingly taken on statutory duties, as mental health officers or in relation to child protection

[6] It is worth noting that the process of *Agenda for Change* may hold further implications for NHS staff as employment arrangements increasingly focus on knowledge and skills.

investigations, with less time and priority given to previous roles such as family therapy.

Local authority responses to enquiries from the CAMHWG reflected this variation. Discussions around the arrangements for implementing the new Integrated Assessment Framework[16] may provide an opportunity to review this matter.

5.1.2.3. Contemporary, comprehensive CAMHS

A contemporary *comprehensive* CAMH services will typically include child psychiatrists, clinical child psychologists, CAMHS trained nurses, occupational therapists, speech and language therapists, social workers, child psychotherapists, family therapists, specialist teachers, a range of creative therapists and other allied health professionals.

As CAMH services develop to reflect the FPPC, there will be an increasing need for practitioners who are competent in working with children and young people whose mental health difficulties co-exist with learning disability or with forensic problems. Training programmes therefore need to adapt to ensure the supply of practitioners who are appropriately qualified in these areas.

It is also important to acknowledge that, in recent times, an additional group has emerged within the NHS CAMHS workforce: the “primary mental health worker”.

A variety of skills are needed to offer a modern, safe, effective community CAMH service. There is now, therefore, a wider group of professionals contributing to specialist CAMHS teams. There is also encouraging evidence[13] of considerable role flexibility within teams. In particular, it is important to recognise that CAMH services both deliver skills, and in their consulting and training role, serve as a reservoir of skills for their communities.

5.1.2.4. Therapeutic skills

CAMH services need to ensure that they have the appropriate range of therapeutic skills available. These will include behavioural, cognitive, interpersonal/psychodynamic, pharmacological and systemic approaches. Some of these skills are appropriately delivered in individual, dyadic, group and family settings.

These skills are not necessarily all vested in particular disciplines. For example, while most clinical psychologists will have been trained in cognitive-behaviour therapy (CBT), there are CAMHS staff from other professional groups who have also developed competence in delivering CBT, by virtue of appropriate training. Similarly not all clinical psychologists will have been trained to registration level in CBT.

It is important to note that, in the NHS in Scotland and elsewhere in the UK, there are both those who have developed therapeutic skills as a “supplement” to their primary role and those whose primary role is as a psychotherapist. So, for example, there are nurses, psychiatrists, occupational therapists and others across Scotland who have undertaken some additional training in relation to therapeutic skills. A small proportion of these have pursued that training to a level which would actually allow dual registration, that is registration in their core profession and as a psychotherapist. Indeed the majority of those working as family therapists and child psychotherapists in NHS CAMHS in Scotland will have transferred into those posts from nursing or social work posts, on completion of their psychotherapy training. But most of those embarking on this kind of

post-qualifying training continue in their primary professional role; this is an important way of ensuring wide availability of these therapeutic skills.

It is important to note the role and contribution made by those who are trained and employed as psychotherapists. We are now seeing the emergence, slowly in Scotland but substantially in England, of psychotherapist posts, which are being taken up by appropriately trained and qualified child psychotherapists and systemic psychotherapists. This is a welcome development which this report endorses. The workforce group envisages the establishment of such posts across Scotland as a way of ensuring that therapeutic practice is rooted in professional structures which guarantee, among other things, proper attention to the development of the currently limited evidence base in relation to children and young people with the most complex mental health problems.

In seeking to develop a workforce with the appropriate range of therapeutic skills, steps will therefore have to be taken to ensure the emergence of posts suitable for specialist therapeutic staff, as well as promoting the uptake of therapeutic training within the wider CAMHS workforce.

5.1.2.5. Skills in application

CAMH services should also ensure that they foster skills in application. In other words those who work in these services have to be able to adapt and customise the way they offer services to the range of contexts in which children and young people, particularly those with complex needs, live their lives.

Liaison and consultation work require well-developed application skills. For example, the skills involved in delivering a CAMH input to tertiary medical setting presents particular demands which may be rather different from those required to work effectively with a secure care setting.

One particularly important example of this application issue is *primary mental health work.* Here the CAMHS worker adapts and applies her/his range of skills to the context of a tier 1 setting, e.g. in primary care or in a school. Given the SNAP report's emphasis on earlier intervention, this is a particularly important set of skills within the contemporary CAMH workforce.

The FPPC indicates that extending the availability of primary mental health work should be an important priority for NHS CAMH services across Scotland. Experience to date appears to indicate that the skills necessary for effective primary mental health work are not unique to one professional group; there is however a need to make available appropriate training for those who develop and deliver these services. However, in terms of commissioning services, there seems to be a risk that, unless staff are actually specifically employed to deliver primary mental health work, competing pressures at tier 3, such as addressing waiting lists, are likely to interfere with the development of such services. For that reason, primary mental health work remits within contracts seems an appropriate development.

The workforce group acknowledged the importance of "primary mental health work", but it was not their remit to consider whether there should be a new *profession* of primary mental health worker.

5.1.2.6. Skills in supervision and training

It has already become clear that many members of staff who are recruited to CAMHS teams require further training to allow them to do the job to which they have been appointed. This means that there is a need for a significant training function in relation to "new-to-CAMHS". Teams and services, in many cases, have therefore to create the capacity to train their own staff, quite apart from any wider role described in the Framework for Promotion, Prevention and Care.

The first implication is that staff who take on these tasks must have the appropriate learning opportunities to prepare for such a role. There is no guarantee that having been taught one knows how to teach. The second is that a proportion of the time of those in senior posts in teams and services should be set aside for supervision and training.

There are two forms of supervision to consider here. The first is generic clinical supervision from a senior colleague, related to day to day clinical practice and case management. This is usually carried out within teams and usually takes place between members of the same profession. The second is supervision in relation to practice development. In this instance an appropriately experienced practitioner provides supervision to a colleague or colleagues who may come from different disciplines, different teams and, not unusually, different services. This is a particularly common issue in relation to therapeutic skills training.

5.1.2.7. Skills in networking and consultation

The section of Partnership Working in the FPPC (p.17) highlights networking and consultation as essential components of good mental health services. In order to develop intelligent networks[1] and provide effective consultation, services need to cultivate:

- The ability to develop shared aims and plans
- The capacity to working across different organisational cultures
- An appreciation of the importance of working with process
- A commitment to developing trust between agencies.
- A creative approach to organisational barriers.

Only Connect, the report of the CAMH SNAP survey[13], provides further detail about this issue.

Specialist mental health services play an important part, with other agencies in the community, in responding to those children and young people, their families and carers, who are in great distress and difficulty. As well as the specific skills required to provide the necessary help, there is also the important task of working with the distress and, at times, dismay which goes along with these difficult situations.

It is important that specialist services, including NHS CAMHS, both recognise and affirm this role and make sure that they develop and maintain the skills and capacity necessary to deliver this role.

5.1.2.8. Skills in research and evaluation

The CAMH SNAP report pointed out the need for development of academic capacity within the CAMH professional community. This means that there remains a need to expand the number of formal academic posts, in a range of disciplines, as that report

recommended. But there is also a need for academic skills to be more widely distributed within the clinical community.

This indicates the need for the establishment of courses, running alongside other "advanced CAMH" training courses, to support and encourage the development of research skills and the establishment of a number of posts, for example in higher training schemes in psychiatry, which offer routes into senior academic posts

It is also important, particularly in light of plans to develop roles and re-focus services, that specialist CAMH services have both the competencies and the capacity to evaluate these developments.

5.1.3. The capacity of NHS specialist CAMHS

The SNAP Report was clear that to deliver on this extended role, greater capacity would be required. As the report highlighted, capacity is a reflection of a number of matters many of which are inter-related:

- *Resources* and, in particular, the number and skill mix of staff within specialist CAMHS are, of course, critically important.
- Improved *deployment* ensures that highly skilled resources are matched to the task patient requirement to the appropriate skill level.
- Expanding the *reach* of that skill through liaison and working through others/ new groups (e.g. parents/ carers etc).
- *Dynamic factors,* such as the relationships between partners in the children's services network or changes in referral patterns, impact significantly on capacity.

  This is a simple concept, but the effects are potentially complex. Take the example of a local authority social work team and their local NHS specialist CAMHS team services, where both team have gone through a period of staff shortages. As each team begins to reach a critical mass, both notice that they are working better with their partners in the other agency. This allows them to progress some aspects of their own work more efficiently, and so the team's capacity increases. However the better communication between the teams leads to recognition of greater mental need among the social work team's clients and so demand increases. This is one version of a phenomenon which is repeated between agencies throughout the network.
- *Recruitment* of the appropriate range of disciplines. Without a secure supply of properly trained workers, the main source is other similar services. In this way poor supply fosters instability within the specialist sector.
- *Retention* of staff becomes a critical issue within a relatively small sector which depends on a highly trained workforce. Issues of service redesign, new and extended roles as well as more flexible working practices will impact on the ability to recruit and retain a competent and skilled workforce.
- Creation of *healthy working environment*s such that capacity lost through sickness/ absence is minimised.

During the workforce mapping, many CAMH services reported that inadequate administrative and clerical support had a significant impact on capacity. The models of service which underpin the FPPC have staff in the community CAMHS from a range of professional backgrounds involved in delivering the range of tasks described, including managing referrals, carrying out clinical work, consulting, liasing and training. Unless

administrative and clerical support is designed around *that* pattern of activity, there is a risk of significant inefficiency arising from inadequate support.

5.1.4. Current guidance

Strategic planning is a relatively recent development in relation to specialist CAMHS. Such as has gone on has largely taken the form of service planning, with limited attention to workforce planning. Where workforce planning has taken place, it has tended to be on a large scale – such as national numbers of psychiatrists and, more recently, clinical psychologists. While this work has been able to benefit, to some extent, from these pre-existing processes, much of what is reflected here has involved breaking new ground.

There is no single method for arriving at the appropriate skill mix in a clinical team. Nor, despite many reports on the subject over many years, has there ever been agreement about the scale of service which should be available. The mental health standard of the English National Service Framework for Children[17] is, therefore, a particularly interesting document. For while it sets out what CAMHS services should be expected to and be able to do, much as the Scottish Framework, it goes on to consider the kind of numbers of professional staff likely to be required to deliver this.

> *Estimating the numbers of staff required to populate viable multidisciplinary teams and services at Tier 3, that can meet all the demands and provide a sustainable service, is not straightforward. Much depends upon the local demography and the range and types of service needed and offered. Nonetheless guidance has frequently been requested.*
>
> *An analysis of a number of attempts to estimate staffing need has suggested the following: a generic specialist multidisciplinary CAMHS at Tier 3 with teaching responsibilities and providing evidence-based interventions for 0-17 year olds would need a minimum of 20 whole time equivalents (WTEs) per 100,000 total population, and a non-teaching service, a minimum of 15 WTEs.*
>
> *Care should be taken to ensure that the number of new cases and overall caseload of each professional is compatible with the complexity of care provided and the specific interventions employed.*
>
> *(para. 9.2, p.28)*

The Department of Health had established a programme of investment in specialist CAMHS in 2003, designed to: *"increase CAMHS by at least 10% each year across the services according to agreed local priorities. (Demonstrated by increased staffing, patient contacts and/or investment)"*[18] and to this end introduced an annual "CAMHS grant". Against that background, experienced CAMHS clinicians, Ann York and Clare Lamb, on behalf of the Royal College of Psychiatrists, reviewed and synthesised guidance on team size and mix from the information published in the UK on the multi-disciplinary resources needed to provide specialist CAMH services.

Their conclusions were arrived at through a process which has some features in common with this piece of work: they addressed themselves to a care group and they considered the workforce as a whole, rather than as single professional groups. They made sensible, pragmatic use of such information as was available, and described this

clearly in their report of this process, *Building and Sustaining Specialist CAMHS*[16]. The Department of Health's publication of their conclusions, as part of their national policy guidance, points to the merit of this work.

This summary is derived from their discussion and illustrates the parameters within which service provision is likely to vary with the size of a specialist CAMHS team. They discussed staffing numbers in relation to units of population and, in accordance with the publications from which they were working, adopted general population numbers as the index.

This table translates and distils some of the ideas in that report:

WTE per 100,000	Age range	Range of problems	Range of services	Emergency provision
5	Partial, e.g. 5-15	Severe MH only; no service for YP with learning disability	Mainly assessment; little therapy or consultation	No
10	0-15	Wider range	Some therapeutic services; some consultation	Feasible
15 – 20	0-17	Full range	Range of therapy services; liaison, consultation	Yes

Table 5.1: illustrative account of services varying with size of teams

In other words, they estimated that to provide the full range of activities of a mental health services for children and young people, such as is described in FPPC, 15 – 20 wte professional staff would be required for every 100,000 of the total population. If the service were smaller than this, then some aspect of the comprehensive service would, by necessity, be missing. Table 5.1 illustrates this point, by giving one permutation of the shortcomings necessary with smaller scale services. It will be clear that there are various permutations, each with a different combination of gaps in service provision.

Applying this to Scotland, the fact that few services in Scotland are able to provide an "out of hours" CAMH service alerts us to the likelihood that numbers may fall in the lower part of the range. In fact the SNAP report noted that in 2002 most services fell short on several dimensions, e.g. age range, range of problems and emergency provision, suggesting therefore that numbers across Scotland were in the lower range. The CAMHS Mapping exercise allows us to test these suppositions.

It will be important, in taking this work forward, to relate the size of the workforce to the size of the young population, rather than the total population. This is important for two reasons: that the proportion of young people in a population varies across Scotland; that the proportion of young people is falling at present, and so using total population figures will distort the numbers needed.

5.1.5. Applying current guidance

5.1.5.1. Overall numbers

Further analysis of the CAMH workforce in Scotland will be taken forward in the main by workforce planners at regional and local level as they develop their workforce plans. The cycle for this is clear within the *National Workforce Planning Framework 2005.* In doing

this they will want to investigate all possible ways in which the capacity of the workforce can be grown. However for the purposes of this paper and to indicate the scope and scale of the task in hand, some assumptions have been made:

- That the Framework for Promotion, Prevention and Care is to be implemented in full
- That the figures quoted by the Department of Health represent the best guide available at present about capacity. They have therefore been used as a benchmark
- That Scotland, with its mixture of rural and island services, and some large areas of significant deprivation, does not, as a whole, fit the criteria associated with the lower Department of Health figure.

The practice of discussing numbers in terms of whole population follows current and recent publications. However, to ensure that it is the needs of the population of children and young people and, as such, should be conducted in relation to the population. This exercise is designed to based on it is important that n light of demographic trends, it will become increasingly important to base discussion on the numbers of children and young people in a population.

Applying these figures to Scotland, with its population of 5 million, indicates that for NHS community CAMH services to be staffed at a level of 15 wte/100,000, there would be 750 wte across Scotland, while the level of 20 wte/100/000 would give 1,000 wte across Scotland.

Circumstances in which the higher ratio is likely to be required include:

- areas with a widely scattered population – as in many parts of Scotland, e.g. NHS Highland;
- services with significant teaching commitments – common within Scottish CAMHS, e.g. those associated with the medical schools or the post-graduate psychology courses; and
- those are where the population served has particular needs, for example in an area of high deprivation, such as NHS Lanarkshire or NHS Greater Glasgow
- where an area has a particularly high proportion of younger people within its population.

This guidance does not necessarily translate readily to the circumstances of Scotland's island communities, where each of the three NHS Boards (Orkney, Shetland and Western Isles) plans and delivers services for small, dispersed communities whose total, in each Board area, is less than 30,000.
The recent report from the Remote and Rural Area Resource Initiative (RARARI) on Paediatric Services[19] contains descriptions of the CAMH services provided by the island Boards and in the rural Highland area, and indicates the rather different ways services are provided and supported in each case. That report also recommends that remote and rural paediatric services should become part of a managed clinical network with a large centre. It would be timely to convene further discussion about CAMH services to these communities, convened at regional level, to allow workforce plans to develop in a way that supports the optimum configuration of services.

5.1.5.2. Skill mix and disciplines

Discussing the application of the ratios set out by York and Lamb, the Department of Health indicates that, in each scenario, 5 wte/100,000 should be allocated to primary mental health work.

York and Lamb summarised the published guidance as to appropriate numbers for a community CAMH service for a population of 100,000, for the following groups:

- child and adolescent psychiatrists 1.5 wte
- clinical psychologists 4 wte (2 wte for tier 2 work, 2 wte for tier 3)
- child psychotherapists 1.25 wte
- community psychiatric nurses 2 "per psychiatrist"

They were unable to identify published guidance in relation to the other professional groups who routinely contribute to the community CAMH services. However, the earlier discussion in this paper has indicated the importance of developing an appropriate skill mix in light of the local needs and illustrated the range of skills needed.

The subsequent discussion about overall workforce is based on the following notional team composition (table 5.2), which is required to allow planning for addressing workforce supply issues. These figures are, therefore, illustrative rather than definitive and would need to be subjected to testing against local need before being adopted or adapted for local and regional planning purposes. However, in that they reflect the experience of the CAMH Workforce Group, they may represent a useful basic template against which to develop local and regional plans. The table outlines a notional discipline mix in a community CAMHS team and scales this up to illustrative Scottish totals.

Discipline	Wte/100,000	Wte nationally @15/100,000
Child & adolescent psychiatrist	1.5	75
Clinical psychologist	4	200
CAMHS trained nurse	4	200
Social worker	1.5	75
Child psychotherapist	1	50
Family therapist	1	50
Allied health professional[7]	1	50
Other	1	50
TOTAL	15	750

Table 5.2 Notional community CAMHS discipline mix and associated national totals

It is important to note that these figures do not include the number of staff required to provide daypatient and inpatient services, nor do they address the need for academic appointments within CAMH services.

5.2. Intensive mental health services for children and young people

There are several contexts in which mental health services are provided for children and young people in a more intensive way. These include:

- Intensive community based services and day services
- Inpatient mental health settings and the new legislation

[7] Occupational therapists and speech and language therapists are likely to occupy most of these posts

- Inpatient mental health places specifically provided for children and young people

This section does not provide a definitive account of how each of these important forms of clinical service should be staffed. The aim in this section is to provide an indication of the workforce implications associated with each and then use the lessons emerging from one of these areas to inform the subsequent discussion.

5.2.1. Intensive community based services and day services

Dedicated inpatient services are provided on a regional basis, for young people, and on a national basis, for children. These are essential services for those whose needs can only be met in this way.

However, pilot initiatives[20] suggest that some children and young people with acute and severe mental health problems can be supported by intensive outreach services in the community.

A number of CAMH services offer more intensive assessment and treatment services provided from a service setting: a variation of a day hospital model. This model has been used mainly, though not exclusively, in association with inpatient units. This can provide an alternative to admission to hospital and may provide an option for early discharge.

The FPPC indicates that Scotland's children and young people need a spectrum of services, and this is an area for further work. As models of care become more clearly defined and NHS Boards and their partners in Regional Planning identify how these services should be configured, it will become feasible to consider the workforce implications.

5.2.2. Inpatient mental health settings and the new legislation

A significant proportion of the young people who are admitted to psychiatric care each year spend part or all of their time in a general psychiatric setting, rather than in a young people's unit. The increase in capacity within specialist units for young people and the development of intensive outreach teams are both likely to help with this situation. However it seems wise to anticipate that the practice of admitting young people to adult wards will continue to some extent for the foreseeable future.

The Mental Health (Care and Treatment) Act (Scotland) 2003 has introduced a new requirement upon NHS Boards in relation to any setting to which a young person (the Act specifies that this means those under the age of 18) is admitted by reason of psychiatric disorder. It states (section 23) that *"a Health Board shall provide such services and accommodation as are sufficient for the particular needs of that child or young person"*.

Local arrangements to meet this requirement may vary, but the implications for the training of mental health staff who work in general wards which admit young people will be similar across Scotland. Addressing these training requirements should form part of the arrangements made to comply with the new legislation.

The Act also establishes the importance of considering the needs of children whose parents are made subject to the provisions of the Act. This too holds implications for the training of the staff who work with these adults.

A number of additional responsibilities follow from the implementation of the Act, for example in relation to the function of Tribunals. These will place additional demands on psychiatric staff who act as Approved Medical Practitioners (AMP) and on social workers who act as Mental Health Officers (MHO). For example, work undertaken in preparing for the introduction of the Act led to the estimate that an additional 2.88 wte of AMP time would be required, across Scotland, to meet the additional demands of the new legislation in relation to the under 18 population.

The changing demand on MHO's will take at least two forms. On the one hand there will be an amount of MHO work in relation to those young people who become subject to the new legislation. This is likely to be proportionate to the demand for AMP time, where a modest additional demand is projected. However, those CAMHS based social workers who are trained MHO's will, in some parts of Scotland, participate in duty rotas to meet the demands of the Act across the age range. It seems possible that *this* activity will impact more substantially on the time of the CAMHS-based MHO, reducing the amount of social work time available to these services. Therefore, while it is important that the capacity to meet the requirements of the Act are put in place, it will be important to monitor how this impacts on service provision feed this into the groups who take forward CAMH workforce planning.

5.2.3. Dedicated inpatient settings for children and young people

The Child Health Support Group's report on these inpatient psychiatric services includes three recommendations with particular implications for workforce planning. These are about commissioning arrangements, the number of places and the model of care.

5.2.3.1. Commissioning arrangements

The first recommendation of note was that these units should no longer be commissioned by NHS Boards acting on their own. In subsequent consultation, agreement was reached that the children's unit should be put forward as a suitable case for national commissioning and that the young people's places should be commissioned at regional level, with the three regions working closely together on this. These recommendations are now being implemented.

5.2.3.2. Numbers of places

The second was that the number of inpatient places for young people must increase significantly. While there should be no change, for the time being, to the nine places dedicated for children under the age of 12 years, there should be an increase in the number of places in specialist units for young people. This number should increase from the current 35. The report comments that, while the number which will be needed in the longer term may be more, the numbers should be increased, "in the first instance", to 60.

The expansion is to be achieved by increasing the number of places at each of the three existing centres. At present Dundee has 7 places, Edinburgh has 12 and Glasgow has 16.

5.2.3.3. Model of care

The model of care for the children's unit and the associated implications for workforce were therefore taken forward in the context of discussions about national designation and will be considered only briefly here.

The CHSG report went on to set out a model of care for the young people's units and consider the staffing requirements in that light. As part of the workforce process, Based on this, while none of the units is currently staffed in line with the model of care, two of the units are currently more closely aligned with this than the other.

5.2.3.4. Workforce implications

Staffing change required to allow the increase in bed numbers and bring the staffing numbers into line with the model of care recommended in the report is an increase from around 190 wte at present, to 391.5 wte.

Details are available (from the National Workforce Unit) of a model which sets out how this increase might be achieved regionally, based on sustained growth over a ten-year period and a phased implementation to 47, 56 and 60 places in 2008, 2010 and 2014 respectively over that period. The model assumes that once the minimum staffing levels are achieved for 8 places in a facility, it is possible to expand from that staffing level on a staffing per place basis from that point forward.

Staffing Requirement			**Base Ideal (WTE)**	**Total Staffing (WTE) Demand**		
	Year		**2004**	**2008**	**2010**	**2014**
	Places	**8**	**35**	**47**	**56**	**60**
Staff Group	**Grade / Discipline**					
Child & Adolescent Psychiatrists	Consultant	1.0	4.4	5.9	7.0	7.5
	Staff Grade / Associate Specialist/ SHO	1.0	4.4	5.9	7.0	7.5
Clinical Psychologists	B Grade	0.5	2.2	2.9	3.5	3.8
	Senior A Grade	1.0	4.4	5.9	7.0	7.5
Psychiatric Nursing	H or I Grade	1.0	4.4	5.9	7.0	7.5
	G Grade	2.0	8.8	11.8	14.0	15.0
	F Grades	3.0	13.1	17.6	21.0	22.5
	E Grades	14.0	61.3	82.3	98.0	105.0
	D Grade	7.0	30.6	41.1	49.0	52.5
	B Grade	6.0	26.3	35.3	42.0	45.0
Social Workers		1.0	4.4	5.9	7.0	7.5
Psychotherapy	Child psychotherapist	0.3	1.3	1.8	2.1	2.3
	Family therapists	0.5	2.2	2.9	3.5	3.8
	Creative Therapists	0.2	0.9	1.2	1.4	1.5
Allied Health Professionals	Dieticians	3.5	13.1	17.6	21.0	22.5
	Occupational Therapists	2.0	8.8	11.8	14.0	15.0
	Speech & Language Therapists	0.5	2.2	2.9	3.5	3.8
	Physiotherapists	0.5	2.2	2.9	3.5	3.8
	Pharmacists	0.2	0.9	1.2	1.4	1.5
Teachers		2.0	8.8	11.8	14.0	15.0
Training, Research & Audit		1.5	6.6	8.8	10.5	11.3
A&C Support Staff	Secretaries & ward staff	2.0	8.8	11.8	14.0	15.0
Domestic Staff		2.0	8.8	11.8	14.0	15.0
	Total Workforce Demand	**52.7**	**228.4**	**306.7**	**365.4**	**391.5**

Table 5.3 Implication of the CHSG Report for wte staff in adolescent inpatient services

These figures have been worked through in detail in the one area where the necessary work about model of care has been carried out. This allows us to develop some indication of the scale of workforce – in the region of 400 wte - required to deliver the service envisaged and also the make-up of that workforce. Further discussion of numbers of staff in relation to these units does not include A+C and domestic staff.

Recalling that the workforce for the children's unit, the day services and any intensive services need to be added to these totals, we should project approximate demand at around 450 wte, for the intensive services.

These figures are based on a more detailed workforce planning exercise than was feasible in relation to community CAMHS, and so may provide a better indication of the eventual staffing required. However, NHS Boards and, particularly in this context, regional workforce directors, will want to keep this under close review in successive workforce planning cycles.

6. Workforce supply in relation to specialist CAMHS

6.1. Profile of current workforce NHS specialist CAMHS

The NHS Information and Statistics Division (ISD) have developed a new, web-based system for collecting information about the workforce in NHS CAMH services. With the help of CAMHS lead clinicians, a list of all staff *working in*[8] NHS CAMHS at May 31st 2005 was gathered. All those members of staff were then invited to submit a range of data, which included demographic data and details of their areas of work. This is an enormously rich source of data and a detailed discussion is beyond the scope of this workforce report. A separate report of the CAMHS mapping exercise, which will be a vital resource for the all those involved in taking forward the CAMHS workforce agenda, will be published shortly. Some key findings are considered here.

6.1.1. Specialist CAMH workforce in Scotland

Initial returns from service leaders indicate a total headcount in NHS CAMHS in Scotland of *699.* At the end of data entry, on September 15th, 2005, 502 (71.8%) staff had completed the survey.

The 502 respondents work a total of 445 wte, an average of 0.88 wte. Applying this ratio to the figure which represents our best estimate of total headcount - 699 – we arrive at a total wte of 615. This is the best available estimate of actual current workforce in NHS specialist CAMHS.

Almost 10% of the returns relate either to training posts (such as psychiatric trainees or trainee psychotherapists) or temporary posts (such as assistant psychologists). It is difficult to present the figures in a way that reflects their contribution to the work, while also acknowledging that they are not part of the permanent workforce. The resolution here is to note the numbers of those in temporary and training posts and separate them from the permanent workforce total used in the benchmarking calculations. With those numbers removed, the permanent workforce is therefore estimated at 555 wte.

It is also important to distinguish those working in intensive services from those working in community services. The information from respondents to date gives a figure of 24%, suggesting that 133 wte of permanent workforce are in intensive services, while community services are provided by 422 wte staff. That is an average of 8.3/100,000 of the population for community CAMH services.

The information will be reported in terms of 501, since one person holds contracts with two NHS Boards.

These 501 people work 445 whole time equivalents (wte). Of the 501respondents:

- 405 (81%) are women
- 363 (72%) work whole time
- 405 (81%) qualified in Scotland
- 178 (35%) are under 35 years old; 241 (48%) are aged between 35 and 49; 82 (16%) are over 50 years of age.

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[8] This included local authority employed staff who were working in NHS CAMHS.

The fact that the response is incomplete means that care has to be taken in interpreting the findings. Despite this caveat, better quality information than ever before is now available to inform workforce planning.

6.1.2. *Specialist CAMH workforce by board*

30 CAMH services were identified across Scotland's 15 NHS Boards. These include:

- Multi-disciplinary CAMHS, including clinical psychology
- Multi-disciplinary CAMHS, excluding clinical psychology
- "Clinical psychology only" services (often working in multi-agency or multi-disciplinary health teams, other than multi- disciplinary CAMHS)
- Island services – provided by two or three professionals

The numbers working in these specialist services vary substantially across NHS Board areas, even when allowances are made for those areas which provide tertiary and regional services. The majority of areas do not reach the lower benchmark for community CAMHS (15 wte/100,000), while 1 in 3 of the mainland Boards fail to reach even half of that level.

6.1.3. *Specialist CAMH workforce by professional group*

Staff Group	Headcount	Wte	Expressed as % of total staff wte
Medical	63	50.46	11.33
Nursing	173	161.54	36.28
Psychology	145	131.42	29.51
Psychotherapy	17	15.30	3.44
Occupational Therapy	20	18.24	4.10
Counselling	2	1.63	0.37
Art Therapy	2	2.00	0.45
Music Therapy	1	0.57	0.13
Family Therapy	7	5.95	1.34
Speech & Language Therapy	5	3.30	0.74
Dietetics	2	1.00	0.22
Physiotherapy	1	0.68	0.15
Social Work	19	16.30	3.66
Educational Psychology	1	0.20	0.04
Teacher	8	6.00	1.35
Other Therapy*	7	6.08	1.37
Other**	28	24.63	5.53
Total	501	445.28	100.00

Table 6.1 Headcount and wte of clinical staff employed in CAMHS in NHS Scotland at 31/5/05 by professional group.

As table 3 professional groups, medicine, nursing and psychology account for 6.1 shows, 77% of the staff wte hours. Of the remaining 14 staff groups, no single group

accounts for more than 5%. Primary mental health work was recorded in this survey as a role rather a profession: there are both those who work as dedicated primary mental health workers and those who include this as part of their range of activities – all told it accounted for 43 wte, that is almost 10%, across the whole workforce.

The figures about the psychology workforce provide a timely reminder of the need to interpret these data carefully. The size of the psychology workforce is recorded here as 131.43 wte. However, if we look at the most recent figures which ISD have published for the clinical psychology workforce for children and young people (see section 6.3), we find that that total is 93.29 wte: a difference of over 38 wte. Two factors explain this difference: a small element is a function of the different survey points – 30/9/04 for ISD compared to 31/5/05 for the CAMHS mapping; a number of clinical psychologists - mainly newly qualified - joined the CAMHS workforce during this period. But the main difference is accounted for by the inclusion of trainee psychologists (9 wte) and assistant psychologists (23.64 wte) in the CAMHS mapping figures. In other words, 25% of the clinical psychology workforce in the CAMHS mapping data is comprised of posts which are not permanent.

6.1.4. *Specialist CAMH workforce by "tier "*

The mapping data allows us to look at how the CAMHS workforce is distributed across the tiers (table 6.2). Time committed to inpatient and daypatient services is the main element recorded under "tier 4".

Tier	wte
1	N/a
2	101.3
3	213.1
4	99.9
Total	414.3

Table 6.2 Reported allocation of time by tier

Table 6.2 indicated that 24% of staff clinical time is spent working to tier 4 services. One of the larger groups of missing data at this stage is from a service with the largest inpatient unit. We can therefore anticipate that this proportion will increase in subsequent iterations, but serves as a useful indicator for the time being.

6.2. Quantifying the gaps in the specialist CAMHS workforce

The numbers in this report are indicative rather than definitive. But they offer the best indication currently available and, as table 6.2 shows, point to a substantial shortfall.

Total WTE requirement	Wte
Indicative numbers for community CAMHS at 15 wte/100,000 (see 5.1.4)	750
Indicative numbers for community CAMHS at 20 wte/100,000 (see 5.1.4)	1000
Indicative numbers for intensive CAMHS (see 5.2)	450
TOTAL	1200-1450
Current numbers (see 6.1.2)	555
GAP	645-895

Table 6.3 Summary of specialist CAMHS workforce numbers

This is a challenging picture, particularly when noting that these estimates reflect the vision for re-designed CAMHS services as described earlier in the report. So, for example, the new NHS roles, such as primary mental health worker, and the extended roles for NHS community CAMHS staff in supporting and developing the mental health capacity within tier 1, are already incorporated in these estimates.

In particular, the picture indicates that the numbers within the specialist CAMHS workforce would need to increase by a factor of more than 2 in order to reach the benchmark figure taken as that required to deliver the undertakings of the FPPC.

Applying the assumptions described earlier, we find that:

- While the FPPC requires more than 75 wte in psychiatry, there are just over 50 wte at present.
- While more than 200 wte clinical psychologists would be needed, we have fewer than 100 wte at present
- There is a case for least 50 child psychotherapists and 50 family therapists; the former group has a third of the numbers needed, while the latter has not yet reached double figures in NHS Scotland.

The *gaps* in the mapping data have a particular bearing on the *nursing numbers* and so it is difficult to be definitive about the shortfall in nursing numbers. It is, however, likely that this is the group where the single largest increase will be necessary. Further work on this will be necessary, including the opportunity to consider whether this demand, taken along with other rising demands for registered nurses in mental health, suggests the need for an increased intake to nurse training.

As has been indicated throughout, the work of this section of the workforce has essentially been based on service planning. The information which will allow more detailed workforce modelling is now becoming available. It should therefore become possible to develop and these estimates, and refine them in light of additional contributions which derive from:

- Improving work environment thereby reducing sickness absence
- Addition of A&C staff to address administrative tasks currently taken on by clinical staff, enabling those staff to more effectively deploy their clinical skills

- Refinement of the indicative staff to population ratios to reflect more directly <18 population and Scotland's needs
- The contribution to specialist mental health provision from local authority, independent and voluntary sector services.

This is not to suggest that these would constitute the exact figures needed. For example, it is reasonable to anticipate that some amount of variation between areas will be appropriate in light of the particular patterns of local need. In other words, this offers a template for the future CAMHS workforce, but the detailed aims and the developmental paths will be worked out, using contemporary workforce planning principles, by those responsible for workforce planning: NHS Boards, regional workforce directors and their partners in local authorities, the voluntary sector and the education sector.

6.3. Workforce trends

At the time of writing there are only two professional groups within CAMHS in relation to whom it has proved possible to gather reliable national data which indicate both numbers and trends in numbers: those groups are psychologists and psychiatrists.

The account of the workforce supply issues can therefore be more robustly evidenced in relation to these two groups. However, it is important to avoid assuming that, the absence of evidence indicated the absence of a problem in relation to the other groups, as the subsequent accounts in relation to each group will make clear.

6.3.1. Medical staffing

Although the whole time equivalent number of consultants in NHS Scotland increased by 40% over the ten years to 2004 (table 6.4), the first of the 10 key messages in that year's *Securing Future Practice: Shaping the New Medical Workforce for Scotland* [21]was that "we are short of doctors – particularly trained doctors" (p.10).

It's particularly salient to note, in that light, that consultant numbers in different specialties grew at different rates during that period and these figures provide a useful comparison. Against the overall growth rate of 40%, there was a growth rate of 27% for consultants in child and adolescent psychiatry. This was not a mental health wide phenomenon: excluding child and adolescent services, consultant psychiatry numbers increased by 49%. That numbers for other specialists working with children grew by 62% over this time confirms that this child and adolescent psychiatry has, possibly by default, been seriously neglected as an area for growth and development.

NHS consultant wte	1994	2004	Change
All psychiatry (exc. C+AP)	232.1	347.0	+49%
Child + adolescent psychiatry	40.3	51.3	+27%
All paediatrics and child health (exc. C+AP)	108.6	176.1	+62%
All consultants in NHS Scotland	2393	3344	+40%

Table 6.4 The change in consultant numbers from1994 – 2004 (source ISD)

6.3.2. *Psychology staffing*

ISD has been collecting systematic data about "the family" of applied psychologists in NHS Scotland[9]: clinical psychologists, forensic psychologists, counselling psychologists, health psychologists, and neuropsychologists, with clinical psychologists occupying more than 90% of these posts. Only two of these groups are recorded as working within CAMHS: clinical psychologists and forensic psychologists.

NHS Applied Psychologists	2001	2002	2003	2004	Change 2001/4
Working with children / young people	66.4	77.2	86.3	93.29	40%
All applied psychologists	325.1	359.3	371	418.6	29%
Percentage working with children/ young people	20.4	21.5	23.3	22.3	

Table 6.5 The change in applied psychology wte numbers in NHS Scotland, 2001 – 2004 (source ISD)

Table 6.5 shows the number of applied psychologists working in NHS Scotland in the last four years. Although the 2004 figures remain well below the levels discussed in section 5, and include a number of assistant (i.e. unqualified) psychologists, these figures indicate some welcome growth in the numbers working with children and young people.

6.3.3. Other disciplines

The kind of information available in relation to psychiatry and psychology is essential to workforce planning. The mental health workforce is a complex group and good quality information, such as is now becoming available through the CAMHS mapping process, will make an essential contribution.

[9] See http://www.isdscotland.org/workforce_psychologyfor latest summary data

7. Implications

The Mental Health of Children and Young People: A Framework for Promotion, Prevention and Care was launched in October 2005 by two Scottish Executive departments: *Health* and *Education and Young People*. The Ministerial foreword reads:

"For the first time, we have a clear and comprehensive direction for children's and young people's mental health in Scotland. We now look to our partners in the NHS and local government to ensure that it is delivered."

Discussing the workforce implications of the FPPC, this report emphasises the importance of building the "mental health capacity" of the *whole* children's workforce. The report has also looked in some detail at the specialist CAMH workforce and indicated the role which the specialist workforce – when adequately developed – plays in the successful delivery of comprehensive mental health services to children and young people. In other words, gaps in specialist CAMHS, are important, but are not the whole story. And while they need to be addressed, there are various opportunities to make a difference to the mental health capacity of the network.

In the following section, the report returns to the question of **increasing capacity** and looks at the strands which can contribute to achieving this. The critical subject of **education and training** is discussed in some detail before turning to the question of **feasibility.** A final section sets out a range of **proposed actions**.

7.1. Increasing capacity

This whole exercise has been based on the picture of how services can and should work together to improve the mental health of children and young people.

7.1.1. Resources

One of the clear expectations of the FPPC is that all agencies working with children and young people will give more time and attention to mental health in all of its aspects. This will have implications for the workforce which will range from study programmes to adapting day to day activities.

While this report goes on to consider a number of ways in which the capacity of the specialist CAMHS workforce can be enhanced, there is a clear need for a major increase in the numbers involved in that workforce.

The numbers and the skill mix of staff within specialist CAMHS are, of course, critically important both in terms of the clinical service provided and also in terms of the role in supporting and developing the contribution of the wider network of services. The work described in this report focuses on describing the kinds of skills needed and the approximate scale of service likely to be necessary. Judgements will have to be made about the appropriate mix of disciplines in each area, in light of the range of needs to be served.

Because of the long lead-in time involved in shaping workforce supply, it is critical that workforce planning and service development go hand in hand and adopt a long term horizon.

7.1.2. Efficiency

Delivering a safe, effective and efficient CAMH service is a demanding task. Those working in the services have to develop relationships with partner agencies and establish forms and routes of referral which enable agreements about how to work together. Within services, systems have to be built to ensure the appropriate distribution of work and the clinical governance of that work.

In such complex systems, there are always numbers of choices to be made about how to organise work and it is important to review these from time to time in the interests of efficiency. HeadsUpScotland has sponsored a number of heavily subscribed Capacity Workshops – one is 2005, two in 2006 – in which service leaders and practitioners have the opportunity to review organisational models and practices in the interest in promoting maximum capacity.

7.1.3. Deployment

One of the dilemmas posed by a system operating significantly below the necessary capacity is that specialisation - often desirable in terms of clinical effectiveness – is in direct tension with maintaining breadth of service. Accordingly it becomes difficult to develop the kind of skills which may allow services to be delivered more efficiently, because of lack of opportunity to specialise.

Developments envisaged in current policy might allow resolution of this dilemma. As investment in primary mental health work grows across Scotland, it should become feasible for “tier 3” teams to focus their clinical resources increasingly on services for children and young people with more complex and severe difficulties. Given critical mass within these teams, the possibility of special interests then become feasible, signalling the possibility of a virtuous circle of specialisation and efficiency.

7.1.4. Expanding the reach

The FPPC proposes that specialist CAMH practitioners develop their liaison and consultation activities. This is not just a way of disseminating the knowledge and skills found amongst specialist practitioners, but also a way of recognising that the co-working with others (professionals, carers, parents, young people) brings an added value.

7.1.5. Dynamic factors

As the respondents to the SNAP survey[13] describe repeatedly, difficulties which arise between teams and between agencies can have an important bearing on the effectiveness of services. As such, processes for managing these relationships and learning about how to work constructively with difference – of

culture and practice, as well as of opinion – can make valuable contributions to sustaining and developing capacity.

7.1.6. Recruitment

A key task for all involved in this field is to establish and promote mental health work with children and young people as an attractive and rewarding career. While there are few services who are not exposed to intense pressure from clinical demand, it is important to seek and take opportunities to introduce the work to potential recruits. These are to be found among medical undergraduates and postgraduates, clinical psychology trainees and nursing students, among others.

Colleagues from other agencies will often be interested in the opportunity to work in a setting of almost unparalleled professional diversity, with more than a dozen professional groups contributing regularly. The opportunity to embark on post-qualifying training in an area of therapeutic practice, in agencies which prioritise supervision, may also be attractive.

7.1.7. Retention of staff

In this relatively small sector which depends on a highly trained workforce, retention of staff is a critical issue. Service development and the options of new and extended roles, supported by appropriate training, will impact on the ability to retain a competent and skilled workforce.

However, it is also important that there are career paths which can be followed *within* agencies. A time of expansion and development, such as beckons over the next ten years, provides an ideal opportunity for services to build opportunities for career progression into service re-design.

Two findings of the CAMHS Mapping exercise are of interest here. The first is that flexible and part-time working are well-established activities, with 28% of respondents working part time. The second is that the workforce is broadly distributed across the age range, with only about 1 in 6 over the age of 50.

7.1.8. Healthy working environments

The capacity for mental health work is not unconnected to the health and wellbeing of the practitioner. An emotionally healthy workforce is therefore important, not only to the extent that time lost sickness and absence is minimised, but also because the practitioners are more able to do the frequently taxing tasks implicit in providing a mental health service. This highlights the importance of routine supervision and support of staff.

7.2. Education and training

The FPPC emphasises the importance of building the capacity of the wider workforce to ensure long-term benefit. An adequate and competent workforce is fundamental to successful delivery of comprehensive mental health services to children and young

people. Investment in training and professional development is essential to creating that workforce if the recommendations laid out in the FPPC are to be realised.

7.2.1. Infra-structure to develop and deliver CAMH workforce plan

In the initial phase the objective of the workforce development activity will be to focus on enhancing the education and training infrastructure aimed not just at specialist CAMHS but at all other professionals and agencies who have a part to play in ensuring the emotional well being of children, young people, their families and carers. This wider workforce is complex and diverse (as outlined in 3.2), with people entering at various stages in their professional lives. Developing a workforce that is trained for purpose is an extremely important issue across children and young peoples mental health services in Scotland, given increasing referrals and shortage of skilled staff.

Many staff enter CAMHS or the wider workforce without any formal qualification in relation to the mental health of children and young people. This can in part be accounted for by a shortfall in specific accredited education and training at post qualification level. There is likely therefore to be a number of professionals working with children and young people, potentially requiring education and training at different levels of competency. The education and professional development provision for staff therefore must be flexible and accessible at all levels from unqualified to qualified workers. More detail on how this might be provided is outlined below.

It is essential that the skills and competencies of this workforce, at all levels of service provision, meet the mental health needs of the population served. In addition to core (generic) skills that are required to work and support children, young people and their families, specialised workers have to be trained and supported to be capable of delivering the full range of therapeutic interventions based on best practice and evidence.

The NESDF provides a foundation from which to take this work forward. It acknowledges the need for a common core of shared knowledge, skills and attitudes across the network of the children's services workforce, which can be built upon depending on the role and remit of staff.

The development of education and training opportunities will provide clear career pathways. New arrangements have to be established in Scotland to support a training infrastructure for sustainable workforce development. The production of any strategy for long-term development of the workforce for the improvement of children and young people's mental health must therefore consider measures of sustainability and future proofing arrangements by:

7.2.1.1. Reviewing the current academic provision for the range of disciplines involved in improving children's and young people's mental health. Taking advice from those who are expert in this area and making recommendations about how the current system might be improved using the NES document as a guide.

7.2.1.2. Investment in continuing professional development (CPD); and educational quality assurance and enhancement (i.e. education that is fit for purpose).

7.2.1.3. Working with a range of partners to ensure that programmes of continuing professional development (of staff working to improve children and young people's mental health) provides skills development opportunities at appropriate levels.

7.2.1.4. Work with training providers to ensure that current training provision takes account of the skills identified in the competency framework in order that these become an integral part of relevant training programmes.

7.2.2. The range of training

A wide, but integrated, range of training is required for such a complex and sizeable workforce.

7.2.2.1. *Under-graduate/pre-qualification training*

All of those working with children and young people should have a broad understanding of a model of mental health and its place in underpinning all learning, development, communication and social functioning. There might be some exploration of the factors that contribute to good mental health and discussion of some strategies for developing and supporting it. There could be some time given to the notion of how resilience is built and the potential contribution that adults can make to that. A high-level introduction to common mental health problems which may be experienced by children and young people might also be helpful. A foundation such as this would be sufficient for those working in a universal context (see 4.1.2)

As this is a fundamental issue for children and young people, this training should aspire to the model of training adopted by those working in child protection, in terms of reach and influence.

7.2.2.2. Staff working regularly with children and young people in difficulty

For this group (see 4.1.3), more detailed training and development opportunities can be made available in a *Continuing Professional Development* (CPD) context. The FPPC indicates that this will, in the fullness of time, be one of the more developed roles of the specialist CAMHS staff.

7.2.2.3. The training of specialist CAMHS staff

Currently, post-qualification specialist training in Scotland is patchy, with many staff funding their own professional development. The availability of courses in Scotland is likely to have some effect on the skills available to the workforce, as travel for study may not be an option for many.

Other experienced CAMHS staff also require clearer pathways for progression and accessible options for training. This should not simply include increasingly specialist knowledge of mental disorders and specific skills relating to that, but should also develop competencies in consultancy and supervision (as described in 5.1.2)

Recent developments have led to proposals to develop a "new to CAMHS " training. Many of those recruited to work in CAMHS often have a limited background in mental

health or in child, adolescent and family development. This programme would be appropriate introductory training for these practitioners.

Discussions are also underway about the design of "advanced CAMHS" training. What is envisaged here is a modular training programme which will allow practitioners to choose from a number of paths, depending on the role they were developing, e.g. in primary mental health work, as a therapist, or as a researcher role (See 5.1.2)

7.2.3. Creating and sustaining availability of relevant training

Currently, there are few opportunities for experienced CAMHS staff to access specialist training in Scotland which is not delivered by others who are also currently working in CAMHS. The result of this is that the already stretched and depleted workforce is unable to move towards a service model as outlined in the FPPC, as commitments to training and development within CAMHS requires significant resource investment. The possibility of increased training outwith CAMHS remains a distant aspiration. New models for delivering post-graduate/CPD training need to be explored and the workforce development manager's post (as outlined in 7.4.2) will assist in that.

The arrangements for training in relation to therapeutic skills already benefited from investment and development work using some of the £1M which the Scottish Executive set aside for CAMH workforce in 2004. It is clear that further work is required so that NHS Scotland has a reliable supply of therapists who are appropriately trained and qualified in psychosocial interventions. At this juncture, there is training available in Scotland to professional qualifying standard for child psychotherapists and for family therapists. However, although many of participants are NHS CAMHS workers, and much of the training takes place in a close relationship with the NHS, the NHS plays no part in planning or commissioning these trainings, which are correspondingly uncertain about their future. The question of commissioning these in the usual way, through NHS Education for Scotland, should be discussed urgently.

7.2.4. The opportunities presented by planning and delivering training on a multi-agency basis

This plan outlines the way forward for the workforce for children and young people's mental health and the NESDF should continue to be used as a fundamental platform for all future training and input to this workforce.

Having such a well-defined competency base as described by NES is one route to developing a shared understanding. A second means is for staff groups to have the opportunity to be trained together. This model (in a Continuing Professional Development context) currently works well in the West Lothian exemplar project where groups of staff from the voluntary sector, the Local Authority (such as Social Work and Education) and the NHS all receive the same input. Although this is still being evaluated, early results seem very positive and West Lothian now makes every effort to ensure that all their training on issues relating to children and young people's mental health is delivered in this manner.

7.3. Feasibility

The framework adopts three principles against which to test judgements on supplying the future workforce. Each of these is discussed below.

7.3.1. Affordability

For the purposes of considering the affordability, two assumptions were made:
- that a period of 10 years would be required to achieve this expansion of capacity.
- that an average wage in a CAMHS team is £25K

The notional cost to the NHS for the current CAMHS staff is £14M. To increase the workforce as described would require between £16M and £22M additional investment. An annual increase, across Scotland, of 10% per year would achieve the lower figure in 8 years and the higher figure in 10 years.

7.3.2. Availability

A number of the elements, which would contribute to improving the overall capacity, are in place. For example:
- some of the necessary training developments are already underway (see appendix C),
- recent developments mean that the number of those graduating as clinical psychologists will increase modestly from 2006, and
- current developments may lead to a new group entering the workforce as part of the applied psychology workforce (see appendix B for details).

However, the indications are that the workforce supply is already under pressure, and with strong competition for those graduating from all of the relevant qualifying courses, likely to be remain so. In fact, with the Scottish Executive now setting out the clear expectation that FPPC will be implemented in full, there will be a need to review the numbers of those entering training of all of the relevant professions.

7.3.3. Adaptability

While this is a workforce with a fair degree of flexibility in how roles are negotiated and allocated, the overall capacity problems often dominate any consideration of service re-design. Adaptability as defined by the Framework 2005 is about ensuring that any workforce expansion is planned such that the existing workforce is able to support and train new staff in the required timescales. Furthermore, it is essential that those workforce plans fit with those for service design.

Initial demand estimates for the three tiers of CAMHS, which are based on assumptions about significant service redesign and role development, imply significant expansion of professional staff. NHS Boards and Regions, in carrying out their responsibilities in workforce planning, will want to investigate the additional contribution to improving capacity which may be made available by improving service environment. For example, additional administrative support might contribute to greater efficiency, while measures to improve health in the workplace may allow minimum sickness absence rates. Further work on such measures will be required to ensure that any expansion is planned to meet this as well as the other feasibility criteria.

7.3.4. An insight into feasibility

In June 2004, £1m over two years was announced to support the CAMHS workforce. This was short-term funding, with no guarantee of continuation. Despite a pressing need to expand the specialist CAMHS workforce, creating new posts was considered an extremely high-risk strategy, bearing in mind the uncertain future of the funding. Instead, the CAMHWG agreed to try to create a more robust infrastructure for CAMHS workforce training and used the knowledge acquired from the SNAP process to make informed judgments about the training needs in Scotland. Using the underlying principles of the wider workforce, an attempt was made to ensure that all tiers of the children and young people's mental health workforce had access to the funding. The diagram in Appendix C shows how the funds have been spent and the span from primary school teachers through to staff in in-patient units has been addressed.

This process has been challenging in many ways, not least of which has been the desire to avoid "flooding" the relatively small specialist CAMHS workforce with too many opportunities which they would have been unable to access due to service pressures. Even though this financial input undoubtedly has been a great boost to the workforce, it has highlighted the need for a more strategic, managed approach to workforce development in the longer-term.

7.4. **Future direction**

7.4.1. Improved information

Workforce planning requires robust structures and processes, which are dependent on good information. In the course of this experience, three different kinds of "information needs" have consistently emerged as important:

7.4.1.1. The need for reliable epidemiological information
It will be important that there is a process of needs assessment, which can be brought to bear on newly emerging need, and that this needs assessment feeds into workforce planning.

7.4.1.2. The need for accurate information about the workforce
The CAMHS Mapping is in its first year. Although the returns were incomplete, the quality of information about the workforce is already substantially increased. As a way of benchmarking and of monitoring trends, it will be an important component of the developmental process. In the future, the Scottish Workforce Standard System developments will complement available workforce information for this group of staff.

7.4.1.3. The need for useful systems for modelling workforce
This process has drawn on a combination of workforce and service modelling. In future the more developed forms of workforce modelling should be available. As this process develops in relation to the CAMH workforce, it will be important to factor in the demographic changes which will take place over time. The service modelling used here was based on total population numbers. It will be important to move to modelling based on young population numbers. For example, the modelling exercise, based on the work of York and Lamb, led to workforce numbers of 1200 –1450 wte. This is a valid measure as a benchmark against which to measure the current provision.

However the feasibility discussion suggests that it will take up to 10 years to grow the workforce to that number. In ten years time, the projected proportion of the population who will be under 18 is significantly smaller than the current 21%. This suggests that, although the workforce still needs to grow very substantially (the adjusted figures being 1100 – 1300 wte), there is a demographic process likely to operate over the relevant period which will also contribute to "narrowing the gap". This again points to the importance of each iteration of workforce planning being supported by accurate and contemporary data.

7.4.2. Capacity to develop and implement the CAMH workforce plan

This report offers a review and way forward with workforce planning for CAMH. Further work will be required to translate this into a plan suitable for implementation across Scotland. The National Workforce Planning Framework 2005 sets out a clear process for developing workforce plans at regional and local levels and the move towards a more 'bottom up' approach that will influence national workforce planning policy It will be the responsibility of workforce planners to consider the issues raised within this report as they develop their workforce plans.

The *workforce development manager* role provides a vehicle to link workforce development to service planning, through the co-ordination of education and training opportunities to support the development of the workforce for children and young people's mental health. Thus, within this context the long-term goal of this short-term post is to begin to develop a training infrastructure to support a sustainable workforce, which takes account of the skills and knowledge requirements of those working within and across agencies striving to improve services for children and young people's mental health.

7.4.3. Some guiding principles

The workforce group recognise that these proposals will require a number of years to be fully realised. Over this time, there will be successive iterations of local and regional workforce plans, and in light of the experience of developing and delivering these in each area, the detail may alter and adapt to fit better to local need.

However, the task of maintaining momentum and clear direction of travel, over a lengthy time scale and in the context of a complex environment, is clearly challenging. The arrangements which the Scottish Executive will introduce to monitor the implementation of FPPC will, no doubt, help to keep this process on track. However, here are some guiding principles to bear in mind as this process unfolds:

- That in every area in Scotland, there should be incremental growth in the CAMH workforce, year on year over the ten year period.
- That investment should always be made in both posts and in infrastructure, particularly in training.
- It may be difficult, but nonetheless vital, to recall the overall strategic aims of promotion, prevention and care. In workforce terms this will mean ensuring investment and development in each of the domains – wider workforce, community CAMHS and inpatient and intensive services - considered in this report.
- The growth of primary mental health work and early intervention is envisaged in national policy. In order to foster this development, a minimum proportion of

community CAMHS "wte" should be committed to this. The figure of 25% is proposed for this in the first instance; this should be monitored and the suitability of the proportion reviewed in light of experience.

8. Conclusions and Recommendations

See Executive Summary on page iii

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Appendix A

The Child and Adolescent Mental Health Workforce Group

Members

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Royal College of Paediatrics and Child Health

Royal College of General Practitioners

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Appendix B

PROPOSALS FOR MASTERS LEVEL TRAINING IN PSYCHOLOGICAL INTERVENTIONS FOR CHILDREN AND YOUNG PEOPLE

Proposals have been developed for a new masters level training in psychological interventions for children and young people. Initial development work has been supported by NES and guided by a steering group representing key NHS & professional stakeholders. A tendering process is currently underway to identify an academic partner(s) to deliver the academic component of the programme. The training will equip honours psychology graduates to contribute to service with a focus upon early intervention in 2 main areas.

1. Early Intervention for Young Children. Empowering families to recognise their strengths and develop resilience. Helping vulnerable families to foster positive relationships and positive parenting. Helping with the early recognition and management of childhood difficulties such as developmental problems or difficulties in sleeping, eating and elimination.

2. Early Intervention to promote mental health and well-being in children and young people. Promoting resilience by using behavioural and cognitive approaches to promote mental health and well-being as well as intervening early in a problem cycle. Examples include self-control and self-coping strategies for chronic illness, problem solving approaches to stress and anxiety management and social skills development.

Students will also acquire research and audit competencies particularly in the areas of service evaluation and clinical audit.

The one-year training will be at least 50 % supervised practice and students will be salaried employees, supervised by clinical psychologists. It is intended that the first intake of students will be in January 2007.

It is envisaged that the MSc will be the first step towards doctoral level preparation for some, but many will follow a career pathway at this new level. Supervision capacity is a concern for several services consulted about these developments particularly in the east where there has been significant expansion in doctoral level training in the past few years. This is less of a concern in the west.

About 850 honours graduates in psychology are produced every year and a recent survey by NES indicates that more than half are interested in a career in psychology in health and social care and more than half of these have expressed an interest in working with children. This new training route represents an opportunity to expand the workforce from a previously largely untapped pool while widening the skill mix in psychology within a relatively brief timescale.

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APPENDIX C

Workforce Development Funded Projects

The workforce development funds (£0.5 M in each of 2004/5 and 2005/6) have mainly been invested in building the capacity of the workforce in the following areas. Examples include:

- Specialist CAMHS staff (therapeutic skills courses)
- Developing staff in In-patient units
- Mental health training for foster and residential carers working with looked after and accommodated children and young people (LAC)
- Developing staff who are 'New to CAMHS'

Workforce Development Funded Projects:

- Diagram 1**,** illustrates the distribution of funded workforce development projects for the financial year 2004-2005.
- Diagram 2 shows the likely areas of investment for the period 2005-2006

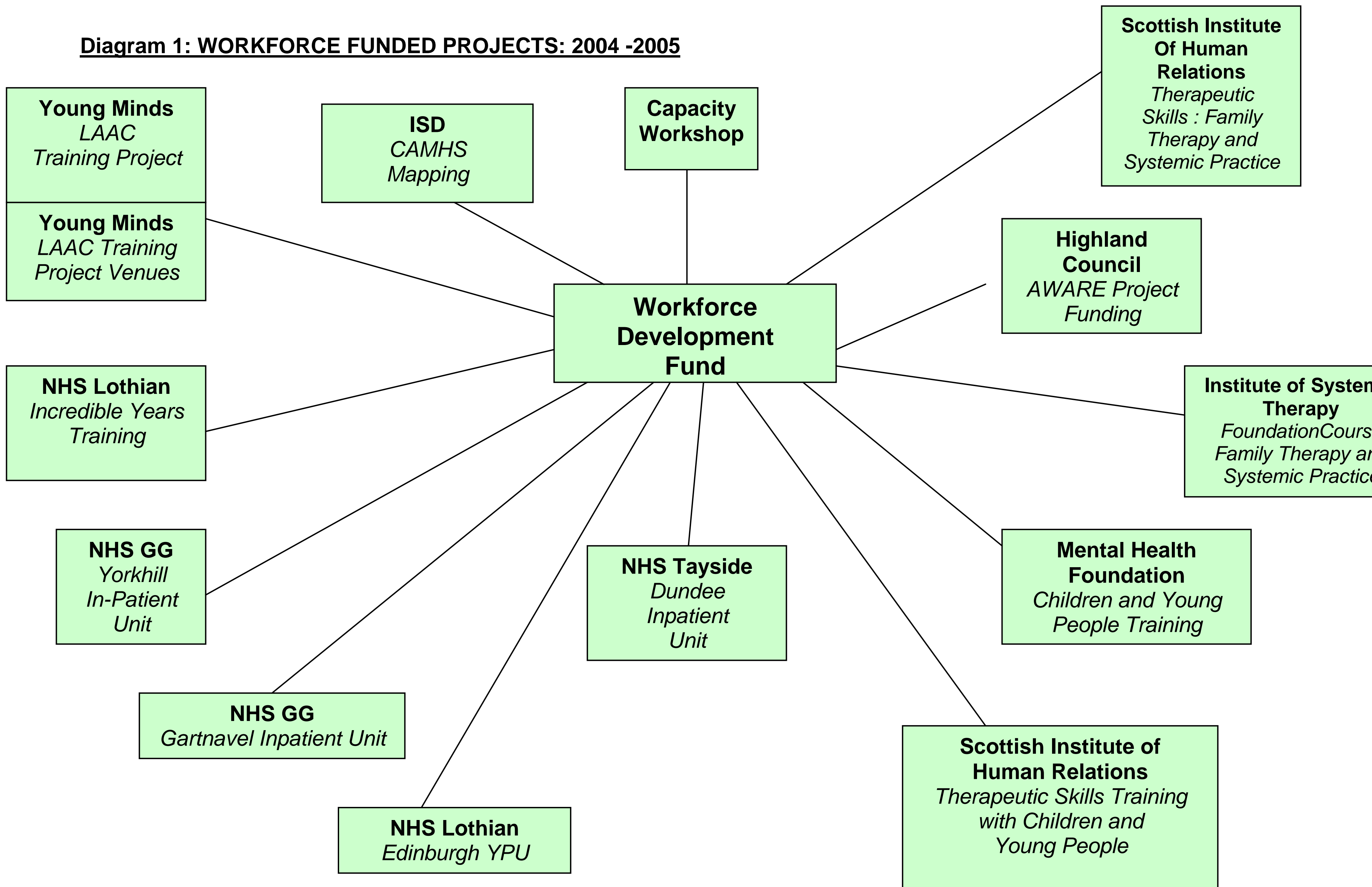
Diagram 1: WORKFORCE FUNDED PROJECTS: 2004 -2005
Young Minds
LAAC
Training Project
Young Minds
LAAC Training
Project Venues
ISD
CAMHS
Mapping
Capacity
Workshop
Scottish Institute
Of Human
Relations
Therapeutic
Skills : Family
Therapy and
Systemic Practice
Highland
Council
AWARE Project
Funding
Workforce
Development
Fund
NHS Lothian
Incredible Years
Training
Institute of Systen
Therapy
FoundationCours
Family Therapy ar
Systemic Practic
NHS GG
Yorkhill
In-Patient
Unit
NHS Tayside
Dundee
Inpatient
Unit
Mental Health
Foundation
Children and Young
People Training
NHS GG
Gartnavel Inpatient Unit
NHS Lothian
Edinburgh YPU
Scottish Institute of
Human Relations
Therapeutic Skills Training
with Children and
Young People

Diagram 2: PROPOSED USE OF WORKFORCE BUDGET: 2005-6