



Wellbeing Practitioners
for Children and Young People

Operational Guidance

South West CYP-IAPT Collaborative

1. Purpose

The purpose of this document is to provide partners within the South-West IAPT collaborative an introduction and operational guidance overview to the new role of Wellbeing Practitioner for Children and Young People (WP-CYP). This document does not intend to provide an operational policy, but exists to support local managers and leaders as they seek to integrate this new role into local working arrangements. Any working arrangements should take full account of and be tailored to meet:

- **The local vision for mental health services for children and young people and the relevant Transformation and Sustainability Plan**
- **The Future in Mind and CYP IAPT principles, and the local intent to deliver services more effectively in each locality**

2. Introduction

The new WP-CYP role provides additional resource to support and intervene with children and young people experiencing common low-level mental health difficulties. It is specifically targeted at meeting the needs of those who **do not** currently receive a service. However, these posts do not constitute a new service and all that implies. The WPCYP is a new role aimed at providing **early intervention** to better address emerging mental health needs. To deliver maximum impact quickly they should be integrated into an existing locality-based provision. The role is intended to provide brief, evidence based interventions at an early stage of need to improve outcomes and reduce the need for future, more costly specialist interventions.

In collaboration with the CYP-IAPT team, and through local WP-CYP steering groups, the posts will be overseen by the local partnerships, which will decide where these posts will have the most impact. It will be vital to consider where they will best receive the required level of support to avoid role dilution and/or the role substituting for existing services. National guidance is clear; regardless of the employing agency WP-CYPs can be deployed from any relevant organisation working with children and young people. **Partnerships are encouraged to actively consider the deployment of the posts into universal services, particularly schools, youth settings and GP practices as the places where low level issues are most likely to be first identified.**

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The primary objectives of the role are to:

- Facilitate access to support from, and provide support to, community services (e.g. schools)
- Offer evidence-based help to children and young people with mild to moderate difficulties
- Reduce waiting lists to specialist CAMHS

It is expected that the WP-CYPs will:

- Work with the whole family
 - Deliver brief, focused interventions
 - Where feasible, work with others to deliver group interventions
- . The national Headline Plan assumes trainee WP-CYPs will be appointed to NHS Band 4 or equivalent with qualified WP-CYPs appointed at NHS Band 5 or equivalent. However, different market conditions and local staffing arrangements and challenges apply across the country, and some partnerships may appoint staff at different pay levels. The local CAMHS partnership (in consultation with the South West CWP Executive Group and South West CWP Regional CWP Steering Group) should make the final decision on the pay grade taking account of:
- The expectations outlined nationally
 - Local market conditions
 - Equity with existing positions requiring similar experience, knowledge and qualifications
 - The need to recruit, motivate and retain staff

3. The WP-CYP role

WP-CYPs will work with children and young people with low-level/mild to moderate common mental health difficulties; anxiety, low mood and behavioural difficulties. The role is not intended to support those services that are working with serious and enduring mental health problems. The role should not work with those with high levels of risk to themselves or others, or who need a more specialist level of care. **It is important that all work is suitably supervised and managed.**

A typical case will involve up to six sessions over a four to six-week period, but may often be less than this or require fewer contacts over a longer period of time. This reflects the lower level of complexity anticipated and the brief, focused but flexible nature of intervention.

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Evidence from the adult arena suggests more regular support sessions are likely to be more effective than less frequent support spread over long periods of time. This reflects the lower level of complexity anticipated and the low intensity, focused but flexible nature of interventions. Within a low intensity approach, cognitive behavioural and social learning theory informed techniques will provide guidance and support, directly drawing from evidence based approaches and materials either through supported self-help or clinically evidenced materials used directly to support face to face sessions and health technologies such as online programmes or smartphone applications (Donker et al., 2013; Farrand & Woodford, 2013; Ridgway & Williams, 2011).

To improve the effectiveness of low intensity interventions, WPCYPs will provide guidance in the use of self-help materials and will receive training focused on the competencies required to support low intensity interventions (Roth & Pilling, 2007). This guidance will be focused on supporting CYP and parents to use and engage with the materials, including helping them to problem solve any difficulties faced and provide motivation and encouragement to work through the materials. Full guidance sessions will last between 35- 45 minutes, but it is important that the WPCYPs show flexibility and offer the minimum session length needed in collaboration with the CYP / and their parents / carers. It may therefore be appropriate to offer brief checks-ins of approximately 15 minutes. Table 1 below outlines the potential scope of the role.

Table 1: Scope of the WP-CYP role

What should WPCYPs be doing?	
WP-CYPs should:	WP-CYPs should not:
Assess and support people with low level mental health problems	Routinely assess and triage children and young people with severe, complex or enduring mental health problems or those presenting with complex issues
Signpost people and facilitate access to other services when appropriate	Support children and young people with high levels of risk or needing a specialist level of care or intervention

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<p>Work through a variety of media such as telephone, internet and face-to-face and in a range of settings close to where families live – such as schools, health centres, community or youth centres or children’s centres.</p>	<p>Work in isolation or in ‘clinic’ style settings</p>
<p>Offer low intensity, focused, evidence based interventions outlined in the WPCYP curriculum and certificate training programme:</p> <ul style="list-style-type: none"> . Behavioural activation . Relaxation . Problem solving . Cognitive restructuring . Exposure and habituation / Exposure and response prevention . Worry management strategies . Social Learning theory based parent support . Behavioural and emotional regulation strategies (sleeping, toileting, feeding etc.) . Computer based CBT . Lifestyle management 	<p>Be involved in complex, or moderate to high need situations or presentations</p> <p>Hold cases referred to CAMHS or co work high need cases</p>
<p>Review children and young peoples’ progress and record outcomes achieved</p>	<p>Close cases until all recording including monitoring of outcomes is completed</p>
<p>Be able to access specialist input quickly when appropriate</p>	<p>Operate without appropriate supervision</p>

The table below summarises the specific difficulties the role could be expected to address, those they should not and identifies those situations where discretion is required and a case by case decision made.

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Table 2 - Guide to presenting difficulties

DO	MAY DO	SHOULD NOT DO
Common mental health difficulties that may respond to early intervention	Conditions which may respond to early intervention but require discretion	Significant levels of need /complex conditions which are not suitable for brief early intervention
Low Mood / Mild to Moderately Severe Depression	Anger difficulties	Pain management
Panic Disorder	Low self-esteem	PTSD
Panic Disorder & Agoraphobia	Mild social anxiety disorder	Bipolar Disorder
Generalised Anxiety Disorder / Worry	Some compulsive behaviours	Psychosis
Simple Phobia (but not blood, needle, vomit)	Mild health anxiety	Personality Disorders
Sleep problems	Assertiveness/interpersonal challenges (e.g., with peers)	Eating Disorders
Stress management	Self-harm is disclosed but is assessed as linked to low- mood but is not assessed as enduring and high risk in	Chronic depression/anxiety
Behavioural Difficulties	nature	Established health anxiety
	OCD	Historical or current experiences of abuse or violence
		Complex interpersonal challenges
		Bereavement
		Active, enduring and significant self-harm
		Relationship problems

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On a day-to-day basis, qualified WPCYPs are likely to be delivering interventions face to face, by phone, and online. They can work individually or on a group basis. Group work approaches can be useful for young people or their carers to address lower levels of needs where individuals present with similar issues. Any intention to offer group work should be carefully scoped to ensure there is viability and no duplication. Ideally this work should be undertaken in conjunction with other professionals, for example youth workers, school behaviour support staff, educational psychology staff, and primary care professionals.

Delivery model

Very careful consideration should be given to the delivery model for this role. The Future in Mind (2015) report says that:

“Services need to be outcomes focused, simple and easy to access, based on best evidence, and built around the needs of children, young people and their families rather than defined in terms of organisational boundaries.”¹

The model adopted by the partnership should reflect this and the ethos of CYP-IAPT, with an emphasis on:

- Improved access (a focus on improved access moving towards young people and their families being able to approach resources directly i.e. self-referral)
- Greater collaboration (an emphasis on shared decision making and collaborative working)
- Outcomes informed practice (working in such a way as to define the goal or end point of all work with children, young people and their families)
- Transformation: The role should provide something different to the way in which mental health services are currently provided - facilitating change across all services providing help to children and young people with their mental health difficulties
- The central role of CYP and Parent/Carer participation in the design, delivery and development of the programme across localities

Local WP-CYP steering groups will be a platform to review and work towards the principles outlined above and clarity on the model adopted will then shape subsequent decisions on how and where these posts are best located and accessed by families. Decisions on where the post will sit will affect:

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- Access arrangements including:
 - Ease and speed of access
 - Self-referral
 - Referral management and process
 - Step up and step down processes
- Management arrangements including:
 - Case supervision
 - Line management
 - Clinical skills development
- Operational processes including:
 - Case recording
 - Progress tracking
 - Administrative support
- Flexibility including:
 - Where people are seen
 - Responses to non engagement
 - Options for group work,
 - Options for joint working,
 - 'Team around the family' working
 - Liaison with universal, primary care and other services

The national recommendations are that where appropriate the posts are initially supervised within statutory CAMHS service to ensure those supervising WPCYPs have the necessary clinical skills, knowledge, and experience. However, it is recognised that these new roles can equally be located in other agencies that contribute to children's mental health and are as likely to sit in community or locality bases. It also noted that CAMHS service staff may not have the knowledge about short-term, low intensity interventions, and caseload management of the same, and this guidance needs to be sought also. It is therefore important for local partnerships to determine where the posts will best be located and that their supervision arrangements can be met.

The table below summarises the benefits and risks to different locations but it is important to note it is **expected these may be different in different areas:**

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Table 3 Location options

Post Location	Benefits	Challenges
<p>Specialist CAMHS</p>	<p>Close to clinical expertise in children and young people’s development and mental health.</p> <p>Provision of supervision and management with oversight of all cases, as well as providing clinical skills and oversight of individual performance.</p> <p>Potential opportunity to fast-track children of concern to specialist CAMHS for triage or treatment.</p> <p>Clear managerial and accountability ‘line of sight’ to CAMHS commissioners and HEE.</p>	<p>Capacity issues in CAMHS may mean WPCYP role is drawn into CAMHS work – for example doing triage or CAPA or even co-working more specialist cases leading to role being compromised or diluted.</p> <p>Supervisor may not have skills in management of brief early intervention approaches or outreach approaches.</p> <p>Possibility of lengthier referral processes – self referral less likely.</p> <p>Creates a conflict of criteria between the specialist CAMHS service and a single early intervention post that could confuse referrers and may create additional referral management pressures for CAMHS.</p> <p>Inequity of access to specialist CAMHS if PWCYPs can fast-track cases and ‘leap frog’ case of similar or higher level needs which are already waiting.</p> <p>Supervisor may not have the knowledge of wider system and local resources.</p>

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		<p>This could lead to inadvertently duplicating provision.</p> <p>More difficult to build and maintain community links and relationships with universal and other services</p> <p>Local data systems cannot support the worker to meet the quarterly monitoring and reporting requirements.</p>
<p>Voluntary and Community Sector (VCS), Schools, Local authority early intervention teams, primary care teams</p>	<p>Good understanding of issues requiring early help.</p> <p>Good understanding of the range of professionals working in early help provision.</p> <p>Easier and quicker access to other professionals involved with the child, young person and family.</p> <p>Closer to community support networks.</p> <p>Closer to the source of referrals enabling speedy access.</p> <p>No additional specialist CAMHS referral route required.</p>	<p>Individual school or GP may seek to 'own' or 'takeover' and fail to recognise the new role as a shared local resource.</p> <p>This may lead to preferential treatment of referrals from the host agency e.g. school, GP practice</p> <p>More complicated managerial accountability to commissioners and HEE.</p> <p>Some local data systems may not be able to support the worker to meet the quarterly monitoring and reporting requirements e.g. schools, GP's.</p>

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	Wider sense of accountability across the system – with key agencies all having a role.	
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4. Case management

When qualified, WPCYPs will see a high volume of children and young people. This reflects the relatively low level of need that will be addressed and the brief nature of the work that is intended.

During their training year the WP-CYPs expected to increase from a caseload of around 12 CYP at the very beginning of the training (post block-teaching period) to a caseload of 25-30 towards the end of the course, with the HEI stipulating the number of clinical hours required to for the practitioner to complete the training. The anticipated completed annual cased when qualified is in excess of 150. This is based on:

- **Up to 25 client contacts per week over 40 weeks (1,000 contacts per year)**
- **Undertaking six sessions per case (between four and eight sessions are anticipated)**
- **Session lengths lasting up to 1 hour for assessments but between 15-45 mins for intervention sessions (allowing for flexibility if needed for developmental and contextual adaptations)**

It is however recognised that different areas have different needs and operating environments meaning the way the posts are deployed will vary. Each partnership will therefore need to establish its own caseload requirements in line with the stated expectations and the training needs.

Access, referral and assessment

As an element of the wider CYP IAPT transformation programme the WPCYP role is designed to improve access to mental health support. Local partnerships should agree to work towards self-referral for this service and develop a plan and timescale for this.

Referral criteria

The role is designed to support children and young people with common mild mental health difficulties between the ages of 5 and 18. Possible presentations are summarised in Table 2 above. The emphasis on early intervention is key and therefore this role should not be taking on work which should be

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addressed in specialist CAMHS services. This means the agreed referral criteria will be different from existing CAMHS referral criteria.

Referral and assessment

In line with the Future in Mind (2015), emphasis on ease of access, criteria for requests for involvement should be made as wide and inclusive as possible, including from young people and families themselves.

Ideally agreement on the best approach should be taken within the context of an existing, local multi-agency framework. This would help to ensure that there is no duplication and professionals involved with the family are working collaboratively. It would help integrate the role into the local infrastructure with local professionals becoming clear where the new role can assist. Such a multi-agency forum also enables full consideration of any additional concerns regarding risk.

Working in this way would mean that the local process for alerting referrers or those with concerns about the next steps (including the family) would be followed. Additional procedures or processes for this role should not need to be created, as it should fit into an existing system or team process.

Signposting and Liaison Work

Advising young people and families where they can access the right sort of early support will be an important element of the WPCYP role. It is therefore very important that they have current information on the range of services available locally. In addition the post holder will need to ensure that local services and teams develop a good understanding of the new role and how it fits into the network of mental health support and services available to children, young people and their families.

Interventions

Where intervention is required, children, young people and their families should be seen/contacted on a weekly or fortnightly basis depending on the level of assessed need. Interventions are expected to be completed within four to six weeks. Flexibility of intervention and contact is an important part of the new role with case load supervision guiding this process e.g. telephone/text

The expectation for this role is that all work is undertaken in full partnership with the family. This means shared decision-making and setting agreed goals for the work together.

Should needs escalate during the work or more complex needs emerge, it will be appropriate to facilitate access to a more appropriate worker or service. This may include social care provision or specialist mental health services and such cases should be discussed as a priority within supervision and in line with the partnerships policies, procedures and care-pathways.

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Case closure

Cases will be closed, according to local protocols when:

- The intervention has been completed
- During the intervention an alternative service is agreed to be more appropriate
- A young person or family repeatedly fails to attend or complete the intervention

On completion of the intervention there are three potential outcomes or destinations:

- No further involvement required (e.g. goals achieved or recovery in progress) and no further targeted support is required
- Further targeted work or monitoring required by professionals in universal services/primary care e.g. school nurse, behaviour support, voluntary agencies, community support group
- Referral to specialist services due to significant identified concerns which cannot be managed by early intervention services (e.g. referrals to Social Care, CAMHS, Educational Psychology, Adult Mental Health team)

Where identified need meets the threshold for specialist services there may be some local challenges with regard to response times. In some CAMHS services waiting times can be significant. Without intervention this risks mental health needs escalating. Local partnerships should consider how best this situation should be managed to ensure that the WP-CYP caseloads do not become blocked, which would impact adversely on throughput and compromise the ambition to improve access to mental health services.

Clinical Practice Training Requirements:

Whilst on the training course, WPCYPs will need to achieve:

- . 80 hours of clinical practice over the course of the programme.
- . See at least ten completed cases (seen to completion / goals achieved), although the WPCYPs will be expected to work up to a caseload of 30 towards the end of training
- . Of these ten completed cases, a minimum of one will need to be working with anxiety, one with low mood, one with behavioural difficulties and one working with parents where the young person has anxiety (parent -led CBT)
- . Receive a minimum of 40 hours of supervision over the course, 20 case management and 20 clinical skills (N.B. clinical skills can take place in groups with 30 minutes being offered per trainee).

5. Supervision

Effective supervision is crucial for the safe and effective practice of WP-CYPs, nurturing their skills development during training and post qualification. No more than two trainees per local supervisor are recommended however some flexibility should be applied to ensure consistency of approach. Regardless of the host agency trainee supervision should involve:

- WP-CYPs receiving weekly clinical case management supervision in which their complete caseload is reviewed
- WP-CYPs receiving a minimum of fortnightly 'clinical skills supervision', which could be provided on an individual basis or as part of a group, covering different interventions
- Supervisors who:
 - Have a thorough understanding of the WPCYP role and the requirements of outcomes monitoring
 - Have good skills in the engagement of young people and their families and a range of techniques and approaches
 - Are able to ensure appropriate levels of work and protect the post holder from external pressures
 - Understand what good practice is within the context of brief and early intervention
 - Provide appropriate management supervision with regular appraisals and feedback
 - Contribute to quality assurance and ensure transparency of decision making
 - Understand how to support staff in a new role and the likely sources of stress or tension which may occur

Before placements are made the partnership needs to ensure these requirements are in place.

All supervisors should attend the supervisor training provided by the University of Exeter. Where appropriate, they should also attend the relevant the skills sessions of the WPCYP course alongside their WPCYPs.

Where different people are providing elements of supervision, support and oversight, good communication between supervisors is essential. Regular meetings particularly early on in placements are recommended. This will be especially important for those WPCYPs not employed /based in NHS organisations.

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6. Outcome Monitoring, Evaluation and Data Recording

Evaluating the impact of the new role will be a central component of its success, spread and sustainability. In order to help support this element of the programme, it is expected that services will use the practitioner support funding to allocate the necessary resources to operationalise this and ensure the collaborative target of over 90% data collection.

Therefore, in-line with the CYP-IAPT values and standards, a minimum data set demonstrating the impact of individual case interventions is to be captured across all services. This needs to be outcome based and be able to demonstrate that interventions are formed through collaboratively agreed goals. Routine outcome monitoring is required, covering two time points using a matched, normed outcome measure.

There is an acknowledgement that across the range of services within the SW collaborative there is a significant variation in IT and data collection infrastructure. Where appropriate the CYP-IAPT team based at the University of Exeter are able to offer support, guidance and if necessary mechanisms in order to facilitate the consistent and coherent collection of data.

The precise allocation of ROM across the range of presentations that the WP-CYP will be working with is, at the time of writing, close to being agreed at a national level. However, table 4 outlines current best thought on the likely assessment, outcome and feedback measurement tools.

Alongside this, for each CYP that engages with a WP-CYP, it will be required that key demographic and care-pathway information will be collected. Specifically, it would be appropriate to collect standard demographic and safeguarding data and referral details. We would look to track young people through assessment and treatment, from service acceptance, reasons for ending treatment and any onwards referral/signposting. We would also look to collect specific appointment details for every contact, including type of appointment (assessment, treatment, review, follow-up), consultation medium, type of clinical contact e.g. telephone, face-to-face (if applicable), session duration, type of low intensity treatment used, duration of appointment and DNA details. As highlighted above, not all services will have the infrastructure to collect this information as standard and appropriate support and guidance will be offered. Table 4 shows the information expected as part of the MDS.

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Table 4: Outcome and Feedback Tools

Presenting Problem	Assessment	Treatment Sessions	Final Session
Depression	Current View		
	RCADS (Full) self-reported, 8+	RCARDS (Depression subscale) self-reported, 8+	RCADS (Full) self-reported, 8+
	RCADS (Full) parent reported, under 8 (This may also be collected if feasible/desirable for young people 8+)	RCADS (Depression subscale) parent reported, under 8	RCADS (Full) parent reported, under 8
	ORS (13+)	ORS (13+)	ORS (13+)
	CORS (6-12)	CORS (6-12)	CORS (6-12)
	Goal Based Outcomes (to be set in assessment)	Goal Based Outcomes	Goal Based Outcomes
	Session Feedback Questionnaire (SFQ)	SFQ	SFQ
	Anxiety	Current View	
RCADS (Full) self-reported, 8+		RCARDS (anxiety disorder specific subscale) self-reported, 8+	RCADS (Full) self-reported, 8+
RCADS (Full) parent reported, under 8 (This may also be collected if feasible/desirable for young people 8+)		RCADS (Specific anxiety disorder specific subscale) parent reported, under 8	RCADS (Full) parent reported, under 8
ORS (13+)		ORS (13+)	ORS (13+)
CORS (6-12)		CORS (6-12)	CORS (6-12)
Goal Based Outcomes (to be set in assessment)		Goal Based Outcomes	Goal Based Outcomes
Session Feedback Questionnaire (SFQ)		SFQ	SFQ

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Parenting/Behaviour	Current View		
	SDQ-Parental	SDQ-Parental	SDQ-Parental
	SDQ-Child (If possible) (11-17)	SDQ-Child (If possible) (11-17)	SDQ-Child (If possible) (11-17)
	Oppositional Defiant Disorder, parent reported (ODDp)	ODDp	ODDp
	Brief Parent Self Efficacy Scale (BP-SES)	BP-SES	BP-SES
	SFQ	SFQ	SFQ

All records of referrals, assessments, and interventions should be recorded on the host organisation record system, and data collected which enables the required reporting. With support from the HEI, the employing agency needs to ensure there is sufficient capacity to ensure all case recording, and multi-agency liaison is kept up to date and is of high quality.

7. Standards and management information checklist

Safety

- All assessments must take account of risk and safeguarding issues
- All WP-CYPs must have training in local risk and safeguarding procedures
- All WP-CYPs must receive regular supervision
- Supervisors must ensure all WPCYPs use evidence-based interventions appropriate for CYP mental health and appropriate to the circumstances of each children and young person
- All WP-CYPs and supervisors must have a clear an appropriate understanding of local service thresholds and understand when and where to appropriately refer on to other services.

Pathway integration

- The role of the WP-CYP has been integrated into a new or existing multi agency pathway.
- Colleagues across CAMHS and partner agencies have been briefed on the new WPCYP role and pathway
- A clear post remit that sets out the work a WP-CYP does and does not do and who with, has been developed and is clearly understood by the post holder, their supervisors and managers, and other stakeholders

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Quarterly activity and outcomes

The following data is recorded, collected and reviewed:

- Routine outcome measures for all cases
- Number of referrals by source
- Number of referrals accepted, by source
- Presenting Difficulty
- Type of support/treatment offered
- Cases held (quarter ending)
- Completed interventions, by:
 - Number 'dropping out'
 - Number recovering i.e.
 - Number where no further intervention is required
 - Number supported by universal /primary care or voluntary sector services
 - Number referred to specialist services (social care, CAMHS, educational psychology, other)
- Number of re-referrals for the same issue within six months
- Key demographic data in line with the MDS

8. Key Contacts – CYP-IAPT South West Collaborative

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