# Referral Criteria Guidelines for Well-Being Practitioners Children and Young People (WP CYP)

| **DO**<br>**Common conditions which may respond to early intervention** | **MAY DO**<br>**Conditions which may respond to early intervention but require discretion – local protocols can determine this decision-making process** | **SHOULD NOT DO**<br>**Significant levels of need/ complex conditions which are not suitable for brief early intervention** |
|---|---|---|
| Behaviours that are indicative of anxiety or low mood eg avoiding lessons, isolating self, irritable. | 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. | Behavioural issues in terms of family relationships. This should be addressed by the family service. Consistently defiant aggressive behaviour, cannot understand consequences. Possible conduct disorder. |
| Low mood. Some isolation and withdrawal and starting to affect relationships within school. Low level negative thinking styles.<br>Irritability as a symptom of depression – (can present as anger) | Some anger issues/emotional dysregulation that have not responded to information on sharing and initial interventions provided by universal services.<br>Must be formulated in terms of unhelpful thoughts or behaviours, and learned interventions can be applied. | Pain management. |
| Panic – psycho education and basic anxiety principles would be achievable. | Some low self-esteem issues that have not responded to information sharing and initial interventions provided by universal services.<br>Must be formulated in terms of unhelpful thoughts or behaviours, and learned interventions can be applied. | Post-traumatic stress disorder WPCYP's not inducing someone in a state of panic when working with panic disorder as a CBT Therapist would. |
| Worry. Shyness and low confidence or unhelpful thinking. | Mild social anxiety issues – specific issues relating to a condition in early onset that has not responded to information on sharing and initial interventions provided by universal services.<br>*Anxiety and internal focus may be seen with close supervision.*<br>Must be formulated in terms of unhelpful thoughts or behaviours, and learned interventions can be applied. | Chronic depression/anxiety |
| Sleep problems. | Mild social anxiety issues – specific issues relating to a condition in early onset that has | Established health anxiety |

| | | |
|---|---|---|
| | not responded to information on sharing and initial interventions provided by universal services.<br>Must be formulated in terms of unhelpful thoughts or behaviours, and learned interventions can be applied. | |
| Simple phobia (but not blood, needles, vomit) to complete psycho education, Subjective Units of Distress Scale (SUDS) and exposure work. | Mild OCD (Exposure and response prevention only) some thoughts and compulsions. Leve l of impact on daily functioning needs to be considered with supervisor, with case by case consideration in terms of whether the interventions available from WP's might prove helpful.<br>NOTE: Training in Exposure Response Prevention (ERP) has not been completed in the training programme due to the need to include additional training request for interventions relating to low self-esteem. This training could be provided by UoN as additional training, or be provided locally, in-house if available.<br>Must be formulated in terms of unhelpful thoughts or behaviours, and learned interventions can be applied. | Obsessive compulsive disorder moderate to severe in nature. |
| Stress<br>Time management/reverse BA/relaxation/problem solving | Assertiveness or interpersonal challenges – eg with peers.<br>Must be formulated in terms of unhelpful thoughts or behaviours, and learned interventions can be applied. | Complex interpersonal challenges, where daily functioning is impaired so that key daily tasks (personal care, education) are affected. |
| Bereavement – signposting to relevant services, likely to be third sector provision; *(for example in Nottingham, CRUISE or SPIRAL for Nottingham Children Bereavement Centre)* | Bereavement – counselling for bereavement is not within the scope of the interventions provided by WP CYP. This will need to be provided by locally available third sector organisations, or if there is an element of mental health concerns consideration for CAMHS interventions may be appropriate. | Bereavement – where the loss has occurred 6-12 months previously and progress through the grief process is not apparent. |
| **History of Self-harm**<br>Past history of self-harm, but no active thoughts/plans/ intent. | **Self-harm**<br>• Thoughts of self-harm, plans, but an unwillingness to | **Active self-harm**<br>• Particularly impulsive actions around self-harm (due to |

| | | |
|---|---|---|
| | undertake actual self-harm behaviour<br>• Superficial self-harm with a clear collaborative understanding about the function – eg unhelpful coping strategy<br>• Wanting to stop self-harm, and a clear risk management plan in place, harm reduction strategies planned. | possible large caseload management)<br>• Severe harm<br>• Enduring self-harm over a long time<br>• Not being able to discuss function/reasons<br>• As a guideline, if more than half of the session times are being taken up with "managing self-harm" and "risk assessment" then this is probably NOT low intensity work, and needs a more focused intervention from crisis/high intensity |
| **Experiences of abuse**<br>Requires interventions NOT provided by WP CYP's. | | Historical or current experiences of abuse or violence, where intervention sessions of 6 or less are not indicated. |
| **Separation anxiety**<br>Psycho education and exposure | **Generalised anxiety disorder**<br>NOT able to provide interventions for young people experiencing intolerance of uncertainty or perfectionism. | **Moderate to severe Attachment disorders**<br>Requiring interventions not provided by WP CYP's |