The Wellness Recovery Action Plan (WRAP) approach to Child and Adolescent Mental Health Services (CAMHS) provision:

A pilot programme for Birmingham.
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Abstract

WRAP stands for Wellness Recovery Action Plan and is a tool for helping individuals understand and maintain their own sense of psychological wellness – and find recovery options if needed. The WRAP approach requires people to perceive ‘mental health’ as a concept of wellness, rather than illness. It aims to alleviate pressure on the services by offering a community-wide, peer-led mental health programme.

Through the pilot, CWI aimed to demonstrate what is possible using the WRAP approach. Of the 80 people who took part, 41 children and 22 adults completed the programme. We measured aspects of each participant’s emotional wellbeing using the established SDQ (strengths and difficulties questionnaire). We also engaged people in unstructured discussions about mental health and what it means to them.

We found that:

• young people had no difficulty in grasping the concepts used in WRAP, and were able to apply them to their own experiences

• there are more young people experiencing mental health difficulties – or situations that could trigger mental health difficulties – than the services appear to be aware of

• young people’s view of mental health appears to be in line with the current social milieu, wherein the phrase ‘mental health’ is taken to represent illness and disorders

We suggest that:

• delivery method is far more important than content when introducing people to the WRAP approach, and the young people in our pilot responded best to games and other engaging activities.

• the WRAP approach’s ability to teach psychological ‘literacy’ (that is, helping young people to understand their feelings and what keeps them well, what distresses them, and when they may need to seek help) could relieve pressure not only on mental health services, but also on other parts of the UK’s social and healthcare systems

• by targeting postcodes, the WRAP approach allows us to forecast problems and where they might occur

• further exploration – and more robust data collection – will enable us to test the potentially far-reaching benefits of involving families, community groups, CAMHS professionals and schools in the WRAP approach.
Several reasons have been mentioned for driving this exploration, including:

- the need to place greater and earlier emphasis on a psycho-social model, rather than the prevailing medical model
- the need to pay greater attention to the prevention of mental health issues, rather than intervention
- the diversity of recipient community groups – and the need to respond to their needs with a variety of approaches
- resources coming under greater pressure, increasing the number of mental health cases requiring intervention, as well as putting pressure on the budget allocated by the local authority and the NHS
- the critical need to adopt different approaches to working with children and young people, their families, guardians and the communities they live in, to create outcomes that reflect the needs of the recipients more than the interests of the providers.

These changes are taking place in the context of:

- militant press intrusion
- rising community expectations on public services
- significant staff constraints through restricted numbers and experience
- other diverse issues affecting communities in the city.

Based on our experience of using the Wellness Recovery Action Plan (WRAP) approach to adult mental health services in Birmingham and across the country, Communities Wellness Initiative Ltd (CWI) was invited to pilot an adaptation of the WRAP approach to mental healthcare for children and young people.
The approach was developed by Mary Ellen Copeland in the United States of America. Ms Copeland and her colleagues (adults who had used or were using psychiatric services) had experienced ongoing mental health challenges themselves; they could identify what made them feel ‘well’ and then develop their own ‘wellness tools’ (their personal WRAPs) to relieve difficult feelings and distressing thoughts.

They view the WRAP approach as a way towards recovery and long-term stability.

An individual’s WRAP is designed to hold the key to them becoming and staying well. It does not necessarily replace traditional treatments; indeed it can be used to complement them.

Key features and benefits

- A WRAP is a plan of action for recovering wellness.
- The WRAP approach gives people a method for exploring wellness and resilience – and recovery options if needed. It requires people to perceive ‘mental health’ as a concept of wellness, rather than illness. It focuses on strengths, not deficits.
- The WRAP approach requires that the recipient leads the process, rather than the service provider. If someone else writes one’s WRAP, it is no longer a WRAP but a care plan. The WRAP approach puts the individual at the centre of the discussion and allows that individual’s social networks to become the natural place for devising and implementing solutions.
- The WRAP approach’s five key principles (page XX) and CWI’s eight-step process to creating a personal WRAP (page XX) offer a robust framework for helping an individual to maintain wellness and resilience.
- The WRAP approach is facilitated by ‘ordinary people’: peers, community leaders, people with real experience of mental health difficulties, and so on. By encouraging people in distress to seek peer support as their first natural help option, rather than relying on public services, it frees up CAMHS professionals. It is therefore cost-effective.
- The WRAP approach readily lends itself to becoming a large-scale, grass-roots programme, which would be both cost-effective and sustainable. It is CWI’s view that investing in people’s psychological literacy early on in their lives will reduce distressing feelings and negative behaviours later on.

WRAP is described and applied by CWI as an approach (as opposed to a model) to mental health, psychological hygiene and literacy.

What is the WRAP approach?

“People are ‘psychologically illiterate’ because they have never had a tool that allows them to explore their psychological wellbeing. Of all the people who came to the WRAP awareness sessions and stayed through to the end of the programme - particularly the 52 facilitators - we can comfortably say that they have the makings of psychological literacy. They understand that psychologically they have to ‘get it together’, what it is that they need to do to get it together, and what it is that gets in the way of them becoming unwell.”

MPUME MPOFU, COMMUNITIES WELLNESS INITIATIVE
CWI suggests that this is rather late. There is a need to identify and address issues in young people at risk of mental health difficulties long before they reach the acute stage. The WRAP approach allows us to engage with young people before they become ill or show outward signs of distress.

Using the WRAP approach, it is possible to forecast where problems are likely to occur and give young people and their families in those localities the skills and support to monitor, reduce, eliminate or minimise:

- uncomfortable or dangerous mental symptoms
- distressing emotional feelings or experiences.

By adopting the WRAP approach, it is possible - indeed probable - that we can create a service which emphasises wellness not illness and strengths not deficits.

Potential savings

Not only does the WRAP approach appear to be valuable to the health of young people, but it could help reduce the financial burden of mental health services on the NHS by:

- giving young people a self-help strategy to maintain their own sense of wellness
- teaching young people to recognise when they need professional help, thus allowing for earlier intervention and reducing the need for more expensive specialist services.

The WRAP approach could also bring savings for other parts of the UK’s social and healthcare systems, by giving young people a greater emotional literacy (that is, making it easier for them to talk about their feelings) and a better understanding of, and control over, their personal behaviour.

It could bring about a shift in society in which people utilise the support of social networks and community groups, rather than relying on public services.

Currently, only a minority of children with psychiatric disorders reach specialist mental health services – several studies estimate the figure at 20 per cent (Offord et al 1987; Burns et al 1995; Leaf et al 1996, Meltzer et al 2000). While a community-wide deployment of the WRAP approach could increase this figure, it would also give people tools to understand and maintain their own sense of wellness and know when it is appropriate or necessary to seek professional help.

The WRAP approach offers quantifiable outcomes and value for money. The pilot has given us a sound foundation upon which we could build a bigger wellness programme.

CAMHS currently uses a ‘four-tier strategic framework’ (Appendix 1) as the basis for caring for children and young people with mental health difficulties. It is generally the case that children and young people with mental health difficulties are commonly not seen by specialist practitioners until they are at the Tier 3 stage, suffering from severe, complex and persistent distress and disorders.
The pilot programme

Aims

We wanted to:

1. Explore and demonstrate new approaches to CAMHS delivery, emphasising:
   • self-help
   • a reliance on social networks and communities rather than on public services
   • sustainable ‘wellness’ tools for young people to use in their everyday lives
   • the prevention of mental health problems (rather than intervention later on)
   • the idea that people do not need to have had a mental breakdown to find public services useful
   • that people with real-life experience of mental health difficulties are key to resolving challenges for others
   • psychological and emotional hygiene – and the vocabulary these are bound up in
   • the potential for links with other aspects of health and social care.

2. Test whether the positive outcomes reported from using the WRAP approach in adult mental healthcare settings (such as the value of self-help and peer support) could be applied by CAMHS.

3. Evaluate whether the WRAP approach could provide young people with a viable personal system for:
   • taking care of their mental health
   • developing their psychological and emotional literacy
   ... and to find out to what degree the WRAP approach might fulfil young people’s needs and lead them towards meeting their aspirations.

4. Test, where possible, the use of a WRAP as a recovery method for young people who may already be experiencing difficulties with their mental health or who are vulnerable to future difficulties.

5. Demonstrate that the WRAP approach represents good value for money for CAMHS, not least by putting people’s mental healthcare into their own hands (and those of their peers) and freeing up CAMHS staff and resources.
CWI was commissioned to:

- introduce at least 60 children and young people to the WRAP approach in Birmingham
- train 30 children and young people and 15 adults to become WRAP ‘facilitators’.

In the end, 41 children and 22 adults completed the programme (from approximately 80 people to whom the programme was introduced).

**Fig 1**

<table>
<thead>
<tr>
<th>Locality</th>
<th>Children and young people</th>
<th>Adults</th>
<th>Total adults</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Boys</td>
<td>Girls</td>
<td>Total children and young people</td>
</tr>
<tr>
<td>BEN</td>
<td>9</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>HoB</td>
<td>11</td>
<td>6</td>
<td>17</td>
</tr>
<tr>
<td>South</td>
<td>7</td>
<td>5</td>
<td>13</td>
</tr>
<tr>
<td>Total</td>
<td>27</td>
<td>14</td>
<td>41</td>
</tr>
</tbody>
</table>

It was agreed at the commissioning stage that we would divide the pilot into the areas served by Birmingham’s three Primary Care Trusts, so:

- BEN = Birmingham East & North PCT
- HoB = Heart of Birmingham PCT
- South = South Birmingham PCT.

The children and young people in our trial were aged between seven and 17 years (the age of eligibility for CAMHS care) and represented all ethnicities of people living in Birmingham.

For the rest of this report, participants will be referred to as ‘young people’.
Selection

We issued an open invitation for young people to attend our WRAP events, based on contacts that had been established by BEN Community Development Workers (CDWs). News spread by word of mouth.

We also made contact with all the schools included in a list provided to us by the BEN CDWs.

All interested parties participated in the WRAP awareness introduction.

Some groups of young people were already established, in sports or homework clubs, community and faith-based groups, or as groups of friends who regularly played computer games together at after-school or evening clubs.

The fact that many of the young people who participated in our pilot already knew one another had both advantages and disadvantages:

**Advantages:**

• their motivation to continue was stronger, as they already had a commitment to their group

• they felt they had a ‘place’ in the programme.

**Disadvantages:**

• we relied on a ‘who knows whom’ approach (although this also means our sample of participants was as randomised as would be required for a scientific study).

Schools issues

Originally, as outlined in our commissioning brief, it was thought that the WRAP pilot would be delivered through ten schools, with PSHE, citizenship, drama or PE lessons acting as natural vehicles for introducing WRAP principles and processes.

But schools appeared unwilling or unable to take part, with:

• teachers and other responsible people citing pressure from their already packed curricula

• students saying they would not participate in an activity that did not directly help with school examinations.

One school took up the WRAP pilot, but this was down to an individual teacher who saw the value in it. He was aware of the WRAP approach in adult mental healthcare, and thought it may help address his school’s efforts with tackling persistent non-attendance.
The pilot programme

Data

The data we recorded included gender, age, postcode and 'circumstance'.

Why postcodes?

Analysing data by postcode can help us to predict possible opportunities and emerging needs before they occur.

For example, participants from postcode B6 who came through the pilot programme reported a pattern of single-parent homes. In postcode B10, cannabis misuse was widely reported.

So the use of the WRAP approach in these areas now could help us counteract problems in, say, five years’ time.

Why ‘circumstance’?

We gave each young person the space to define their own home situation and what it meant to them. This helped to remove value-judgements from our data (for example, that single-parent homes are inferior, or living with an aunt is not ideal) by taking individual differences in perception into account.
As part of the original commissioning brief we were asked to use an established instrument of measurement, along with bespoke participant feedback (which we gathered on an ongoing basis throughout the pilot).

The young people participating in the WRAP pilot recorded their feelings in SDQs (strengths and difficulties questionnaires). The SDQ is defined as a “brief questionnaire that can be administered to the parents and teachers of 4-16-year-olds and 11-16-year-olds themselves. Besides covering common areas of emotional and behavioural difficulties, it also enquires whether the informant thinks that the child has a problem in these areas and, if so, asks about resultant distress and social impairment” (Goodman et al, 2000. p. 534).

Each young person in our pilot had a list of the following questions and was asked to tick whether each statement was ‘not true’, ‘somewhat true’ or ‘certainly true’ for them:

<table>
<thead>
<tr>
<th>Measurements</th>
</tr>
</thead>
<tbody>
<tr>
<td>I try to be nice to other people. I care about their feelings.</td>
</tr>
<tr>
<td>I am restless. I cannot stay still for long.</td>
</tr>
<tr>
<td>I get a lot of headaches, stomach-aches or sickness.</td>
</tr>
<tr>
<td>I usually share with others (food, games, pens etc).</td>
</tr>
<tr>
<td>I get very angry and often lose my temper.</td>
</tr>
<tr>
<td>I am usually on my own. I generally play alone or keep to myself.</td>
</tr>
<tr>
<td>I usually do as I’m told.</td>
</tr>
<tr>
<td>I worry a lot.</td>
</tr>
<tr>
<td>I am helpful if someone is hurt, upset or feeling ill.</td>
</tr>
<tr>
<td>I am constantly fidgeting or squirming.</td>
</tr>
<tr>
<td>I have one good friend or more.</td>
</tr>
<tr>
<td>I fight a lot. I can make other people do what I want.</td>
</tr>
<tr>
<td>I am often unhappy, down-hearted or tearful.</td>
</tr>
<tr>
<td>Other people my age generally like me.</td>
</tr>
<tr>
<td>I get easily distracted. I find it difficult to concentrate.</td>
</tr>
<tr>
<td>I am nervous in new situations. I easily lose confidence.</td>
</tr>
<tr>
<td>I am kind to younger children.</td>
</tr>
<tr>
<td>I am often accused of lying or cheating.</td>
</tr>
<tr>
<td>Other children or young people pick on me or bully me.</td>
</tr>
<tr>
<td>I often volunteer to help others (parents, teachers, children).</td>
</tr>
<tr>
<td>I think before I do things.</td>
</tr>
<tr>
<td>I take things that are not mine from home, school or elsewhere.</td>
</tr>
<tr>
<td>I get on better with adults than with people my own age.</td>
</tr>
<tr>
<td>I have many fears. I am easily scared.</td>
</tr>
<tr>
<td>I finish the work I am doing. My attention is good.</td>
</tr>
</tbody>
</table>
We also recorded ‘impact’ data – that is, how young people said their perceived difficulties impacted on their lives:

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
</table>
| Overall, do you think you have difficulties in more than one of the following areas: emotion, concentration, behaviour, or being able to get on with people? | No  
Yes – minor  
Yes – definite  
Yes - severe |
| If yes, how long have these difficulties been present?                  | Less than a month  
1-5 months  
6-12 months  
More than a year |
| Do these difficulties upset or distress you?                            | Not at all  
Only a little  
Quite a lot  
A great deal |
| Do the difficulties interfere with your everyday life in the following areas? | Not at all  
Only a little  
Quite a lot  
A great deal |
| Do the difficulties make it harder for those around you (family, friends, teachers, etc)? | Not at all  
Only a little  
Quite a lot  
A great deal |
The pilot programme

Who delivered the WRAP pilot?

To run the WRAP pilot, CWI used:

• a Programme Lead (a head of a national children’s services branch with 20 years’ experience of working with children and young people)

• four teams of two facilitators to introduce the WRAP approach and its concepts to the groups

• two coordinators (in their early 20s with a background of working with children) to organise the logistical side of the programme, such as arranging venues, games and refreshments and liaising with the families for each group we engaged with. These two coordinators are included in the number of adults that were trained to be WRAP facilitators. Half of them are employed in other jobs (although providing services to young people) while the other half are volunteers.

The role of CAMHS within the pilot

As we introduced young people to the WRAP approach, we became aware that CAMHS professionals, both at primary and secondary care, were ‘absent’.

In order to relieve the pressures of conforming to CAMHS’ expectations, we took the decision to continue without including them.

We are aware that this had both advantages and disadvantages:

Advantages:

• our process became reflective of the needs of the recipients (the young people) rather than the providers (CAMHS)

• the pilot was not weighed down in jargon and we did not have to explain the WRAP approach in psychiatry terms. No one, especially the young people, felt they were under a microscope, which was freeing.

Disadvantages:

• without professionals on hand, there may be limitations in making natural links between our findings and medical good practice, as well as other strategic issues. We see this as one of our lessons learned from the pilot

• some young people who took part in our pilot might benefit from becoming visible to CAMHS; they could have been immediately signposted to the services that would best serve their needs

• there would need to be some careful discussions about the roles of psychiatrists and psychologists in delivering the WRAP approach. Creating a WRAP is down to the individual and it is valuable to keep this power and control in the individual’s hands.
As an approach, WRAP is based on five key concepts. These are the pillars on which the approach is built:

1. **Hope**
2. **Personal responsibility**
3. **Support**
4. **Education / information**
5. **Self-assertion / advocacy.**

Then there are eight steps for each individual to take in creating their own WRAP:

<table>
<thead>
<tr>
<th>Step</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Wellness</td>
<td>What is wellness for me?</td>
</tr>
<tr>
<td>2. Wellness tools</td>
<td>Identifying my tools</td>
</tr>
<tr>
<td>3. (Daily) maintenance plan</td>
<td>What do I do each day, when I am feeling well?</td>
</tr>
<tr>
<td>4. Triggers</td>
<td>What are my triggers, and what is my response to each one?</td>
</tr>
<tr>
<td>5. Early warning signs</td>
<td>What are early warning signs for me, and what is my action plan?</td>
</tr>
<tr>
<td>6. When things are breaking down</td>
<td>How do I know? Breaking-down list and responses / action plan</td>
</tr>
<tr>
<td>7. Crisis plan</td>
<td>How to know when I am well, when in crisis, who my supporters are, what I want, what needs to be done and how to know when I am well again?</td>
</tr>
<tr>
<td>8. Post-crisis plan</td>
<td>What have I learned, what needs to change?</td>
</tr>
</tbody>
</table>

These eight steps enabled the pilot programme to be delivered in bite-sized chunks, giving young people time and space to carefully consider each stage.
Results: SDQs

In South, the 11 who stated that they had difficulties said these difficulties had been present for more than a year. It would certainly be useful to look at how the young people respond after participating in the WRAP programme, helping us to see how effective it is in dealing with long-term difficulties.

It would be interesting to look at how, for example, a young person’s ethnic origin affected their SDQ responses or the split between male/female respondents, but this data was not recorded consistently enough on the questionnaires to yield any useful results.

The raw data shows that 35 of the 59 respondents said it was either ‘certainly true’ or ‘somewhat true’ that they got ‘very angry’. Fifty said they get ‘easily distracted’.

From the raw results, the big issues appeared to be:

- hyperactivity (especially for the South group)
- emotional problems (again, in South)
- a lack of pro-social behaviour (especially in the older HoB group).

The older HoB group was the only group which appeared to have significant problems with behavioural conduct, such as anger, fighting, stealing and so on.

Thirty-seven of the young people completed the ‘impact’ data part of the SDQ, although only 18 of them had said they had difficulties. Of these, however, four said their difficulties were severe.
Understanding WRAP terms and concepts

Before the pilot, we were concerned that younger participants might not understand the terms used in the WRAP approach. But while they occasionally struggled with words and their definition, they had no trouble grasping concepts. Indeed, they found the idea of ‘wellness’ easier to grasp than many adults have in previous WRAP programmes (with the latter tending to use ‘unwellness’ as their reference point).

This applied to all the young people who participated, whether English was their first or other language.

For instance, in discussing the five key concepts of WRAP:

• “Self responsibility? I know what responsibility means. My mum is always telling me to take responsibility for cleaning my own room” – a response from an eight-year-old boy from Aston.

• Support “goes beyond the admiration of a posse” – a response from a 15-year-old in Smallheath.

Not only this, but the young people taking part in our pilot said that our efforts to make the terms used in WRAP more ‘child-friendly’ was patronising. They objected to our use of the term ‘kid-speak’, which we had thought could be useful and trendsetting.

Instead the young people absorbed the WRAP terms into their own vocabularies and were able to apply them themselves.

Understanding notions of wellness

The young people in our pilot grasped notions of wellness quite readily. They understood the idea of taking steps on their own (and in their own personal circumstances) to retain and maintain their individual sense of wellness.

However, we cannot assume that they all completely understood wellness by the time we reached Step 2 (looking at ‘wellness tools’) in Mary Ellen Copeland’s eight stages of WRAP. There may need to be a discussion about the order in which the steps are carried out.

It was significant that, as with our experience from adult mental healthcare services, young people’s view of mental health was in line with the current social milieu, wherein the phrase ‘mental health’ is taken to represent illness and disorders.
Understanding notions of recovery

It was our view that the young people in our pilot would benefit from having more information about what constitutes mental illness and mental disorder. Through the pilot, we got a sense that many of them were living with, or aware of cases which, if looked at by professionals, would be classified as mental illness or disorder.

These young people (and especially those much younger) appeared to have normalised illness and disorder. They had started to develop strategies for dealing with their circumstances, whether for themselves, their families (siblings and/or parents), their friends or school colleagues.

By introducing young people to the WRAP approach, we were able to begin informing them about:

- what can be considered illness
- the implications of illness (such as child protection issues)
- the consequences of ‘untreated’ symptoms.

Understanding the eight steps of WRAP

Again, the young people in our pilot showed great aptitude in grasping and applying the eight steps of WRAP. They tended to leap to number four and beyond, though, focusing on the idea of combating negative feelings rather than maintaining the positive ones. They reported enjoying the latter stages of WRAP more, and became more lively and engaged when discussing ‘the distress continuum’; that is: triggers, early warning signs and signs of breaking down.

Our experience of using the WRAP approach in many adult mental healthcare settings is that adult participants tend to default to these same elements too.

Our view is that with greater use of the WRAP approach, adults and young people alike will begin to question and change their underlying assumptions about mental health and, with this, their language and vocabulary.
Results: delivery methods

CWI was commissioned to deliver WRAP content, but also to test effective delivery methods.

Our experience was that the method used to deliver WRAP concepts appeared to be more important than content in successfully getting the ‘message’ across.

In BEN

In BEN, young people were ‘taught’ the WRAP content, lecture-style, in workshops held over five Saturdays. By the end, BEN’s group had diminished in size from 17 participants to just seven.

We realised early on in BEN that participants’ interest in the pilot appeared to wane the further we went into the programme. We put this down to the fact that our efforts were focused and delivered within a ‘school’ context.

Certainly for some of the young people, WRAP workshops and our teaching approach had become associated with school, and this was not appealing for them.

In HoB

In HoB, however, young people were asked how they would like their sessions delivered. There was an emphasis on ‘play’ – rather than a ‘school’ feel. HoB’s group numbers increased from ten to 15.

in HoB, we appeared to have found the middle ground between ‘work’ and ‘play’, with WRAP coordinators asked to determine when young people had had enough of both.

By offering a peer-based discussion approach followed by a week between sessions and then a reflective facilitated discussion on participants’ experience, we felt young people’s understanding of the WRAP concepts was supported effectively.

The language and vocabulary aspects of these sessions were also informative and have helped to shape our view of what appears useful and effective when delivering sessions on WRAP.

While the approach we took in HoB seems to have worked, our recommendation would be to define ‘appropriate’ levels of work and play within the WRAP programme, ensuring an agreed standard delivery of both content and process.

In South

Sessions in South took the form of games. There were 22 participants at the start – and 22 at the end. More young people had enquired about joining the group in between.

Based on our experience from the BEN and HoB cohorts, we found it was possible for WRAP concepts to be discussed through programme ‘games’.

South coordinators planned their activities in a way that would, through board games and other interesting activities, lead participants towards experiencing the principles and steps of the WRAP approach. Finally, the coordinators would initiate a discussion that articulated WRAP approach’s key principles and steps.

Our experience in South suggested to us that the best approach for delivering the WRAP approach (of all those we tried) is to create a balance between articulating the programme’s principles and processes and then pointing them out while young people ‘play’ or undertake other absorbing tasks.
Games

The lecture-style sessions did not appear to work, then, but the structured yet flexible method - which the WRAP approach naturally provides - and games (including jigsaw, puzzles and a Monopoly-style WRAP game) were popular with the young people in our pilot.

Residential programmes

Participating in ‘residential’ programmes (where young people stay away from home overnight or for a couple of nights) is very popular with young people, as reported by our coordinators and the young people themselves.

During one residential trip, some of the boys helped us develop a computer game for teaching the WRAP approach. This game has the potential to be extremely effective, as it is designed by the very audience it needs to target.

However, we are aware of the effort required and problems involved in organising residential trips.

Sport

As well as helping us reach young people in faith-based groups, sport presents a significant opportunity for ‘preventative, resilience and wellness’ efforts.

Our pilot showed it is also possible – and effective – to introduce the WRAP approach through sport, encouraging young people to make links between WRAP concepts and, for example, football.

They can compare their WRAP daily maintenance plan to the idea of training and practising in order to improve their skills on the pitch.

Faith groups

Some of the coordinators reported that, for many young people, community and faith groups have become valuable places to address their existential issues, issues of self, identity, wellbeing, and so on.

It was our coordinators’ view that these groups appear to have emerged as a method for inculcating moral values in children and young people, especially for those living in inner cities.

It is our view that the WRAP approach presents a significant opportunity for such groups to have a positive impact on young people's views on self, their peers and their circumstances.

Our conclusion is that by focusing more on WRAP’s message and less on how it is delivered may cause young people to disengage from the programme.

“I struggled to get them to laugh until the question of football came up and this was clearly something that makes them tick.”

WRAP FACILITATOR
Results: delivery methods

An example of a WRAP exercise

Figure 3. The tree of life: an example of a WRAP exercise
What do you think should be included in your tree of life?
Young people living with difficulties

There appeared to be a higher number of young people living with a degree of difficulties than the services might be aware of. Of the 80 young people who underwent the WRAP pilot, about a third appeared to live in circumstances which – as defined by them - were less than ideal.

For example, it appeared that the number of children who lived ‘alone’ was higher than generally acknowledged by the families themselves. Thus there were far more children preparing themselves for school and returning home on their own than generally recognised.

The young people reported that as a result of this ‘idle time’ they tended to find other activities to occupy themselves with - a good number of which they recognised as being ‘not suitable’.

By participating in WRAP programmes, young people are made aware of the ideal living circumstances. They can compare their circumstances with their peers’ circumstances to determine this ideal - and the impact of their own circumstances on their personal mental health.

Through the WRAP approach, it becomes possible for young people and their peers and facilitators to forecast where problems are likely to happen, and work out how best to address them.

Positive feedback

The participants in our pilot programme reported that they valued exploring and addressing their mental health and psychological wellbeing in different and fun ways. Most said they will continue with the strategies they learned.

Parents who visited the pilot sessions were very keen to participate in a complementary programme which offered the chance to help their relationships with their children.

Professionals who came into contact with the WRAP pilot have expressed an interest in seeing the programme used more widely in CAMHS provision and to complement secondary care provision.
Potential for community groups

The WRAP pilot showed that there appears to be a scarcity of positive community-based and peer-driven programmes for young people. The young people who took part in our pilot reported that of the programmes on offer, many seem to be ‘problem-based’: focusing on, for example, tackling drug and substance misuse, gangs and violence, extremism, societal stereotypes, and so on.

However, the community groups that took part in the pilot were eager and highly motivated in embracing the WRAP approach. Young people from these groups devised particularly creative and original approaches to exploring notions of WRAP.

The WRAP approach provides community group leaders with a framework for engaging with the young people who attend their sessions. These leaders represent for us a ready-made pool of people who are willing and able to lead young people in exploring issues of mental health and psychological wellbeing – and to reach out to those at risk of mental illness. Up to 20 such leaders were trained as facilitators during the pilot programme.

Cost-effective solutions

Through the pilot, we began to build up outlines of what young people consider significant to their wellbeing, mental health and psychological literacy. These findings give us a strong base for creating self-help programmes that are cost-efficient and effective.

More than 50 people across Birmingham have now been trained to facilitate the WRAP approach. These people are involved in community groups, faith groups, homework clubs, playgroups and other community-based setups. They are from a wide range of backgrounds in terms of their ethnicity, age, ‘social class’, faith (or no faith), sexual orientation and other ‘self labels’. These facilitators see themselves as representing a cost-effective option to giving young people and their families resilience in mental health - and in helping those in recovery.

We have the foundations, then, for helping people to look after themselves and their families, friends and communities – at the same time reducing their reliance on public services.
Results: insight gained

Saturation in schools

Schools appeared underwhelmed by the idea of taking on ‘yet another initiative’ and reported that they are ‘initiative-saturated’. The responsible adults in the schools we approached said they were overworked and thought that unless the WRAP approach was included in the curriculum, there would be little appetite for it. Pupils wanted to know if the WRAP approach was part of their mandatory coursework before considering it.

‘Substitutes’ are significant

Our findings seemed to show that if a young person lacks meaningful activities in her life, she will find substitutes – for example, by playing truant. She may be willing to give up a negative activity, such as smoking cannabis, but she will need a substitute to replace it.

It was reported that some current efforts in young people’s services appear not to work because they seek to ‘tell’ young people not to do something without offering an acceptable substitute. Thus substitutes can be positive or negative.

Young people participating in the pilot reported that they were looking to find places where they feel accepted. Community groups, sports clubs and friends can act as substitutes for absent parents, family, community and public services.

Some young people in our study who lived only with their mothers said they didn’t necessarily need their father around, but they did want a male figure in their lives. Substitutes can also take the form of people, then: significant people such as mentors or father/mother figures.

Current CAMHS approaches are problem-based

In our discussions with young people, the current healthcare system was reported as engaging with them “when things have already gone wrong”, focusing on symptoms such as drug misuse, gang membership, truancy or poor school performance. But a key lesson from the WRAP approach is that an absence of symptoms does not represent wellness. Removing a problem (such as drugs) from a young person’s life does not necessarily translate into that young person being ‘well’ again.

The pilot programme seemed to show that father and sibling ‘deficits’ were significant in creating negativity in some of the participants’ lives. Deficits included absent dads, not getting along with parents’ new partners and having half-siblings or step-siblings with different cultural identities (“They don’t get me”).

One example was of a mixed-race boy being raised in an all-white family, after his mother split up with his African Caribbean father and met a new, white partner. This new partner was racist towards the boy.

The WRAP approach allows for the exploration and possible reduction or elimination of the symptoms of mental health difficulties, while simultaneously allowing a young person to explore his own best interests.

It was our observation too that secondary care CAMHS moves young people very rapidly to high-end acute services (those services principally characterised by specialist efforts) long before the young people and/or their families understand the significance of such referral and intervention.
Our discussion also showed that there are some young people who are known to have entered specialist services and are perceived to be ‘stuck there for life’. Many people take a ‘Hotel California’ view of mental health difficulties: “You can check out any time you like, but you can never leave”.

Our view is that there are examples of where mental wellness programmes have led to a gradual stepping-down of cases of people ‘stuck’ in services – and indeed a stepping-down of cases where people are fast-tracked to acute, expensive services.

In the future, we would like to see two sets of figures recorded when people leave specialist mental healthcare: not only the number of people discharged, but the number of people discharged who resume normal ‘well’ lives and no longer need the services. If the WRAP approach became a mainstream programme, this could be a valuable measurement of its efficacy.

Services were also seen as reflecting the expertise and interests of professionals, rather than always coinciding with the needs of individual young people, their families and their circumstances. As such the young people (and even more so the coordinators) in our pilot reported that communities in general and neighbours were reticent to report cases until there was clear danger to young people. Often this happened very late on.
1. Hope

We spent a significant amount of time discussing with each group what hope represented for them in the context of psychological wellbeing – and helping them make distinctions between positive and false hope. We believe it would be beneficial to continue and extend this conversation over a 12-month period.

2. Personal responsibility

We discussed in depth what personal responsibility meant to each participant. It is interesting to note that many young people considered partaking in programmes such as WRAP as a means of taking responsibility for themselves and their own wellbeing.

Through our discussions, we realised that many young people considered psychological wellbeing to have a prior claim over all other forms of wellbeing, including physical, financial or material wellbeing. There was a sense that being psychologically well puts an individual in a stronger position in all other aspects of their life.

Some people wanted to distinguish psychological wellbeing from spiritual or social wellbeing, and we allowed them to do this.

3. Support

The young people in our pilot programme appeared to understand notions of support very well. As one participant said, support is not just about having the admiration of a fan club, it’s about “people that have your back” (that is, they look out for you through the good times and bad times, they tell you the truth and they help to ‘make you a better you’).

4. Education / information

Our discussions in the WRAP pilot showed us that while young people considered it fairly easy to access health information, getting information on specific areas of mental health was not so easy. For this they tended to rely on word of mouth and items they saw or read in the news. The young people in our pilot programme tended to look at people with mental health difficulties and base their definition of ‘mental health’ on them.

These discussions allowed us to begin defining what young people consider important when accessing information on mental health. Young people, we believe, need information that helps them 1) make better personal decisions and 2) understand what it means to be psychologically well.

Education is also key to understanding psychological wellbeing. Currently, young people seem to have a parochial view of education – that people go to school in order to pass exams. Through the WRAP approach, we can change people’s opinions on what education means and help them understand the value of lifelong learning.
5. Self-assertion / advocacy

Our discussions with young people revealed that cultures define ‘assertiveness’ differently. There was a presumption that the western world’s view of assertiveness is taken to be the overriding definition – and this presented difficulties for some of our participants, who thought the western view of assertiveness sometimes bordered on aggressiveness. Meanwhile, their own definition of assertive might be seen as too docile from a western point of view.

The WRAP pilot enabled us to explore with young people from various cultures and backgrounds the possibility of combining the world of their heritage with the world in which they live in the UK – and how they can be assertive within both settings.

Our discussion also showed that there are some young people who are known to have entered specialist services and are perceived to be ‘stuck there for life’. Many people take a ‘Hotel California’ view of mental health difficulties: “You can check out any time you like, but you can never leave”.

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What it means to be well

Throughout BEN, HoB and South, the top two definitions of what wellness meant to participants were:
- having control over their lives
- being able to make choices about the things that affected them.

Our interpretation of this is that young people need ‘power’ and information in order to maintain their sense of wellness. Through the WRAP approach, young people can engage with the significant adults in their lives and gain a perceived higher level of control over the things that are important to them.

Four out of ten young people in our WRAP pilot defined wellness as “having balance in my life”, in relation to mental, spiritual and physical health, as well as circumstantial factors. It is important to note that the notion of balance is unique to each individual.

Other factors that our young people talked about when defining wellness related to:
- good health
- being part of a happy family
- being able to do what they enjoyed
- not having to make adult decisions (such as what to eat).

Wellness tools

Six out of ten participants said that family is a key wellness tool.

Four out of ten talked about good housing as part of their wellness tools.

Three in ten talked about participating in sport as a wellness tool.

Three in ten said that ‘being part of something significant’ (such as getting involved with a community group or faith group) and having a positive impact on other people made them feel good.

Seven in ten said that being able to talk to their family and friends was key to their wellbeing, and six in ten said being part of a family was important.

Six in ten talked about having fun, by being able to (for example) go to the cinema, get involved in social events and do other things that their friends were doing.

Seven in ten talked about healthy living – by eating the right sort of food, for example, and sleeping at the right time.
Results: qualitative feedback

Triggers for emotional distress

Five out of ten young people who took part in the programme felt that being disrespected was their trigger for emotional distress.

Three out of ten young people cited stress as a trigger for emotional distress, and said it was induced by circumstances both in school and at home – namely, ‘not getting on with people’. (Stress is perhaps both a trigger and a symptom, which might be worth exploring further in future WRAP programmes.) It is interesting to note that bullying was not mentioned as much as we had expected, though, given its prevalence in the news.

Two in ten young people said that being confused was a trigger.

Two in ten talked about facing new situations or new people as a trigger.

Four in ten reported being in an unhappy home – and said problems within their family were a trigger. Within this, several young people said they disliked ‘being taken advantage of’ – for example, being used as an excuse for parents to stay home from work or claim false benefits, or being used as an emotional weapon between arguing parents.

Early warning signs

We encouraged the young people in our pilot programme to talk about their ‘early warning signs’ of emotional distress.

Six in ten young people said they start to ‘withdraw’.

Four in ten said they lose their appetite for food – or their eating habits change or deteriorate suddenly. One in ten (of both genders) talked about abusing food – either by not eating, by over-eating, or by eating all the wrong foods.

Three in ten said their sleep pattern is affected. They spend a lot more time on computers and on the internet (especially social networking sites), especially at night when parents and guardians are sleeping.

Five in ten talked about persistent anger as an early warning sign.

Four in ten talked about truancy and ‘playing up’ generally.

Six in ten said they deviated from their usual activities and routines (by getting up or going to sleep at different times of the day, by seeing certain people and avoiding others, by staying away from home longer than usual or staying at home longer than usual, by watching films considered unsuitable for their age range, and so on).
Signs of breaking down

We asked the young people in our pilot programme to talk about the signs that show they are ‘breaking down’.

Three in ten said they started to misuse substances.

Four in ten said they started to hang around with inappropriate people.

Four in ten said they play truant from school.

Three in ten talked about physical fighting.

One in ten talked about fighting with friends, including being verbally abusive.

What is a crisis?

When we asked the young people in our pilot what they defined as a personal crisis, two out of 15 said they considered themselves in a crisis when they were excluded from school (or facing the threat of it), either temporarily or permanently.

The young people in our pilot did not consider school detention to be a crisis – in fact, they actually defined being issued with a detention as something cool, showing you are ‘not a wimp’.

Three in 20 of the young people reported being involved with the police as a crisis, whether they are the cause of it directly, and whether it involves an incident at home or in school.

Two in ten talked about being in crisis if an injury or illness has resulted from their behaviour.

Seven in ten young people reported being in a crisis when their parents or guardians have to get involved.

The post-crisis phase

The young people who participated in our pilot said the post-crisis phase was usually out of their control. We did not have the time or resources in the pilot programme to tackle this issue in any depth, but it seems to relate back to the idea of young people needing greater control over their lives and their wellbeing.
1. The importance of focusing on wellness, not illness.

Young people are willing to learn and talk, if only we give them the space to do this. WRAP allows for important discussions.

2. Young people are grappling with issues of power and identity.

Discussions revealed time and time again that young people need acceptance; they need information; they need to know who they are; and they need to be able to talk about how they feel. The WRAP process provides a safe, guided and facilitated space to do this.

WRAP provides young people with a lifelong approach to addressing their issues in a positive way. More than anything, it opens the door for them to consider the elements that are significant to their mental health.

3. Structured appropriately, WRAP can become a core programme.

We will need to present WRAP in the right way, giving young people a programme they can identify with and tools they can implement in their daily lives.

When I get angry or upset...

- **My Behaviours**
  - I cry
  - I lash out at other
  - I smash things up
  - I smash my teddy again
  - I sit in the dark
  - I stop eating
  - I get really upset
  - My head hurts

- **Positive Behaviours**
  - Try and walk away
  - Ask for help
  - To write my feeling down
  - To cry in to a tissue
  - To talk to someone who cares
  - To keep myself safe

I will ask for help before my problems get out of control.

Figure 4. A PowerPoint slide created by girls taking part in the WRAP pilot

4. Young people have the opportunity to use WRAP themselves, wholly and authentically.

A great deal of money and time have been invested in programmes aimed at ‘empowering young people’ which, when tested for authenticity, have been shown not to work.

We believe that WRAP is a process which young people can ‘take up and run with’ themselves. This is especially important if we are to place greater emphasis on mental and psychological hygiene rather than on mental health recovery.

Results: lessons learned

The importance of focusing on wellness, not illness.

Young people are grappling with issues of power and identity.

Structured appropriately, WRAP can become a core programme.

Young people have the opportunity to use WRAP themselves, wholly and authentically.
Limited sample and data

Our sample of participants in the pilot programme was small, which makes a detailed interpretation at this stage fairly limited. We may have generated more useful findings by asking participants to complete SDQs at set time points (before, during and after the WRAP programme) and comparing their scores, but this proved problematic because:

- completing an SDQ at the start of the programme was voluntary – and some participants opted not to complete one until they knew what the programme was about
- some participants completed an SDQ at the start but didn’t complete the programme (for various reasons, including the disbanding of one of the groups due to an issue with CRB checks for facilitators)

However, we were not only looking to see the impact of creating a WRAP on an individual’s sense of wellbeing (which a time comparison may have helped show us), but to test whether SDQs could help highlight the kinds of issues and thoughts that affect mental health. Therefore, despite being limited, all of the data we gathered was useful.

For a future WRAP programme, we would recommend that participants complete an SDQ at the beginning, at the end, and at quarterly points in between in order to standardise the data gathered.

On SDQs

In Goodman et al’s assessment of the effectiveness of SDQs, they found that the sensitivity of the questionnaire in identifying psychiatric disorders “was substantially poorer with single-informant rather than multi-informant SDQs” (2000. p.534).

They proposed that “child psychiatric disorders are common and treatable, but they often go undetected and therefore remain untreated”. They concluded that “community screening programmes based on multi-informant SDQs could potentially increase the detection of child psychiatric disorders, thereby improving access to effective treatments” (Goodman et al, 2000. p. 534).

To increase the WRAP approach’s ability to detect psychiatric disorders, then, we may be wise to complete multi-informant SDQs for the young people taking part, involving parents, teachers, group leaders and older children (such as siblings) in the process. We would need to carefully consider the following:

- There are obvious methodological challenges involved in collecting multiple-informant SDQs

- Goodman et al state that the “SDQ prediction works best when SDQs have been completed by all possible informants, namely parents and teachers in all instances, and young people themselves from the age of 11 onwards”. They found that “information from parents is slightly more useful for detecting emotional disorders while information from teachers is slightly more useful for detecting conduct and hyperactivity disorders” (2000. p.538). Because WRAP focuses on the individual – the young person – it is our thinking that the young
Discussion

On SDQs

The person in question should be able to nominate which adults or older children become their informant.

- Other informants (parents or teachers or older children) can only look at a young person's behaviour from an external aspect; only the young person himself truly knows his own feelings and what causes him stress.

Furthermore, the SDQ was designed for a psychiatric setting and is essentially a tool that looks at illness, not wellness. Other measurement scales would have presented the same difficulties (such as HoNOS, which was researched and developed by the Royal College of Psychiatry and therefore have a psychiatric slant).

It might be worth considering a CORE-OM (Clinical Outcomes in Routine Evaluation – Outcome Measure) system in the future, which is a self-report questionnaire designed to be administered before and after therapy.
Discussion

The validity of the SDQ scores

We cannot be sure that all of our participants truly understood the SDQ and its purpose. There is a possibility that some of the young people in the pilot tried to second-guess what we might be looking for from them, tailoring their responses accordingly. In the case of SDQs that were completed by facilitators on behalf of the younger participants, the responses may have been affected by the facilitators’ own thoughts and ideas.

Parents were ‘missing’ from the study (but willing to take part)

Some parents were keen to see first-hand what their children were participating in. The parents who came along to WRAP sessions liked them and expressed an interest in taking part themselves.

There would be pros and cons in involving parents in future WRAP programmes:

Advantages:

• it is always good to encourage parents and their children to engage with one another, especially in exploring the issues of wellness, resilience and recovery covered within our WRAP discussions
• if parents were more involved, maybe schools would become more interested in WRAP
• WRAP could be a process through which some parenting deficiencies might be addressed – for example, families could use a WRAP approach for exploring difficulties created by father and sibling deficits
• shared aspirations often create links between people, making peer support a natural next step. Participating in a WRAP programme can provide people with opportunities to start peer-supporting, community-based wellness programmes. Therefore it makes sense to initiate as many people into WRAP programmes as possible.

Disadvantages:

• young people are less likely to talk openly when their parents are around, especially those from families where difficulties already exist
• there may be a mixture of issues related to differing generations, roles, expectations and needs.

Criminal Records Bureau checks

The need for CRB checks was a significant obstacle in recruiting facilitators - and had the potential to hold us up.

Longitudinal evidence

It is conceded that longitudinal evidence of the WRAP approach’s efficacy is not yet available, but efforts to remedy this are already in progress. As part of our proposal for the next WRAP programme (should we be able to go ahead), we wish to further evaluate WRAP’s long-term efficacy.

Birmingham has the potential to become a beacon site for the WRAP approach.
Discussion

How can the WRAP pilot’s outcomes be used to meet CAMHS priorities?

- The WRAP approach offers a sound base for a community-based psychological wellness and resilience programme, on a city-wide basis, using existing community group structures and facilitators. Established faith groups and sports clubs have expressed a willingness – indeed a readiness – to start implementing mental health programmes in general and WRAP specifically. They recognise and support the need to prevent mental/emotional disorder before it occurs.

- There appears to be scope for a robust outcomes framework which reflects the immediate and dynamic needs of recipient groups. WRAP presents us with the opportunity to do this.

- The CAMHS professionals who have become aware of WRAP as a concept (albeit in their private capacities) have reported it as being a good complementary treatment for young people and their families that are already receiving mental healthcare services.

- Experience from our work in adult mental healthcare services – and partly from this WRAP pilot – shows us that WRAP provides a ‘whole person approach’ to understanding causes of mental health difficulties and possible responses by both professionals and the service recipients themselves. Building links with other health and social care services will be vital in both the short and medium term.

- WRAP can be adapted into various modes of delivery, allowing both the message about mental health – and the way it is presented – to be tailored to reflect the recipient rather than the provider. The NHS’ New Horizons initiative captures the essence of this emerging trend well, as “a move from something which should be done to service users by the system, towards a system of support built by the person and their advocates”.

- WRAP demonstrates self-help and mutual/peer support in action, within the community.

- Measurable outcomes are possible, and the things we measure can be tailored to the Pan Birmingham Commissioning priorities.

- ‘Foot soldiers’, in the form of trained WRAP facilitators, are ready to send results back relatively quickly, without tying up the time of CAMHS professionals.

- It IS possible to provide CAMHS services differently, in ways that are more fun, which use new and different people and new and innovative approaches (such as social networking sites and new technologies). CAMHS can start targeting resources more specifically towards people’s needs and aspirations – without the need for using any more resources. Communities can do more for themselves than services can, and with fewer resources. When people are trusted with deciding what they like, they generally get it right.

- Discussions about mental health can be fun and inspiring.
There seems little point in identifying a greater number of young people with psychiatric disorders if the only consequence is greater access to – and pressure on – ineffective services. Through the WRAP approach, SDQs may pick up on psychological or circumstantial issues that could potentially trigger (or be precursors to) psychiatric disorders. Issues surrounding self-identity, sexuality, family life, violence in the home or even a sense of dislocation from one’s home country are all non-psychiatric issues which could lead to psychiatric breakdown. CAMHS will need to be able to meet this challenge.

The WRAP approach WRAP offers the potential for a large-scale, grass-roots, peer-led system.

The WRAP approach can focus on wellness not illness; strengths and not deficits; solutions not problems.

A key element of the WRAP approach is the opportunity it presents for young people to address and resolve their identity issues (“Who am I?”), potentially forestalling mental health difficulties.

Using WRAP, forecasts are possible.
What is Wellness?

What is wellness to you is not wellness to me.
Is it just a concept or is it a dream.
Is it a fantasy or a reality?
Is it my hero or is it just me.
Is it wholeness to you, what’s wholeness to me?
A difference of opinion, or a melancholy dream.
A difference of opinion or a jovial dream.
A different opinion, the differences is me.
What is wellness to you is not wellness to me.
A care plan tied up, like ribbons on a tree at Christmas time for all those to see.
A care plan so careful, written by you, without consultation, without even me.
What is wellness to you is not wellness to me.
A place explored, like rivers that flow into seas
A place of emptiness, of just a full stop.
A place like a valley explored by a lot.
A place of just saying I will not.
What is wellness to you, Is not wellness to me.
I live in a world that isn't a dream
I live in a world that's my reality
I live in a world that has a hold on me.
A world that won’t change, a world that says not.
A world with no play just lots of full stops...
What is wellness to you is not wellness to me
Every child matters don’t you agree, every child matters should be given a chance.
Even a place, to even just dance.
Consider my world, it's something I have.
Deals that are played are they really just chance.

Figure 5. A poem created during a WRAP pilot session
Discussion: recommendations for the WRAP approach

1. Develop a structured WRAP programme.

Coordinators of community-based young people’s clubs agree that there is a need for a concerted effort in mental health and psychological hygiene.

It would also appear that there is an urgent need for an initiative that is both simple and accessible; one that many people are able to use. The WRAP approach appears to meet that need. It has the benefit, among many others, of being able to direct resources where they have the potential for best impact.

Community and faith groups appear to offer the ideal basis for a large-scale, grass-roots, peer-driven wellness programme, focused on mental health and psychological hygiene.

There is also a significant opportunity for placing mental health discussion into sports settings, especially for young men in inner cities. Not only can sport give improvements to people’s physical health, it can provide an ideal platform for discussing mental wellness too.

It would be good to find a way, in conjunction with local education authorities, to introduce the WRAP approach into the curriculum and help schools teach it as part of PSHE or citizenship lessons.

2. Identify strategic adults to introduce to the WRAP approach.

In BEN, HoB and South, we encountered sports coaches and group leaders who were looking for useful and inspiring ways to engage with young people.

The WRAP approach gives groups and the adults in charge of them an opportunity to engage more closely with young people in their communities.

3. Use games as a vehicle for delivering the WRAP approach.

The young people in our study responded well to WRAP board and computer games – and there is enormous potential to expand on this offering, particularly with online games.

Because the games are developed by young people themselves, we know they will resonate well with their target audience.

There are also opportunities to engage and communicate with young people through social networking websites.

The groundwork for such developments has been laid as part of the pilot programme.

4. Make mental health and psychological hygiene ‘mainstream’.

A further pilot programme could be considered in collaboration with the Department for Children, Schools and Families, introducing the WRAP approach as a core part of PSHE or citizenship lessons. Through this, we could ‘catch’ many young people before they develop mental health difficulties, giving them the skills and coping mechanisms they need to combat future stressors.

CWI emphasises that it has already been adequately demonstrated through many studies that by investing in the prevention of mental health issues, significant financial and health gains are realised downstream.

Even taking into account sizeable resource constraints – both current and envisaged over the next three to five years – it is likely that investing in preventative services now will reduce pressure on mental healthcare services in a few years’ time.
5. Target localities, not groups.

Targeting groups of people – whether by gender, nationality, religion or family set-up – means attaching instant labels, which can be damaging. Instead, it is far better to target localities or even individual streets, and address the needs of a city one postcode at a time.

6. Turn WRAP into a large-scale, grass-roots wellness programme.

The WRAP approach offers great scope for tackling mental health problems not least because it is peer-led and encourages people to pass on their knowledge and tools for maintaining wellness.

We have already had interest from several Islamic faith groups, whose members can see how powerful the WRAP approach could be in tackling negative stereotypes and exploring what it means to be a Muslim in Britain.
The WRAP approach provides a sound basis for teaching psychological literacy and promoting psycho-social wellbeing. When people understand mental health, they learn to engage with mental health services more appropriately.

The WRAP approach and its replicable strategy for treating problems could build a community’s capacity to introduce people to ideas of self-help and mutual support, leading to a reduced reliance on expensive professional intervention. Fewer people may require acute services.

Suggestions

We would like to bring families and communities into the equation, placing them – rather than the services – at the centre of young people’s wellness.

The WRAP pilot has succeeded in telling us the kind of data it would be possible to collect. We should create a targeted, robust evaluation questionnaire for every session and make sure each individual participant completes it. Over time, not only will this help us to gauge individual attitudes towards personal wellbeing, but it will help us to build a bigger picture of ‘community wellness’ through baselines that measure:

- Psychological awareness by gender, age group, postcode and circumstance
- Ease of access to services (including ‘enablers’ and obstacles)
- Diversion options (that is, people’s awareness of alternative options to engaging with the services)
- Ongoing information about psychiatric symptoms and psychological distress.

We can gather quantitative data (‘Forty five per cent of people say they are …’) as well as qualitative (‘Being happy, to me, means …’). We can test commissioning priorities against the outcomes of our WRAP sessions and learn to closely match what people want from mental health services with what they actually receive.

Every participant should complete three SDQs (before, during and after taking part in the WRAP programme), giving us quantitative data and helping us screen for psychiatric disorders.

We should also use the ten-question (CORE-10) version of CORE-OM at three separate time points to look for psychological disorders.

We can deploy 20 coordinators each for BEN, HoB and South (of those, five will be from faith groups, five from community or social groups, five will be from school-based groups and five will come from other groups, such as sports clubs), and they will introduce ten young people to the WRAP approach every month.

One participant in every ten can be trained in WRAP facilitation, passing on the skills and knowledge to his or her peers.

We would like to compare the costs of mental health services at each of the CAMHS tier stages with the relatively low cost of the grassroots, self-help WRAP approach.

We can collect and interpret any other data sets that CAMHS might deem appropriate.
THE WRAP APPROACH TO CAMHS PROVISION: A PILOT PROGRAMME FOR BIRMINGHAM
CAMHS: Four-tier strategic framework

Child and adolescent mental health services (CAMHS) deliver services in line with a four-tier strategic framework which is now widely accepted as the basis for planning, commissioning and delivering services. Although there is some variation in the way the framework has been developed and applied across the country, it has created a common language for describing and commissioning services.

Most children and young people with mental health problems will be seen at Tiers 1 and 2. However, it is important to bear in mind that neither services nor people fall neatly into tiers. For example, many practitioners work in both Tier 2 and Tier 3 services.

Similarly, there is often a misconception that a child or young person will move up through the tiers as their condition is recognised as more complex. In reality, some children require services from a number (or even all) of the tiers at the same time.

The model is not intended as a template that must be applied rigidly, but rather as a conceptual framework for ensuring that a comprehensive range of services is commissioned and available to meet all the mental health needs of children and young people in an area, with clear referral routes between tiers.

Tier 1

CAMHS at this level are provided by practitioners who are not mental health specialists working in universal services; this includes GPs, health visitors, school nurses, teachers, social workers, youth justice workers and voluntary agencies.

Practitioners will be able to offer general advice and treatment for less severe problems, contribute towards mental health promotion, identify problems early in their development, and refer to more specialist services.

Tier 2

Practitioners at this level tend to be CAMHS specialists working in community and primary care settings in a uni-disciplinary way (although many will also work as part of Tier 3 services).

For example, this can include primary mental health workers, psychologists and counsellors working in GP practices, paediatric clinics, schools and youth services.

Practitioners offer consultation to families and other practitioners, outreach to identify severe or complex needs which require more specialist interventions, assessment (which may lead to treatment at a different tier), and training to practitioners at Tier 1.
Appendices

Appendix 1

CAMHS: Four-tier strategic framework

Practitioner agencies

Practitioners working in CAMHS will be employed by a range of agencies. Many (but not all) of those working at Tier 1, for example, will be employed directly by the Primary care trust (PCT) or the local authority (LA).

CAMHS specialists working at Tier 2 are less likely to be working for the PCT (although some of them might be), and more likely to be working for another NHS trust (or the LAs in the case of educational psychologists).

Most practitioners working in the more specialised services at Tiers 3 and 4 will usually be working for other types of NHS trust (such as mental health trusts, acute trusts or care trusts, for example).

Clear supervisory arrangements and structures should be in place to ensure accountable and safe service delivery.

Where service delivery demands effective partnerships between agencies (e.g. children and young people with complex, persistent and severe behavioural disorders) joint protocols should be agreed at senior officer level between the NHS, social services and education.
CAMHS WRAP SDQ IMPACT Questionnaires (completed – 17)

<table>
<thead>
<tr>
<th>Overall, do you think you have difficulties in one or more of the following areas: emotions, concentration, behaviour, or being able to get on with people?</th>
</tr>
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<tr>
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If yes:

<table>
<thead>
<tr>
<th>How long have these difficulties been present?</th>
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<tbody>
<tr>
<td>Not all</td>
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<table>
<thead>
<tr>
<th>Do the difficulties upset or distress you?</th>
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<tr>
<td>No</td>
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<table>
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<th>Do the difficulties interfere with your everyday life in the following areas?</th>
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<td>Home life</td>
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<th>Do the difficulties make it harder for those around you (family, friends, teachers etc)?</th>
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HOB Group B - S 11-17 - Impact Data Questionnaires completed: 3

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If yes:

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### CAMHS SDQ
#### All Groups data

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Communities Wellness Initiative would like to thank the following for their part in the WRAP pilot and in creating this report:

- all the young people who took part; their families and friends; event co-ordinators, Waheed Saleem; Nasreen Akhtar; Aeisha Wright; Ann Cowder; Susan Galloway; Mohammed Sajad; Israr Khaliq; Alison Maunsell; Ivora Ferreira-Bean; Ros Thompson; Sakhile Mphofu and Ngqabutho Mphofu; “Q”; churches and masjids; The Definitive Design Co; Good As Gold Writing Services; Waverley School; Continental Star; Alum Rock Football Club; Maryam House; Connexions Aston (Aston Pride and Aston Ascend); Vee’s delicatessen and many others.

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A pilot programme for Birmingham.

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