

**Well-being Practitioners for Children and Young People**

**Operational Guidance**

# Purpose

The purpose of this document is to provide guidance to CAMHS partnerships on the introduction of the new role of Wellbeing Practitioner for Children and Young People (WPCYP). This document does not provide an operational policy but is intended 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 Transformation and Sustainability Plan
* The Future in Mind and CYP IAPT principles, and the local intent to deliver services differently and more effectively in each locality

# Introduction

The new WPCYP role provides additional capacity to tackle common low-level mental health difficulties in children and young people. It is specifically targeted at meeting the needs of those who do not currently receive a service. These posts do not constitute a new service and all that implies. The WPCYP is a new role providing early intervention to better address emerging mental health needs. To deliver maximum impact quickly they need to be integrated into 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 CAMHS interventions.

The posts will be overseen by the local CAMHS partnerships, which will decide where these posts will have the most impact and where they will best receive the required level of support to avoid role dilution, or the role substituting for existing services. National guidance is clear that regardless of the employing agency WPCYPs 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 and GP practices as the places where low level issues are most likely to be first identified.

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 anticipated that the WPCYPs will:

* Work with the whole family
* Deliver a brief focused intervention
* Work with others to deliver group interventions where feasible

The national Headline Plan assumes trainee WPCYPs will be appointed to NHS Band 4 or equivalent, with qualified WPCYPs 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 should make the final decision on the pay grade taking account of:

* The expectations outlined nationally
* Local market conditions
* Equity with existing roles requiring similar experience, knowledge and qualifications
* The need to recruit, motivate and retain staff

# The WPCYP role

WPCYPs will work with children and young people with low level common mental health 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. This reflects the lower level of complexity anticipated. The table below outlines the potential scope of the role.

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| --- |
| What should WPCYPs be doing? |
| WPCYPs should: | **WPCYPs should not:** |
| Assess and support people with low level mental health problems | 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 |
| 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. | Work in ‘clinic’ style settings |
| Offer brief evidence-based interventions | Be involved in complex, or moderate to high need situations or presentationsHold cases referred to CAMHS or co-work high need cases |
| Review children and young peoples’ progress and record outcomes achieved | Close cases until all recording including monitoring of outcomes is completed |
| Be able to access specialist input quickly when appropriate | Operate without appropriate supervision |

**Table 1 WPCYP role**

The table below summarises the specific conditions 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.

|  |  |  |
| --- | --- | --- |
| DOCommon conditions which may respond to early intervention  | MAY DOConditions which may respond to early intervention but require discretion and close supervision.  | SHOULD NOT DOSignificant levels of need /complex conditions which are not suitable for brief early intervention |
| Low mood – Brief Behavioural Activation | Irritability as a symptom of depression – (can present as anger) | Anger management training, Chronic depression |
| Worry management | Low confidence, Assertiveness or interpersonal challenges – e.g. with peers | Low self-esteem, social anxiety disorder |
| Anxiety/Avoidance:Graded Exposure – brief e.g. simple phobias, separation anxiety | Some in vivo exposure within low intensity time parameters | Extensive exposure sessions, imaginal exposure. Blood, needles, or vomit phobia |
| Panic Management |  | Behavioural experiments to induce panic symptoms when working with panic disorder (as a CBT Therapist would) |
| Assessing self-harm and supporting alternative coping strategies. Clients with history of self-harm, but not active. | Thoughts of self-harm, superficial self-harm with clear collaborative understanding between the young person and the therapist about the function of the self-harming behaviour. Basic Harm reduction techniques | Severe, active, high risk self- harm.  |
|  |  | Historical or current experiences of abuse or violence  |
|  |  | Pain management |
| Sleep Hygiene | CBT for insomnia (CBTi) with further training/CPD post qualification | PTSD, trauma, nightmares |
| Behavioural difficulties – identification, and brief parenting support |  | Conduct disorder, anger management, Full Parenting programmes (e.g. Triple P, Solihull Approach).  |
| Thought Challenging – negative automatic thoughts | Simple behavioural experiments with further training post qualification (CPD), and close supervision.  | Core beliefs, rules for living |
| Problem Solving | Assessment of complex interpersonal challenges, step up where needed | Relationship problems -counselling for issues such as relationship problems may be better suited to school counsellors. |
| Training parents and teachers to support interventions with children |  | Treatment of parents’ depression and anxiety. |
|  | Mild/early onset OCD – Exposure Response Prevention (ERP) only. Will require post qualification training in ERP (e.g. CPD) and close supervision | Obsessive compulsive disorder moderate to severe in nature. |
|  | Children that are displaying rigid, ritualistic behaviour that may or may not be within a diagnosis of ASD. Following assessment, interventions can be considered in terms of whether they may prove helpful on a case by case basis.  | Moderate to severe attachment disorders**, r**equiring interventions not provided by low intensity. Assessment and diagnosis of developmental disorders and learning difficulties. |
|  |  | Established health anxiety |
|  |  | Bereavement – where the loss has occurred 6-12 months previously and progress through the grief process is not apparent. |
|  |  | Eating disorders, Body Dysmorphic Disorder |

**Table 2 Conditions**

On a day-to-day basis qualified WPCYPs are likely to be delivering interventions face-to-face, by phone, and online when it becomes available. 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 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 (FIM) 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]](#footnote-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 (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 must 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)

Clarity on the model adopted will shape subsequent decisions on where these posts are best located and accessed by families. Decisions on where the post will sit will affect:

* 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 expectations are that the posts are initially supervised within the 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 more likely to be sited in community or locality bases. It also noted that CAMHS 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. 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 these may be different in different areas:

|  |  |  |
| --- | --- | --- |
| Post location | Benefits | Risks |
| Specialist CAMHS | Close to clinical expertise in children and young people’s development and mental health.Provision of supervision and management with oversight of all cases, as well as providing clinical skills and oversight of individual performance.Potential opportunity to fast-track children of concern to specialist CAMHS for triage or treatment.Clear managerial and accountability ‘line of sight’ to CAMHS commissioners and HEE. | 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.Supervisor may not have skills in management of brief early intervention approaches or outreach approaches.Lengthier referral processes – self referral less likely.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.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.Supervisor may not have the knowledge of wider system and local resources. This could lead to inadvertently duplicating provision.More difficult to build and maintain community links and relationships with universal and other servicesMay seek to ‘own’ or ‘takeover’ the role rather than see it as contributing to local transformation workLocal data systems cannot support the worker to meet the quarterly monitoring and reporting requirements. |
| Schools, local authority early intervention teams, primary care teams (e.g. school nurses), VCS agencies | Good understanding of issues requiring early help.Good understanding of the range of professionals working in early help provision.Easier and quicker access to other professionals involved with the child, young person and family.Closer to community support networks.Closer to the source of referrals enabling speedy access.No additional specialist CAMHS referral route required.Wider sense of accountability across the system – with key agencies all having a role. | Individual school or GP may seek to ‘own’ or ‘takeover’ and fail to recognise the new role as a shared local resource. This may lead to preferential treatment of referrals from the host agency e.g. school, GP practiceSplitting clinical supervision and line management may cause fragmented oversight.More complicated managerial accountability to commissioners and HEE.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. |
| Multi-disciplinary teams - early intervention services | Close to the source of referrals enabling speedy access.More holistic initial assessments.Easier and quicker access to other professionals involved with the child, young person and family.Less likelihood of duplication or substituting for other agencies provision.Close to community support networks.No additional specialist CAMHS referral route required.Protected from caseloads being diluted as ethos of early intervention well understood.  | Splitting clinical supervision and line management causing fragmented oversight More complicated managerial accountability to commissioners and HEE. |

**Table 3 Location options**

# 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 WPCYPs are expected to see approximately 30 cases. This could rise to 167 annually when qualified. 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 six sessions are anticipated)

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.

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

### Referral and assessment

In line with the FIM 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 -disciplinary forum/group (e.g. early help hub, CAF meetings or care navigation meetings). 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 systems or team processes.

### 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 will be seen on a weekly or fortnightly basis depending on the level of assessed need. Interventions are expected to be completed within four to six weeks.

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.

## 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 WPCYP caseloads do not become blocked, which would impact adversely on throughput and compromise the ambition to improve access to mental health services.

# Supervision.

Effective supervision is crucial for the safe and effective practice of WPCYPs, and to nurture 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:

* WPCYPs receiving weekly clinical case management supervision in which their complete caseload is reviewed
* WPCYPs 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 local partnership needs to ensure these requirements are in place.

All supervisors should attend the supervisor training provided by the University of Northampton. They should also attend the relevant the skills sessions of the WPCYP course alongside their WPCYPs. The criteria for supervisors will be agreed by the HEE National Curriculum Group and is anticipated to require two years post qualification experience in CAMHS in the modality being supervised (e.g. parenting, behaviour activation, graded exposure) as well as a practitioner qualification.

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

# Recording and monitoring

All records of referrals, assessments, and interventions should be recorded on the host organisation record system, and data collected which enables the required reporting. Where the WPCYP is not employed by an NHS agency the responsible CAMHS supervisor or manager should contribute to quality assurance to ensure case recording is of a good standard.

In line with the CYP IAPT values and standards a minimum data set enabling the impact of individual case interventions to be captured is required. This needs to be outcome based and be able to demonstrate that interventions are based on collaboratively agreed goals. Routine outcome monitoring is required using session-by-session outcome measures and covering two time points, pre and post intervention using a matched, normed outcome measure.

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.

# Standards and management information checklist

## Safety

* All assessments must take account of risk and safeguarding issues
* All WPCYPs must have training in local risk and safeguarding procedures
* All WPCYPs 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 WPCYPs 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 WPCYP 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 WPCYP 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

## 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
* 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

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1. Future in mind Promoting, protecting and improving our children and young people’s mental health and wellbeing p.14 Department of Health 2015 [↑](#footnote-ref-1)