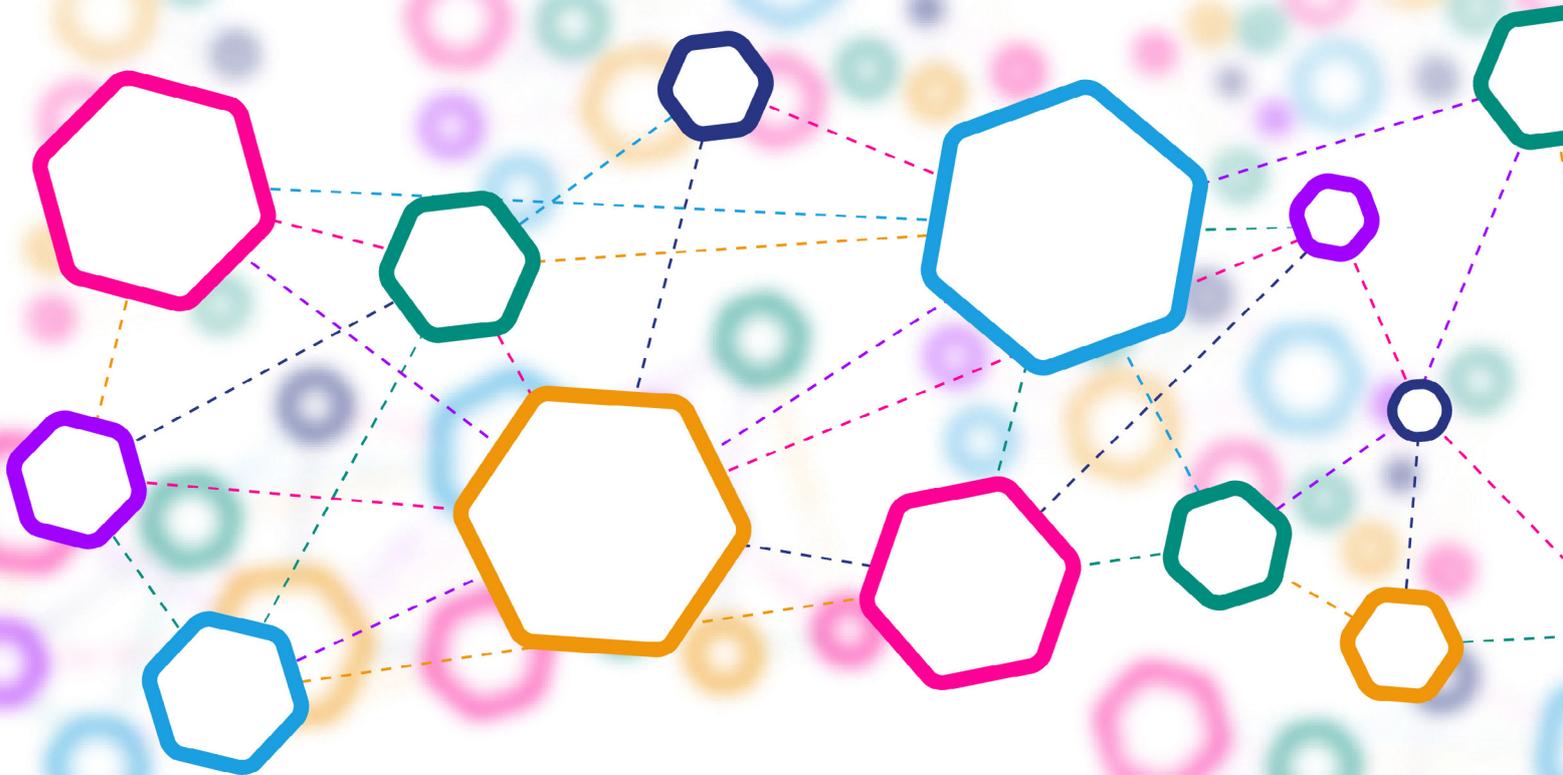


Matrics Plant

Guidance on the Delivery of Psychological
Interventions for Children and Young People in Wales



Commissioned by Improvement Cymru on behalf of the
Together for Children and Young People Programme and the
National Psychological Therapies Management Committee

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Glossary

Context – the settings around children and young people, the things they are a part of and which have an influence on how they grow up. This includes systems in which the child or young person has day to day relationships such as family, school, peer group, community, as well as systems which influence those, such as culture, religion, politics and social media.

System – similar to context, but thought about in terms of the ways in which each part or member interacts with other members including the child or young person.

Trauma – an event that is very frightening and which has significant negative impact on how the person to whom it happened views themselves, the world and other people.

Relational – thinking about things in terms of the person's relationships with other people.

Developmental – thinking about things in terms of the person's cognitive, social, emotional and physical development.

Values based practice – basing the way in which you do your job on the values that are important to you as a professional, to the profession in which you are qualified and to the organisation in which you work.

Evidence based practice – basing the way in which you do your job on the findings of published research.

Practice based evidence – evidence generated through the systematic evaluation of the outcomes of any aspect of clinical practice, including therapeutic relationships.

Theory based practice – innovative psychological intervention based on sound theoretical principles that may not yet have generated significant published evidence.

Therapeutic relationship – the relationship between a psychological professional and the person they are helping.

Systemic case conceptualisation – a way of trying to understand what is going on for someone that includes thinking about the role of relationships, systems and contexts.

Developmental trauma - things that happened, or should have happened and didn't, whilst the child or young person is growing up and which have a significant negative impact on their social and emotional development including attachment, often including emotional regulation, the way in which they see and relate to themselves, the world and other people in it.

Family – this can mean very different things to different people at different times. In this document, family can mean the people with whom a child or young person lives with and who may or may not be related to them, as well as people to whom they are related.

Distress – sustained, rather than transient, emotional pain which may present through words or actions and may include an increase or decrease in certain behavioural patterns.

Embedded – where a psychological practitioner's time is allocated to a specific team or service, which may be within or outside the health service and where that practitioner's time is available to that service without requiring a referral.

Practitioner – a person who is in a professional role in relation to children and families and where part, most, or all of that role involves at the very least noticing the emotional wellbeing and mental health needs of the child or family.

Psychological services – services where the core business is providing intervention to improve the emotional wellbeing or mental health of children and families.

Psychologically minded services – services whose core business includes interacting with children and families where there are often high levels of distress and which therefore need to hold psychological principles at the forefront of what they do. These services may or may not offer specific intervention to improve emotional wellbeing or mental health of children and families, but the services they offer will have an impact on emotional wellbeing and mental health.

Psychological intervention – a purposeful course of action underpinned by psychological theory and driven by a psychological formulation with the intention of improving the child's emotional wellbeing or mental health.

Psychological therapy – a psychological intervention derived from a specific psychological theory and formulated into a model or treatment protocol which may be verbal or non-verbal.

Specialist psychological therapy – a psychological therapy which draws on multi theoretical frameworks to create and deliver bespoke interventions which may be verbal or non-verbal.

Role appropriate – a level of psychological understanding that is appropriate to the reach and remit of the role and service.

Introduction and Context

Matrics Plant has been designed for practitioners working in psychological services for children, young people and families to assist in the development, planning and delivery of a Wales wide approach to providing psychological services to children¹, young people and their families. This requires an evidence-based theoretical framework to guide the provision of a range of interventions, in addition to the delivery of direct therapy specific interventions. Matrics Plant does not recommend specific models of service - accepting that models may vary and change over time. It does however have a number of organising principles for services which recognise that children and young people:

- Live in their own specific circumstances
- Will have their own developmental needs
- Will have differing levels of control over their lives and/or the ability to seek support
- Should receive appropriate and proportionate psychological services based on distress/need rather than always requiring a mental health or other diagnosis
- May be best helped by services working with the people that the child or young person spends time with as well as offering individual work with them when this is needed.

Services should be designed to ensure that they are able to meet the needs of the child or young person at the earliest appropriate opportunity as well as at the earliest possible stage in their development. This would include ensuring that suitably qualified practitioners are available to provide psychological interventions across the full range described in this document; including targeted training, consultation to networks or individuals, intervention with main carers/parents and intervention directly with the child or young person. This may be in addition to ensuring that services and support are available to the child or young person, their parent(s) or main carer(s) as well as health, social care, education and third sector staff within the child or young person's system and who may be responsible for delivery of all or part of a psychological intervention.

Unless otherwise indicated, it will usually be in the best interests of the child, young person and family for the practitioners already involved to remain involved. This maximises a sense of stability and safety, value, worth and belonging for the child, young person and family.

These principles are inclusive of all children and young people from 0-17. This does not exclude children and young people on the basis of neurodevelopmental profile, physical health needs, disability, legal status, living arrangements, method of communication, preferred language or any other characteristic. It is acknowledged that the needs, context and influences for each child or young person will be different based on their own particular profile, age and developmental stage.

1 When this document refers to children and young people, it refers to all those aged 0 to 17 years

Matrics Plant has been developed under the auspices of the Together for Children and Young People Programme Board and overseen by the National Psychological Therapies Management Committee (NPTMC) that developed Matrics Cymru². The consultation draft was also reviewed by the National Youth Stakeholder Forum.

A process for reviewing the evidence tables, which are currently published as addenda to Matrics Cymru, is being developed. Evidence tables in respect of children and young people will be included. These will be developed to encompass interventions in a variety of settings and services and include but not be limited to, child health, children with additional needs, looked after children, children with learning disabilities and neurodevelopmental needs. In the interim, practitioners are referred to the Scottish Matrix³ and National Institute for Clinical Excellence⁴.

As with Matrics Cymru, it is anticipated a national plan will be developed to support health boards and their partners in the delivery of Matrics Plant.

Matrics Cymru was published in September 2017, following extensive work and collaboration between service user and carer representatives and representatives from the seven health boards in Wales, Welsh Government, the National Psychological Therapies Management Committee and Public Health Wales. Matrics Cymru as a framework for practice, has as its focus, the provision of psychological therapy within mental health services for adults and older adults, including those with a learning disability.

Service structure and the focus of work within psychological and psychologically minded services for children, young people and families differs sufficiently from the model outlined in Matrics Cymru to require adapted guidance. Many of the recommendations set out in Matrics Cymru can apply where the intervention indicated following assessment and formulation is direct therapeutic work with the referred child or young person. This is not always the dominant service model in services for children, young people and families, where intervention with the child or young person's parent(s) or carer(s), teachers, or wider systems is a common practice for enhancing psychological wellbeing in a child or young person. Many intervention services for this population are provided through partner agencies.

For the purposes of this document, psychological interventions are defined in the following way:

Psychological interventions are purposeful courses of action driven by a formulation which itself will be based on an assessment of need and informed by one or more psychological theories. The formulation should consider where in the child or young person's system an intervention can be most effective for improving psychological resilience and wellbeing. As such, evidence-based psychological interventions encompass a wide range of courses of action including:

2 <http://www.1000livesplus.wales.nhs.uk/sitesplus/documents/1011/Matrics%20Cymru%20%28CM%20design%20-%20DRAFT%2015%29.pdf>

3 https://www.nes.scot.nhs.uk/media/420chmra/matrix_-_children_youngpeopletablesfinal_2015.pdf

4 For example, for possible depression: <https://www.nice.org.uk/guidance/ng134/chapter/Recommendations>

- Targeted training to upskill key members of a child or young person's system
- Network consultation to support the development of a shared framework for understanding and responding to the child or young person's specific presentation
- One off or ongoing consultative support to an individual or specific team
- Intervention with main carers/parents
- Intervention directly with child or young person.

Whilst the formulation driven psychological intervention will seek to create more favourable conditions for the child or young person's social and psychological development, the recipient of the intervention will not always be the child or young person.

When considering who service users are, there is therefore a need to encompass:

- The child or young person
- Their parent(s) or carer(s)
- Health, social care, education and third sector staff who may receive targeted training and/or consultation and who may be responsible for all or part of a psychological intervention.

Matrics Cymru consists of seven sections. In considering applicability to services for children, young people and families, the wider system around the individual has been included and many aspects of these mutually complementary frameworks are relevant across the age span and can be considered where relevant. Breadth of approach is extended for section 1 (Psychological Therapy Services Model – this has been reframed A Psychologically Minded Whole Service Approach for Children, Young People and Families) and 2 (Psychological Therapy – reframed Psychological Interventions) with a more inclusive approach and substantial new content. Similarly, greater breadth in how services and interventions can be delivered is reflected in section 3 (Psychological Therapists – reframed Practitioners Providing Psychologically Minded Interventions), with wider content developed.

The guidance in sections 4 (Supervision), 5 (Training) and 6 (Audit and Data Collection) of Matrics Cymru are generally applicable across all services with a few additional considerations and as such, a short addenda for children and young people has been developed.

Reviewing the evidence in relation to psychological interventions in services for children, young people and families fell outside the scope of this initial piece of work and as such, general guidance has been provided. This is provided in section 7.

Section 1: A Psychologically Minded Whole Service Approach

The stepped care model for mental health is described in the Mental Health (Wales) Measure 2010 National Service Model for Local Primary Mental Health Support Services⁵. In work with children, young people and families, there will be some interventions and services that will cross different tiers of provision and some interventions/services which do not neatly fit within this framework. Stepped/tiered care services adopt an incremental approach to service provision, best described as pyramidal in structure, with high volume, low intensity interventions being provided at the base of the pyramid to people with the least severe difficulties. Subsequent steps are usually defined by increasing levels of case severity and increasingly intensive forms of treatment rather than levels of contextual complexity.

This model of service organisation fits well where the primary model is direct work with the referred individual, where the referred individual is help seeking on their own behalf, has the agency to make changes in their environment or routines and where that individual has the resources and ability to independently attend appointments. For children and young people, it is often the case that they are referred due to the concerns of others, have less agency to make changes in their environment or routines and often need parental support with transport to appointments.

Children and young people usually exist within a context which they have limited power to change. This is described in Bronfenbrenner's Ecological Model of Child Development (Bronfenbrenner 1979)⁶, which illustrates the layers of influence that impact on a child's development and wellbeing. Practitioners working with children, young people and families should intervene in the part or parts of the system that will create the most meaningful and lasting improvement⁷.

Children and young people are continually developing and learning, often at a rapid pace. Subject to their cognitive, social, emotional and physical development children have the potential to:

- adapt and develop different ways of relating⁸
- survive or thrive in response to their developmental opportunities, relationships and environment.

5 <http://www.wales.nhs.uk/sitesplus/documents/863/Mental%20Health%20Measure%20-%20Primary%20Care%20Model.pdf>

6 [https://books.google.co.uk/books?hl=en&lr=&id=OCmbzWka6xUC&oi=fnd&pg=PA3&dq=Bronfenbrenner%E2%80%99s+Ecological+Model+of+Child+Development+\(Bronfenbrenner+1979\)+&ots=yyQ0Q4SSf-b&sig=P6QLhTS5CiaJ04R00Q002eONwdc#v=onepage&q=Bronfenbrenner%E2%80%99s%20Ecological%20Model%20of%20Child%20Development%20\(Bronfenbrenner%201979\)%20%2C&f=false](https://books.google.co.uk/books?hl=en&lr=&id=OCmbzWka6xUC&oi=fnd&pg=PA3&dq=Bronfenbrenner%E2%80%99s+Ecological+Model+of+Child+Development+(Bronfenbrenner+1979)+&ots=yyQ0Q4SSf-b&sig=P6QLhTS5CiaJ04R00Q002eONwdc#v=onepage&q=Bronfenbrenner%E2%80%99s%20Ecological%20Model%20of%20Child%20Development%20(Bronfenbrenner%201979)%20%2C&f=false)

7 <https://www.bps.org.uk/sites/bps.org.uk/files/Blogs/Files/The%20Child%20%26%20Family%20Clinical%20Psychology%20Review%20-%20Summer%202015.pdf>

8 The impact of the first 1000 days on infant mental health should be considered particularly in the context of perinatal mental health

All practitioners working with children, young people and families should be able to understand and respond to expressions of distress and within a relational, contextual and developmental framework⁹. They should look to build resilience in children and young people and families with a clear focus on hope and recovery. The United Nations Convention on the Rights of the Child¹⁰ should be given central consideration.

It is important for all practitioners working with children and young people to understand that they may communicate their difficulties or distress in a wide range of ways due to individual, gender or developmental differences. Expressions of distress do not necessarily indicate that something is 'wrong' with the child or young person, but may indicate that something is not right/unhelpful or historically has not been right/unhelpful within one or more of the child's or young person's contexts or relationships. Services addressing the emotional wellbeing and mental health of children, young people and families should be able to assess, formulate and deliver meaningful interventions within this framework.

Each service working with children, young people and families will usually undertake a proportionate assessment of emotional wellbeing and mental health need and develop a formulation with the child, family, or service as appropriate. This supports an understanding of the factors that are contributing to the maintenance of the presenting issue. Factors internal to the child may be also highly relevant, including their social, emotional and physical development, temperament and personality, physical or learning disability and long term or severe medical conditions.

These internal factors will both be affected by and affecting, current and historic experiences, environment and developmental opportunities. Understanding the impact and interplay of these internal and external factors will assist in reaching a working understanding of the development and maintenance of the presenting difficulties, which in turn can lead to a sound understanding of what and with whom the most effective psychological intervention will be.

Adverse Childhood Experience reports¹¹ have highlighted the importance of life experiences and environment on children's and young people's development. Developmental trauma and toxic stress¹² may have a direct and long term effect on both a child's and young person's sense of self and their physiology.

9 <https://www.bps.org.uk/sites/bps.org.uk/files/Blogs/Files/The%20Child%20%26%20Family%20Clinical%20Psychology%20Review%20-%20Summer%202015.pdf>

10 <https://www.unicef.org/child-rights-convention/convention-text>

11 <http://www.wales.nhs.uk/sitesplus/888/page/88524>

12 Toxic stress response can occur when a child experiences strong, frequent, and/or prolonged adversity—such as physical or emotional abuse, chronic neglect, caregiver substance abuse or mental illness, exposure to violence, and/or the accumulated burdens of family economic hardship—without adequate adult support. This kind of prolonged activation of the stress response systems can disrupt the development of brain architecture and other organ systems, and increase the risk for stress-related disease and cognitive impairment, well into the adult years. <https://developingchild.harvard.edu/science/key-concepts/toxic-stress/>

A sound understanding of these alongside appropriate trauma informed competencies and compassionate alliances is essential in responding to the needs of children and young people¹³.

There are many children, young people and families who are best supported in settings within their own communities, by people with whom they already have relationships (Making Sense Report recommendation 1)¹⁴. There are others who would benefit from more specialist support, who may, for a number of reasons, not take it up. In these cases, it may be more helpful to support the people who are already present in the system to provide psychologically informed support.

Practitioners working with children, young people and families usually have access to and engagement from many elements of a child's or young person's developmental context – parents or carers are usually keen to see change and practitioners such as those working in education, youth service, local authority, third sector etc. are often available and able to be involved in creating more favourable developmental and relational conditions for the identified child or young person.

This can be especially relevant where the presenting concerns are expressed by adults in the child or young person's system rather than by the child or young person themselves. It is essential that the expertise and support that exists within the tiered system is available to practitioners in embedded services in the form of easy to access consultation, advice and role appropriate supervision, as well as skilled psychological and other practitioners being embedded within these systems.

Psychologically minded services for children, young people and families should therefore:

- Be able to engage children and young people in a way that supports their level of ability and communication
- Be able to offer interventions with children, young people and families' immediate and wider contexts and systems as well as with the identified child or young person
- Be trauma, attachment and ACE (Adverse Childhood Experiences) informed with appropriate competencies and skills
- Engage proactively with health, local authority, education¹⁵, third sector and youth organisations in order to create conditions to foster positive child development
- Understand presenting difficulties within a relational, contextual and developmental framework, recognising that difficulties are most often understandable responses to difficult circumstances and environments

13 (e.g. The Scottish Psychological Trauma and Adversity Training Plan 2018) (<https://www.nes.scot.nhs.uk/our-work/trauma-national-trauma-training-programme/>).

14 <https://www.hafal.org/wp-content/uploads/2018/07/A-report-by-young-people-on-their-well-being-and-mental-health.pdf>

15 Whole school approach - <https://gov.wales/written-statement-joint-ministerial-task-and-finish-group-whole-school-approach-mental-health-and>

- Help children, young people, their families and the systems around them to understand the emotional and psychological needs of the child or young person within this relational, contextual and developmental framework
- Help children, young people and families to have a say in how services which support children and young people's psychological wellbeing are delivered
- Contribute to strengthening the evidence base, drawing on and developing practice based evidence and evidence informed models.

And in direct psychological work with the child, young person or family be able to:

- Offer a service in Welsh
- Deliver evidence-based care via appropriately qualified, supported and supervised staff
- Provide an appropriate choice of evidence-based interventions
- Operate within a framework of values-based practice which places children's needs as central
- Communicate effectively according to the developmental needs of the child – this may include non-verbal interventions such as through play, music, art or drama
- Deliver measureable outcomes improving and/or associated with psychological health and wellbeing
- Help children, young people and families to achieve personally meaningful progress
- Evaluate and respond to feedback from children, young people and families about the appropriateness of the service, quality of the therapeutic relationship and progress towards therapy goals at every stage of therapy.

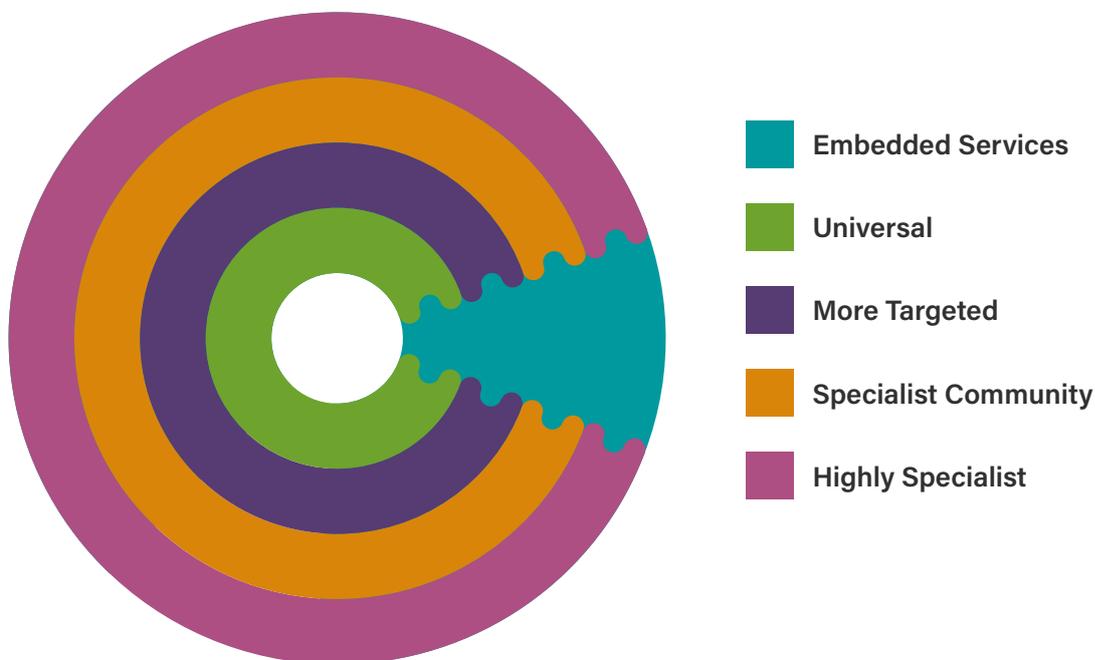
In practice, this means having practitioners within the workforce who:

- Are able to deliver a service in Welsh
- Are trained to recognised standards with the competences necessary to deliver psychological interventions effectively within the service context in which they work
- Are delivering interventions which make sense in respect of the presenting needs and are supported by the best possible evidence
- Are operating within a well-governed system which offers regular high quality, psychological supervision (model-specific where appropriate) support and relevant Continuing Professional Development (CPD)
- Are monitoring the quality of the therapeutic relationship, recognising that this is an essential factor in achieving a successful outcome
- Have a role appropriate understanding of social, emotional, psychological, cognitive and physical development and the impact of acute, chronic or life limiting physical health problems on emotional wellbeing and mental health
- Have a role appropriate understanding of systemic case conceptualisation

- Have the ability to communicate¹⁶ effectively with children, young people, their carers and practitioners in their contexts, the systems and to maintain a compassionate approach
- Have an awareness of the impact of attachment, developmental trauma and ACEs with role appropriate competencies
- Have role appropriate training to appropriate standards with the competences required and the support necessary to deliver psychological interventions effectively within the service context in which they work
- Contribute to innovative and reflective practice.

Types of Service

The Joint Commissioning Panel for Mental Health (2013)¹⁷ outlines the tiered structure of Child and Adolescent Mental Health Services (CAMHS), differentiating the four tiers based on how a child or young person accesses the service. Services which sit outside the traditional tiered framework are more difficult to stratify, since although some services will have a specific remit for mild or very severe complexity, severity and level of emotional distress, others are able to respond flexibly across the broad range of presentations that are met within community settings. Five types of services are described here. It is anticipated these will be available in all health boards across Wales as services mature and develop in line with a developing national plan. It is not the intention that children, young people and families should only ever be supported by one of these types of services. It is essential for seamless working that different aspects of these services be available as necessary to jointly support a child, young person, or family when appropriate.



16 Specific attention should be paid to Welsh language and any reasonable adjustments that need to be made in order to deliver an equitable service.

17 <https://www.jcpmh.info/good-services/camhs/>

Embedded services take many forms. One of the key characteristics of this approach is the organising principle around intervening with the system first, providing a service aligned to the context rather than solely the individual child or young person. Outcomes for children, young people and families are typically improved when good communication and collaboration occurs between systems and agencies and this approach is therefore robustly advocated. In particular, it is suggested the recommendations of *No Wrong Door: bringing services together to meet children's needs (2020)*¹⁸ can helpfully support this way of working. Where different agencies work together, it is essential that appropriate service level arrangements and protocols are in place.

Key features are:

- Access to the service is based on distress/need rather than always requiring a mental health or other diagnosis
- Proactive engagement with existing systems/services and psychologically skilled practitioners being embedded within services. These practitioners are able to offer interventions flexibly and according to need, without requiring a qualifying referral to a mental health service
- Services which may seek to prevent development or escalation of difficulties, as well as to promote psychological understanding and ways of working throughout community settings and services. This promotion and prevention may be both early in the life of the difficulty, as well as early in the life of the child or young person
- Services which may work closely, often being co-located and embedded within communities, social care and education services to support practitioners already involved with families to develop clear psychologically informed formulations and to support delivery of well supported psychologically informed interventions
- Services which may be multi-agency, multi-disciplinary services and able to deliver a high level of intensive and flexible psychological interventions and support for children and young people about whom there is the highest level of concern.

Nature and focus of the Intervention

These services can be organised in different ways. Often, practitioners with psychological expertise will be embedded within, or proactively engaging with, supportive services across the health, education and social care sector.

Psychological consultation, support and training would be organised around the service and its context as well as the specific needs of any identified child or young person.

¹⁸ <https://www.childcomwales.org.uk/publications/no-wrong-door-bringing-services-together-to-meet-childrens-needs/>

For example:

- A service aiming to promote understanding of complex trauma and attachment need could engage through training and ongoing team psychological consultation with teams who work with children and young people presenting with these needs (such as social work teams, specialist educational settings, family court systems etc.), supporting the development of a deeper understanding of the impact of these experiences and ways in which their services could most helpfully meet these needs
- Psychological practitioners embedded within early years or family intervention teams supporting a contextual, normative and developmental understanding of the children and young people the team works with and offering proactive, preventative programmes of work
- Psychological practitioners working with teams around children and young people in the care of the local authority. The resilience of the system can be supported by engaging with the many practitioners (health, education, social care, foster or residential carers) through psychologically informed training, psychological consultation and formulation. The needs of the individual children and young people, as well as specific needs of their carers can be met through direct psychologically informed work, where many presenting difficulties are more often linked to complex developmental trauma than mental health difficulties and so referral thresholds for traditionally oriented services may not fit. A service model which allows psychological practitioners to be alongside and available flexibly can often meet the needs of this population more appropriately than a refer-treat-discharge model
- Psychological practitioners embedded within paediatric physical health teams supporting a psychological understanding of the impact of an acute, chronic or life limiting physical health condition and the treatment regime, who are able to offer intervention directly with the child, young person, or family as well as consultative support to the team.

Universal services such as early years services and all primary care agencies including general medical practice, midwifery, school nursing, health visiting and schools. These services aim to promote mental wellbeing, recognise when a child or young person may have developmental or mental health problems that this level of service cannot meet and know what to do when this is the case. Universal services may be provided by a range of agencies both inside and outside the health service.

Nature and focus of the Intervention

Community based provision for children and young people and their families, provided by a range of practitioners. These services will often be supporting the child, young person, or family for reasons other than mental health need. Psychological/specialist consultation and support to the systems around the child, young person and family could include training around specific presentations and helpful responses, consultative/formulation support to assist the professional network around the child or young person to understand and respond to their needs.

For example:

- Involvement of families would usually focus on group or individual psychoeducation and advice about how to respond to the child or young person
- Direct work with the child or young person could take the form of general skills building/preventative group work, individual or group work.

More targeted services such as youth offending teams, primary care mental health services, school and youth counselling. This includes support for children and young people with less severe mental health problems. These are services where there is usually a single practitioner involved in supporting the child, young person or family, though that practitioner will usually be part of a team. Staff may work with the child or young person directly, or indirectly by supporting practitioners working in universal services and include school counsellors and voluntary sector youth counselling services.

Nature and focus of the Intervention

Community based provision for children and young people, involving health, education or social care practitioners, sometimes including parent/carer involvement. Psychological/specialist consultation and support to the systems around the child, young person and family could include training around specific presentations or needs and helpful responses, consultative/formulation support to assist the professional network around the child or young person to understand and respond to their needs, or supporting the design and delivery of an intervention carried out by staff already working with the family.

For example:

- Involvement of families would usually focus on psychoeducation and/or supporting delivery of psychological therapy approaches with the child or young person
- Direct work with the child or young person could take the form of individual or group work, or both and could be focused on development of key skills such as emotional regulation.

Specialist Community Teams – the nature and provision of these vary across Wales. They are multi-disciplinary teams of practitioners providing a range of interventions to children, young people and families, including teams with specific remits, such as:

- Child and Adolescent Mental Health Services
- CAMHS learning disability teams or Child Learning Disability Teams
- Neurodevelopmental Teams
- Child Health Psychology
- Community forensic CAMHS (FACTS)
- Adolescent substance misuse Teams

- Crisis/home treatment teams preventing admission to hospital or supporting discharge from hospital
- Liaison teams providing CAMHS input to children and young people in acute care systems
- The types of specialist community teams and their focus/organisation will vary across Wales according to local service organisation and may not include all types of teams mentioned above, or may include other specialist teams.

Nature and focus of the Intervention

Outpatient provision for young people with complex difficulties and young people who pose a risk to themselves or others, guided by psychological formulation which can involve a team of mental health and multi-agency practitioners and usually includes parent/carer involvement. Often more than one professional will be involved in supporting the child, young person or family. Where needed, this is usually supported by some level of out of hours crisis support availability.

Psychological/specialist consultation and support to the systems around the child, young person and family could include training around how to respond to a young person's specific needs within a context where other practitioners have a relationship with that young person, e.g. educational settings. It could also include consultative/formulation support to assist the professional network around the child or young person to understand and respond to their needs. Working alongside and in collaboration with staff in the social care and education sectors where there is a mental health or risk component to the child or young person's needs is also often helpful.

For example:

- Work with families could be formalised family therapy approaches, or involvement of families in supporting highly specialist psychological intervention with the child or young person
- Direct work with the child or young person could take the form of individual or group work, or both and be focused on either development of key skills such as emotional regulation, or specialist psychological therapies.

Highly specialist services such as day and inpatient services, very specialised outpatient services and increasingly, services such as crisis/home treatment services which provide an alternative to admission. These are generally services for a small number of children and young people who are deemed to be at greatest risk of rapidly declining mental health, or from serious self-harm who need a period of intensive input and are often provided on a regional or supra-regional basis. There are also a small number of very highly specialised services including, but not limited to, medium secure adolescent units, services for those with gender dysphoria and highly specialist obsessive compulsive services.

Nature and focus of Intervention

Day and inpatient provision for highly complex and/or young people who pose a high risk to themselves or others; involving a team of mental health practitioners working together to support the child or young person, usually including parent/carer involvement.

Psychological/specialist consultation and support to the systems around the child, young person and family could include training around how to respond to a young person's specific needs within a context where other practitioners have a relationship with that young person, e.g. educational settings, consultative/formulation support to assist the professional network around the child or young person to understand and respond to their needs.

- Work with families could be specialist family therapy approaches, or involvement of families in supporting specialist psychological therapy approaches with the child or young person
- Direct work with the child or young person could take the form of individual or group work, or both and be focused on either development of key skills such as emotional regulation, or specialist psychological therapies.

Section 2: Psychological Interventions

Psychological interventions are purposeful courses of action typically driven by a formulation, which itself will be based on an assessment of need and informed by one or more psychological theories. The formulation should consider where in the child's or young person's system an intervention can be most effective for improving psychological resilience and wellbeing. As such, evidence-based psychological interventions encompass a wide range of courses of action including:

- Targeted training to upskill key members of a child or young person's system
- Network consultation to support the development of a shared framework for understanding and responding to the child or young person's specific presentation
- One off or ongoing consultative support to an individual or specific team
- Intervention with main carers/parents
- Intervention directly with child or young person.

Whilst formulation driven psychological intervention will seek to create more favourable conditions for the child or young person's social and psychological development, the recipient of the intervention will not always be the child or young person.

When considering who service users are, there is therefore a need to encompass:

- The child or young person
- Their parent(s) or carer(s)
- Health, social care, education and third sector staff who may receive targeted training and/or consultation and who may be responsible for all or part of an intervention.

Psychological interventions encompass a wide range of practice. Interventions described in this document refer to psychologically informed and/or psychological therapy interventions. Intervention goals and the type of intervention should be based on the areas of life or developmental skills that are identified during assessment and formulation as priorities and which are most likely to create the conditions for improvement in psychological wellbeing. Psychological interventions may or may not be linked to a particular diagnosis and diagnosis is not a requirement for access to a psychological interventions. When providing psychological interventions, where services work together, outcomes for children, young people and families are more likely to be efficient and effective¹⁹.

¹⁹ <https://www.childcomwales.org.uk/publications/no-wrong-door-bringing-services-together-to-meet-childrens-needs/>

Psychological interventions with children, young people, their families and systems, have an increasing evidence base demonstrating both clinical effectiveness and economic benefit²⁰. However the language, cultural and presenting needs of children, young people, their families – systems are often complex and multiple and do not fit well into traditional research models, leading to a relative lack of direct clinically applicable evidence. As such, much work with this population is dependent on practice based evidence as well as gold standard evidence²¹ and often innovative theory based practice²².

There is emerging and well-grounded practice based evidence that interventions other than directly with the child or young person can achieve good and lasting outcomes²³. Family and group interventions are already well researched as effective²⁴.

Where the presenting needs fit within diagnostic criteria²⁵, the published evidence base is growing and there are well supported interventions, as well as some promising interventions which are widely used. A formulation shared by all parties involved is frequently the process from which an appropriate intervention should be developed.

Psychological Formulation

Psychological formulation can be used in addition to, or instead of, a diagnostic process in order to offer the best possible care and support for improving psychological wellbeing in a child or young person. The psychological formulation details the matters that have come together to create the presenting need as well as what might be maintaining the situation. It recognises strengths and challenges. Psychological formulation should be carried out as a collaborative process, whether that is with an organisation or team around a theme²⁶, or practitioners working with the child, young person or family, or directly with the child, young person or family in relation to the presenting needs. Psychological formulation informs decisions around care and choice of intervention for the child, young person and family such as where intervention is likely to have most impact (e.g. system, family, parent/carer and/or individual) and what interventions are likely to be helpful. It will also identify factors which may facilitate or hinder progress and helps goals to be collaboratively agreed. A shared psychological formulation is key to the engagement of all parties in any courses of action necessary for progress towards shared goals.

20 <https://www.ncbi.nlm.nih.gov/pubmed/11473907>

21 See NICE Guidance

22 <https://fhcappg.org.uk/wp-content/uploads/2019/01/practice-based-evidence-report-300119.pdf>

23 <http://centaur.reading.ac.uk/75842/> and [https://www.jaacap.org/article/S0890-8567\(19\)30173-X/fulltext](https://www.jaacap.org/article/S0890-8567(19)30173-X/fulltext)

24 [https://onlinelibrary.wiley.com/doi/pdf/10.1111/1467-6427.12032#:~:text=Systemic%20interventions%20are%20effective%20in,children%20\(Myers%2C%202011\).&text=Systematic%20narrative%20reviews%20concur%20that,is%20family%2Dbased%20and%20structured.](https://onlinelibrary.wiley.com/doi/pdf/10.1111/1467-6427.12032#:~:text=Systemic%20interventions%20are%20effective%20in,children%20(Myers%2C%202011).&text=Systematic%20narrative%20reviews%20concur%20that,is%20family%2Dbased%20and%20structured.)

25 See NICE Guidance

26 E.g. Things to consider when working with those that may be presenting with challenging behaviour

Psychological formulation should be proportionate to the level at which a service is being provided and draw upon an understanding of psychological theory, as well as knowledge of intrinsic factors such as developmental level, genetic, biological and health needs. As such, whilst psychological formulation is a skill, the application of that skill depends upon a role and service appropriate depth of relevant knowledge and expertise.

Psychological formulations are not intended to be static and will often develop over the course of an intervention as more information becomes available or as the outcomes of different aspects of an intervention become known²⁷.

This document considers four main psychological formulation driven courses of action, which may be offered individually or simultaneously:

- Intervention directly with child or young person
- Intervention with main carers/parents
- Intervention with wider systems/consultation
- Targeted training.

Intervention directly with child or young person

Often, it is identified through assessment and psychological formulation that an intervention directly with the child or young person is indicated either as the main or only intervention, or in combination with interventions targeting other parts of the child or young person's system. Interventions directly with children or young people can occur across the spectrum of need, delivered by health, social care, education, or third sector agencies and can take the form of group or bespoke individual interventions. The intervention itself could be befriending/mentoring, support with community engagement, psychoeducation, development of strategies to be tried in day to day life, or a formal therapeutic intervention.

Individual interventions at any level can include skills development such as emotional literacy, emotional regulation, social skills or a psychological therapy. Examples can be found at Annex 1. Where the intervention is an individual formal therapeutic intervention, the competence frameworks for each therapy modality should be followed, whilst holding in mind the importance of child development and context. Both the Scottish Matrix Evidence²⁸ tables and National Institute for Health and Care Excellence (NICE)²⁹ guidelines should be used as a reference guide to competencies required where these are not yet set out in Matrics Cymru.

27 <http://www.sisdca.it/public/pdf/DCP-Guidelines-for-Formulation-2011.pdf>

28 <https://www.nes.scot.nhs.uk/our-work/matrix-a-guide-to-delivering-evidence-based-psychological-therapies-in-scotland/>

29 <https://www.nice.org.uk/>

Intervention with main carers/parents

Children's and young people's relationships are central in terms of their development, their ability to respond to adversity and the way they see themselves. It is within relationships that children and young people come to understand their emotions and develop strategies to manage them. Children and young people's relationships play a significant role in maintaining and changing presentations of emotional distress. Parents and carers will have their own unique set of experiences/needs and consideration should be borne in mind when developing any interventions³⁰.

The assessment and formulation process considers the role of these closest relationships and identifies opportunities for intervention. Interventions with main carers/parents can occur across the spectrum of need, delivered by health, social care, education, or third sector agencies and can take the form of group or bespoke individual intervention. The intervention itself could include psychoeducation, involvement in therapeutic strategies to be tried in day to day life, or formal family focused therapy. Examples can be found at Annex 1.

Intervention with wider systems/consultation

Psychologically informed consultation is an intervention that can be offered to adults who are part of the child's or young person's life as a stand-alone and/or ongoing intervention or as part of an intervention. The format will usually be a meeting during which a consultant³¹ or consultants enable a consultee or group of consultees to collaboratively explore a concern or dilemma. This may lead to the development of a shared formulation, often leading to actions. The role of consultant requires the utilisation of appropriate highly specialist experience and knowledge of psychological theory and practice to support the consultee or consultees to take forward recommendations and actions from the consultation. This can be provided flexibly to an individual, group, team, service or network around a child or young person and their family.

Psychological consultation can support earlier intervention by practitioners already involved with the child or young person and can support those systems to "hold on" and maintain existing relationships. Children's and young people's systems, including friendship groups, school life and local community life have an impact on the possibility and sustainability of positive outcomes following intervention. Engagement with these systems alongside other interventions through consultation and joint working can add to the efficacy of interventions.

30 It is understood that where carers or parents have experienced ACE's and have acute or chronic difficulties such as physical or mental health difficulties, cognitive or learning disabilities, substance misuse or dependency, have relational problems or experience trauma (e.g. domestic violence), in addition to financial and housing issues, their parenting capacity may be impacted. In such circumstances, a multiagency approach is essential to support the immediate system around the child in addition to any psychological intervention.

31 This is usually a professional with relevant training, knowledge and experience linked to psychological models and interventions.

Psychological consultation can also support the adults and networks in the child's or young person's life to better understand and respond to their needs. This enables the context in which the child or young person is developing to be adjusted to create conditions in which the child or young person can achieve better developmental outcomes. Psychological consultation can be considered to be both a preventative intervention and an intervention offered following assessment and formulation and can be offered alongside other interventions or as an intervention in its own right. Psychological consultation increases the skill, knowledge and confidence of the consultees to respond to similar needs in future and can maximise the availability of professional expertise. Examples can be found at Annex 1.

Targeted Training

Targeted training is an intervention that can be offered to the adults who are part of the child's or young person's life to enable them to better understand and respond to the child's or young person's needs. It can be useful as a stand-alone intervention and/or alongside other interventions such as direct work with a child or young person and their family. Supporting adults in this way allows the context in which the child or young person is developing to be adjusted to create conditions in which the child or young person can achieve better developmental outcomes.

It also supports the systems around a child, young person and family to remain involved, supporting the maintenance of existing relationships. Targeted training can be considered to be both a preventative intervention (e.g. open access sessions) and an intervention offered following assessment and formulation (e.g. needs identified after an individual or systems assessment and formulation). Example of targeted training can be found at Annex 1.

Section 3: Practitioners Providing Psychologically Minded Interventions

Historically, there has been a focus on defining competence and skill in relation to specific therapeutic approaches. This document seeks to be inclusive of practitioners engaged in psychological interventions more broadly, as well as those engaged in specific therapeutic work.

When working with children, young people and families, formulation is pivotal to understanding and responding and whilst considerations around the therapeutic alliance remain central, it is important to note that when direct work is carried out, it is often not, or not only, the child or young person with whom a therapeutic alliance is created. Where the work is focused within the child's or young person's system, the relationship with the practitioners or parents needs careful consideration. Established models (e.g. Roth and Pilling³²) have focused on competencies required for individual therapeutic work within mental health services. The landscape of provision for children and young people's emotional wellbeing and mental health is broader than this, encompassing not only mental health services, but also the wider health sector, education, social care and third sector provision. As such, a framework of levels of psychological understanding and practice when engaged in work around children's emotional wellbeing and mental health that can be applicable across sectors and settings is proposed.

The workforce addressing mental health and emotional wellbeing for children, young people and families is located in the health service (both in mental health services and in other parts of the health service), local authority services including education and social care, as well as in the third sector. As such, the definition of a practitioner providing psychologically minded interventions for children, young people and their families can be as broad as a person interacting in a professional capacity with a child, young person or their systems.

Within this wider definition, there is a broad range of competency. At the most generalist end of the spectrum, all practitioners working with children, young people and families should have an awareness of child development (psychological, emotional, cognitive and physical), the impact of developmental trauma, family development and transition, and the systems around a child or young person; as well as the skills to identify psychological needs and give advice/support. At the more highly specialist end of the spectrum, practitioners will have the relevant experience and qualifications to provide appropriate psychologically minded interventions and support others to do so. This will include specific training at or above Masters Level.

32 <https://www.ucl.ac.uk/pals/research/clinical-educational-and-health-psychology/research-groups/core/competence-frameworks-11>

Levels of Psychological Understanding and Practice

Level	Staff Group	Assessment	Intervention	Core Skills	Knowledge
1	All practitioners working with children and young people	Identify psychological needs	Information giving, empathic communication, emotional support	Awareness of systems around child or young person	<p>Awareness of child development (psychological, emotional, cognitive and physical)</p> <p>Impact of developmental trauma</p> <p>Family development and transitions</p>
2	Practitioners with additional responsibility for emotional wellbeing	<p>As above and</p> <p>Screen for psychological needs</p>	<p>As above and</p> <p>Problem solving and informal counselling</p>	<p>As above and</p> <p>Ability to engage with systems around and with the child or young person</p>	<p>As above and</p> <p>Ability to respond in a role-appropriate manner to needs identified in respect of child development (psychological, emotional, cognitive and physical)</p> <p>Impact of developmental trauma</p> <p>Family development and transitions</p>

3	Practitioners with specific training in psychological approaches ³³	As above and Assess psychological needs and devise formulation and intervention	As above and Delivery and monitoring of formal/specific psychological interventions	As above and Ability to consult to and with systems and practitioners around the child or young person in order to guide, lead, or jointly deliver intervention	As above and Ability to incorporate into formulation and intervention and support systems around the child or young person to more fully understand
4	Practitioners with highly specialist training in psychological approaches ³⁴	As above and Assess complex psychological needs and develop shared formulation and/or intervention	As above and Multi-theoretical frameworks used to create and deliver unique interventions	As above and Ability to consult to and with systems and practitioners around the child or young person in order to guide, lead, or jointly deliver interventions where the presenting needs are highly complex	As above and Ability to lead the development of a complex shared formulation and intervention across multidisciplinary and multiagency contexts

33 See Annex 3

34 See Annex 3

Section 4: Supervision of Psychologically Minded Interventions and Psychological Therapy

There are clear modality specific requirements for appropriate clinical supervision where the intervention being carried out by practitioners working with children, young people and families is formal psychological therapy and there are clear minimum standards in relation to supervision for many professions. It is essential that any practitioner delivering a formal psychological intervention or therapy has access to appropriate clinical supervision to ensure it is being delivered to an appropriate standard³⁵. Clinical supervision should be regular and ongoing and take account of modality and profession specific minimum standards.

In addition to the skills and training requirements set out therein, it will be necessary for anyone providing supervision for a practitioner working with children, young people and families to have a good knowledge and understanding of child development (physical, emotional, social and cognitive), systems around the child or young person including family development and transitions. Practitioners should have role appropriate level of skills and awareness regarding trauma informed practice and the impact of developmental trauma³⁶.

Where the intervention being carried out by practitioners working with children, young people and families is other than formal psychological therapy, the requirements for model specific clinical supervision is less pertinent, but the knowledge outlined above and an understanding of the system in which the professional is working, the resources available to them, a compassionate and relationally informed approach are essential. The nature and focus of this supervision should fit for the particular scenario and staff group and could include reflective practice and case discussion as well as personal reflection.

In all cases, one of the focuses of supervision will be supporting, educating and enabling the supervisee in understanding the presenting needs in the context of relationships and development and to support the practitioner to deliver the most appropriate intervention competently and safely.

Where an intervention is being led or delivered by a professional working outside of a core mental health service, careful consideration needs to be given as to how supervision can be provided and accessed. It is likely that multiagency agreements and protocols will need to be developed and practitioners employed within core mental health services will have a lead responsibility in this. The model of having highly skilled psychological practitioners embedded within other services also addresses this need.

35 The standards used for supervision in Wales will be those identified in the University College London competence framework which were commissioned by Care Services Improvement Partnership (CSIP), Skills for Health and NHS Education for Scotland) (NES).

36 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6088388/>

Of equal importance at every level of service provision and every level of expertise, is the availability of appropriately skilled and knowledgeable support, supervision and consultation – each service must be appropriately supported.

Levels of Supervision, Support and Psychological Consultation

Level	Staff Group	Requirements for support, supervision, consultation
1	All practitioners working with children and young people such as teachers and youth workers	Access to a practitioner with appropriate skill and knowledge to support identification of psychological needs and to support the process of information giving, empathic communication and general psychological support
2	Practitioners with additional responsibility for emotional wellbeing such as wellbeing leads	Access to a practitioner with appropriate skill and knowledge to support screening for psychological needs and to support the processes of problem solving, informal counselling and engagement with the systems around the child or young person
3	Psychological practitioners such as those with relevant qualifications or experience	Access to a practitioner with appropriate skill, knowledge, qualifications and training to support the assessment of psychological needs and the development of formulation, intervention plans and to support the process of consulting to and with systems around the child or young person in order to guide, lead or jointly deliver intervention Where delivering formal psychological therapies, access to appropriate expert clinical supervision
4	Highly specialist psychological practitioners such as those with a relevant post-graduate qualification	Access to a practitioner with appropriate skill, knowledge, qualifications and training to support the assessment of complex psychological needs, development of shared and jointly held complex multi-theoretical formulations and unique intervention plans and to support the process of consulting to and with systems around the child or young person in order to guide, lead or jointly deliver intervention where presenting needs are highly complex Where delivering formal psychological therapies, access to an accredited supervisor or supervisor accredited in the field

For practitioners providing services outside core or commissioned NHS services, the above levels of support should be considered as good practice and it would be good practice for staff working in core or commissioned NHS services to consider how to proactively support these practitioners in order to create safe, robust, skilled and knowledgeable multidisciplinary and multiagency approaches to improving emotional wellbeing and mental health in children and young people.

Section 5: Training

There are clear frameworks in relation to specific therapeutic modalities and within overarching frameworks (e.g. Matrics Cymru; Scottish Matrix)³⁷. The UCL/NES Competence Framework for Child and Adolescent Mental Health Services further sets out universal core requirements.

In addition, it is important that all practitioners both within and outside NHS services working with children, young people, their families and systems have training in:

- Typical and atypical child development (social, emotional, cognitive and physical; to include attachment)
- Understanding of adverse childhood experiences, developmental trauma and the impact on a child's development and functioning
- Understanding of factors that promote resilience
- Understanding and working with systems around a child or young person.

Opportunities should be provided in house to ensure that all NHS staff working with children, young people and their families have a role appropriate level of knowledge and skill within these areas. Where a service is being provided outside of a core mental health service, careful consideration needs to be given as to how this knowledge can be developed and assured. It is likely that multiagency agreements and protocols will need to be developed and practitioners employed within core mental health services will have a lead responsibility in this. The model of having highly skilled psychological practitioners embedded within other services also provides an opportunity for appropriate skill development.

³⁷ See Annex 2

Section 6: Audit and Data Collection

The principles outlined in Matrics Cymru and the Working Together Toward Common Goals: Outcome Measurement in Wales paper³⁸ can be considered to apply. In addition, it is important to consider the contexts in which the child or young person exists and how outcome data will be collected, where the psychological intervention is not direct therapy and where the psychological intervention is provided within the system rather than with the child or young person directly.

Where the intervention takes the form of direct psychological intervention, whether individual, family or group, appropriate outcome measures should be collected from the child or young person (where their development allows) and from their parent(s) or carer(s) subject to age and consent.

Outcome measures currently recommended by Welsh Government are SDQ (Strengths and Difficulties Questionnaire), SWEMWBS (Short Warwick Edinburgh Mental Wellbeing Scale) CGAS (Children's Global Assessment Scale), GBOs (Goal Based Outcomes), Social Services and Wellbeing Care and Support Plan 10 point scale and CHI-ESQ (Children's Experience of Service Questionnaire).

Where the intervention takes the form of consultation or targeted training, outcome measures should evaluate whether the need identified has been met by the intervention – this may be increased confidence, skill, system resilience or understanding leading to better outcomes for the child or young person. Careful thought and multiagency co-operation will be required where interventions are led or delivered by practitioners employed outside of mental health and emotional wellbeing services. The published evidence in relation to emotional wellbeing and mental health services for children and young people is significantly less expansive than that for adults of working age. As such, where possible and appropriate, outcome data should be collated, embedded into practice to support service improvement and learning and shared across services through communities of practice to support innovation and learning where appropriate and possible. Children and Young People's Improving Access to Psychological Therapies programme have published a resource booklet³⁹, Child Outcomes Research Consortium also provides access to a wide range of resources, as do the Evidence Base Practice Unit⁴⁰.

38 <http://www.1000livesplus.wales.nhs.uk/sitesplus/documents/1011/2019-08-20%20OUTCOME%20PAPER%20-%20Final.pdf>

39 http://www.burdenbasket.co.uk/media/files/CYPIAPT-ResourcePack_1_4.pdf

40 <https://www.corc.uk.net/outcome-experience-measures/> and <https://www.ucl.ac.uk/evidence-based-practice-unit/publications-resources/resources-professionals>

Section 7: Evidence Base

The 2017 Adult Matrics Cymru Guidance document and Evidence Tables⁴¹ outlines current available evidence base and practice based evidence, for a wide range of mental health and other difficulties experienced by adults. The evidence tables' document outlines the rationale for evidence-based practice and practice based evidence. It states:

Psychological services play a particularly important role in mental health services for children and young people. Although this remains an under-researched area compared to mental health overall, much of the evidence of “what works for whom” in relation to children and young people comes from the adult or generic psychological therapies literature.

It is also the case that various forms of psychological therapy contribute to “generic” CAMHS clinical practice and within services for children and young people, given the need for clinicians to develop skills in communicating effectively, for example, with younger children or with families. It is noted that the use of diagnostic, rather than developmental frameworks for describing children's experiences of difficulty and distress within their complex context of care and to index effective practice through these means, may not be appropriate or helpful in psychological services for children and young people.

Currently, services and practitioners should refer to relevant evidence including the Scottish Matrix 2015 evidence tables and existing NICE guidance. It is noted that these documents although current are now more than five years old. A process is being developed in partnership with the NPTMC to update and publish further tables. These documents may also inform the commissioning of appropriate psychological therapy services alongside the key principles and standards outlined in the current document.

Underpinned by theoretical models and understanding of developmental processes, a wide range of art, play based and creative therapeutic interventions are delivered to children and young people in Wales. It is acknowledged that there is a limited evidence base for certain children or young people (e.g. those with a learning disability and those who are looked after), whereby adaptations of pre-existing interventions are necessary.

The Scottish Matrix⁴² is a helpful resource in that it reviews the available evidence base for delivering psychological interventions for children of all ages (including attachment and infant mental health), those who have neurodevelopmental conditions (e.g. Autism Spectrum Disorder and Attention Deficit Hyperactivity Disorder) or behavioural difficulties, common mental health presentations, self-harm and interpersonal problems, substance misuse, trauma, neuropsychological conditions (e.g. acquired brain injury and epilepsy) and interventions linked to paediatric psychology (e.g. adherence, chronic pain and adjustment to

41 http://www.1000livesplus.wales.nhs.uk/sitesplus/documents/1011/evidence-tables_final.pdf

42 <https://www.nes.scot.nhs.uk/our-work/matrix-a-guide-to-delivering-evidence-based-psychological-therapies-in-scotland/>

chronic illness).

It also reviews the available evidence for children who have experienced certain circumstances (e.g. children at risk of going into care, looked after, adopted and refugee children).

A process for the future review of evidence tables will extend the current inclusion criteria of the Scottish Matrix and also include peer review case studies and qualitative research. The process will include the range of interventions discussed in this document. The development of a repository for practice based evidence, as well as leadership for collaborative sharing of practice and outcomes, could be helpful in driving forward innovative effective practice across Wales and would be congruent with the Parliamentary review⁴³.

⁴³ <https://gov.wales/sites/default/files/publications/2018-01/Review-health-social-care-report-final.pdf> and which supports clinical leadership in informing Once for Wales approaches regarding the accessibility and implementation of models of practice for which there is good evidence of effectiveness.

Annex 1: Examples

Targeted training

Following assessment and formulation, it is identified that staff in school could respond more helpfully to a child or young person with severe and complex mental health need, and this would reduce the amount of missed education days and support recovery. School staff could be supported by training from Specialist CAMHS practitioners to understand and respond safely, helpfully and in line with assessed needs to a young person with severe and complex mental health needs.

Often parents feel they do not know how best to respond to ongoing high levels of emotional distress in their children and as a result, respond in a variety of ways and experience significant distress themselves. Open access to psychoeducational sessions could be provided to enable parents to understand and respond helpfully to their child when presenting with emotional distress. Following assessment and formulation, it could be that accessing psychoeducation could form part of an intervention plan.

Relationships are central to how children and young people develop, learn and manage their emotional experiences. Children and young people who have experienced developmental trauma including attachment disruptions often need additional focus on quality of relationship in order to manage and often their internal stress is manifested behaviourally. Whole teams can be supported through training to understand the impact of complex developmental trauma and attachment needs and become more able to adapt their team's approaches to work to be attachment and trauma informed, benefitting every child and young person and creating conditions in which children and young people with additional sensitivities in this area can begin to thrive.

Consultation

A member of school staff is finding that all reward and sanction strategies are ineffective in shaping behaviour that is difficult within a classroom context and seeks consultation in order to understand the presentation from within a psychologically informed framework. This leads to an attachment informed shared understanding and a school action strategy that prioritises relationships and arousal regulation over more traditionally accepted behavioural strategies.

A child has been referred to services due to concerns around angry outbursts. It is clear from shared multiagency knowledge that there has been significant involvement of family support services and that the family struggles financially. A network consultation bringing all relevant parties together to develop a shared understanding of how the child's presenting needs have come to be and are being maintained could lead to a multiagency response involving parenting support, outreach youth work and practical support to allow the child to attend age appropriate extra-curricular activities. The impact of this could be monitored through follow up network consultations, with the shared formulation and action plan being adapted accordingly.

Ready, referral free availability of an expert consultant embedded within a team working with a population of children or young people where these needs are present allows ongoing consultation in relation to appropriate strategies and approaches which may prevent the escalation of presenting need and create more favourable conditions for positive development.

Intervention with main carers/parents

A child has been referred to services due to high levels of anxiety impacting significantly on their daily functioning including attendance at school. Assessment and formulation identifies that the way in which the family understand and respond to the child's anxiety is contributing to the perpetuation of the difficulties. Intervention with parents could include psychoeducation around physiological, cognitive and behavioural aspects of anxiety as well as supporting the parents, either individually or in a group format, to understand and apply principles of Cognitive Behavioural Therapy within the home and the child's environment.

A child has been referred to services due to increasing levels of oppositional behaviour, emotional dysregulation and risk taking. Assessment and formulation identifies that, due to adverse experiences for the child and parents, the parent-child relationship is punitive and conflictual rather than supportive. Intervention with parents could include psychoeducation around the impact of adverse childhood experiences and support to alter the way in which they respond to the child (e.g. Non Violent Resistance, Circle of Security, Dyadic Developmental Psychotherapy and Theraplay).

Relationships are central to how children develop, learn and manage their emotional experiences. Where an emotional wellbeing or mental health need has been identified, it is helpful for the key adults with whom the child interacts on a daily basis to be able to respond from a therapeutically informed position. This can allow in the moment management or therapeutic strategies to be deployed with greater frequency and real world generalisability than can be achieved with outpatient appointments. If the skills are embedded within the family, they can be used repeatedly in the future should difficulties re-arise.

Intervention directly with child or young person

A child has been referred to services due to high levels of emotional distress or mental health difficulties. Assessment and formulation identifies that the child has some patterns of belief and/or thinking and/or feeling and/or behaving that are contributing to the perpetuation of the difficulties. Intervention directly with the child could include specific therapy modality informed work, or specialist work to support change in these patterns in order to improve emotional wellbeing and mental health. The choice of therapeutic intervention should be informed both by the existing evidence base and formulation identifying the areas of greatest need and the child's developmental needs and individual agency.

Annex 2: Training

Training and skills development are key to:

- The delivery of psychological therapy and supervision
- Increasing the capacity of the current and any new workforce to deliver effective interventions at both the required quality and volume.

Values base and recovery focus

All staff working in mental health services will be operating from the values base as described in the 10 Essential Shared Capabilities. The 10 essential shared capabilities were originally developed and published by a partnership involving the Department of Health, the Sainsbury Centre for Mental Health, the National Institute for Mental Health in England and the NHS University in 2004. It is important to note that these organisations worked closely with service users and carers to ensure that they reflected their priorities. It is intended that they will enable service users and carers to have increased awareness of what to expect from staff and services.

The 10 essential shared capabilities

1. Working in partnership	6. Identifying people’s needs and strengths
2. Respecting diversity	7. Providing service user-centred care
3. Practising ethically	8. Making a difference
4. Challenging inequality	9. Promoting safety and positive risk taking
5. Promoting recovery	10. Personal development and learning

Over time there may be other values based standards that will require the training of staff. In addition to training in values based care and recovery, all mental health staff should have a basic level of psychological ‘awareness’ and ‘literacy’. This should include:

- Training in a psychological model within which they can construct a basic psychological formulation of service user’s difficulties
- Training in listening and communication skills
- Training in basic counselling skills
- Training in self-awareness and the role of the therapeutic relationship.

Psychological therapy services also need to ensure they comply with the terms of the Welsh Language Act 1993 and the Welsh Language Measure (2011).

Psychological interventions and therapy

Psychological therapies interventions can be subdivided in line with the tiers in a stepped-care model as below:

- Low intensity treatments
- High intensity therapy
- High intensity specialist therapy
- Highly specialist therapy and interventions.

The mapping of levels of training against the tiers of the matched/stepped-care system is shown in Section 3, Table 3, "Minimum training to deliver different levels of therapy in Wales". Competence to practice within a specific psychological therapy model e.g. Cognitive behavioural therapy (CBT), systemic therapy should also be consulted (see Page 36 and 37).

In June 2017, there were no all Wales training schemes that deliver training for the 10 essential shared capabilities, or for the workforce delivering low intensity interventions. It is therefore important that local training schemes are structured around the relevant competence frameworks identified in Matrics Cymru and that those delivering the training have the appropriate level of expertise.

The standard of competence required to deliver high intensity specialist psychological therapy has been set intentionally high at Diploma level, in order to ensure fidelity to the evidence base. However, it is recognised that some staff currently delivering high intensity psychological therapy will require additional training to meet this standard. In addition to direct practice based training, staff will also need training in accountability processes and procedures, including legal obligations, how to manage complaints, second opinions and investigation of errors or potential errors.

The effectiveness of therapy, supervision and the state of the therapy relationship are profoundly affected by the accuracy and reliability of record keeping. Partial and inaccurate records can mean lost opportunities, missed risks, misunderstandings and misrepresentations of the service user. Staff need to know how to check the accuracy of their records with service users, use electronic recording devices to improve accuracy and what they can or cannot change in records and the process they need to follow to change it. It is essential that any opinion is identified as an opinion and all the facts leading to that opinion are given, so that subsequent clinicians can assess the situation for themselves and errors can be better identified and addressed.

Local PTMCs should develop and oversee a training strategy for each health board area. The NPTMC should carry out an option appraisal for developing all Wales training in these areas.

Annex 3: Levels of Psychological Understanding and Practice

Intensity of intervention	Client group / level of severity	Treatment delivered	Competence / training routes
Low intensity:	<p>Common mental health problems – stress/ anxiety/depression</p> <p>Severity: Mild/moderate, with little complexity and limited effect on functioning</p>	<p>Low intensity evidence-based interventions e.g.</p> <ul style="list-style-type: none"> ▪ Supported self-help ▪ Solution-focused/ problem solving ▪ Structured anxiety/ depression management groups ▪ Self-help coaching ▪ Telephone CBT (TCBT) <p>High volume courses:</p> <p>For example:</p> <ul style="list-style-type: none"> ▪ Mindfulness ▪ Acceptance and commitment ▪ Stress control 	<p>Level of competence: Must meet the ‘Skills for Health’ low intensity competences and the standards referenced within the Matrics Cymru</p> <p>Staff with additional training plus intensive, ongoing clinical supervision</p>
High intensity:	<p>Common mental health problems or those whose difficulties are beneath the threshold of secondary care</p> <p>Severity: Moderate/ severe with significant complexity and effect on functioning</p>	<p>Standardised psychological therapy delivered to ‘protocol’</p> <p>Treatment duration as specified in NICE guidelines (usually up to 16 sessions)</p> <p>Specialised supervision</p>	<p>Level of competence: As a minimum training that meets the Centre for Workforce Intelligence (CWFI) definition for a psychological therapist</p> <p>Must meet the ‘Skills for Health’ high intensity competence</p>

<p>High intensity specialist:</p>	<p>Moderate/severe mental health problems with significant effect on functioning</p> <p>Specialist areas</p> <p>For example:</p> <p>Schizophrenia, Personality disorder, Bi-polar disorder, eating disorders, substance misuse etc.</p> <p>Severity: Moderate/ severe with significant complexity and effect on functioning</p>	<p>Standardised psychological therapy delivered to 'protocol'</p> <p>Treatment duration as specified in NICE guidelines (usually up to 16 sessions)</p> <p>Specialised supervision</p>	<p>Level of competence: Must meet the 'Skills for Health' high intensity competence</p> <p>Diploma level therapy training, plus further training in application of advanced therapy techniques to specialist area</p> <p>Further knowledge and skills may be acquired through formal training or through specialist supervision</p>
<p>Highly specialist:</p>	<p>Complex, enduring mental health problems with a high likelihood of co-morbidity and beyond the scope of standardised treatments</p> <p>Severity: Highly complex</p>	<p>Highly specialist, individually tailored interventions, drawing creatively on the theoretical knowledge base of the discipline of Doctoral Level Psychology and Consultants in Medical Psychotherapy</p> <p>Normally lasting 16 sessions and above</p> <p>As per NICE guidelines</p> <p>Specialist supervision at all levels</p> <p>Providing advice, consultation and training to multi-disciplinary colleagues</p>	<p>Level of competence: Specialist knowledge of a range of theoretical and therapeutic models. Ability to formulate complex problems using a range of psychological models, taking into account historical, developmental, systemic and neuropsychological processes. This will include:</p> <ul style="list-style-type: none"> ▪ Doctorate in Clinical or Counselling Psychology, Consultant Medical Psychotherapist, individual clinicians with highly developed special skills and expertise, normally including involvement in research and equivalence to doctoral qualification. Identified by health board PTMC as having the requisite knowledge and skills. Qualifications and practice consistent with National Standards