1.0 Introduction

A ‘care pathway’, also sometimes referred to as a ‘clinical pathway’, ‘integrated care pathway’ or ‘care map’ can be defined as a tool which is used to manage the quality in healthcare concerned with the standardisation of care processes. Care pathways seek to promote organised and efficient client care which is built upon evidence based practice. Evidence shows that the implementation of care pathways significantly reduces the variability in clinical practice and improves outcomes (Panella, 2003).

This document presents how Tameside & Glossop Healthy Young Minds (HYM) Service (previously CAMHS) sets out to meet the needs of children, young people (CYP) and their families presenting with mental health difficulties. In line with the recent and ongoing service transformation, the care pathways detailed have been conceptualised in a manner consistent with ‘Thrive’, a model of service delivery for child and adolescent mental health services (CAMHS) developed by The Tavistock and The Anna Freud Centre (Wolpert et al., 2014).

The THRIVE model of CAMHS sets out a service delivery model whereby service users’ needs are conceptualised within four key domains. These include:

1. Coping/Getting Advice
2. Getting Help
3. Getting More Help
4. Getting Risk Support

This is outlined in more detail in figure 1 below.

The Severe Mental Illness (SMI) Pathway is a treatment pathway for Schizophrenia, Psychotic illness including drug-induced psychosis, Organic Psychosis (due to physical health problems) and Bipolar Illness.
2.0 Definitions and Diagnostic Criteria: Indicating Appropriateness for Pathway

The diagnostic criteria laid out in the ICD-10 (WHO, 2010) are used within the HYM service, and young people who meet the criteria for psychotic illness (including drug induced) and bipolar disorder would be treated on this pathway. Psychosis and Bipolar illness are both rare in children and young people but are serious forms of mental illness, and usually present around 13-14 years of age.

2.1 Psychotic Illness

Such disorders are characterized by fundamental and characteristic distortions of thinking and perception and by inappropriate and blunted affect. This can usually manifest in wide variety of symptoms such as paranoid ideation, persecutory beliefs, hallucinations of any modality and persistent and fixed beliefs and experiences. There can be acute presentations which could be organic (physical health reasons), functional (possible schizoprenia) or drug induced. There are also rare circumstances when these symptoms could be due to an organic illness (physical health problems such as a tumour in the brain) which would need close liaison with Paediatrics.
2.2 Bipolar Disorder

The Bipolar illness is characterized by repeated episodes in which mood and activity levels are significantly disturbed, consisting of some occasions of elevated mood and increased energy and activity and others of lowering of mood and decreased energy and activity. Characteristically, recovery is usually complete between episodes. The incidence is equal between males and females. Some of the manic or depressive phases can have psychotic symptoms of delusion and auditory hallucinations. The hypomanic symptoms need to be continuously present for at least several days and manic episodes at least 2 weeks. There are four types of Bipolar disorder depending upon the intensity and type of mood changes.

2.3 Prodromal Phase of Psychotic Illness

The presence of vague psychotic symptoms with accompanying changes in personality, and also functioning in social and educational life, fall under the category of a prodromal phase of psychotic illness. This is the most common presentation in HYM where the evidence suggests regular monitoring and early detection and treatment is key to achieving a good prognosis.

3.0 Coping/Getting Advice

CYP described as ‘Coping/Getting Advice’ are supported to manage their mild or temporary low mood or other non-psychotic symptoms in the community, outside of the HYM service. There would be certain situations where rather than reflecting severe mental illness, some symptoms could be present either as part of a grief reaction, depressive illness, in the context of trauma or other environmental factors. For this group of CYP, a consultation with HYM would be beneficial and the appropriateness of other HYM care pathways could be considered to access support.

3.1 Psychosis

All such presentations should be discussed with HYM. Any CYP with unusual psychotic symptoms will be offered an appointment within two weeks, or even earlier depending upon the presentation. The referral information would help to determine if the symptoms are possibly due to drug misuse, related to other life events, other mental illness, early prodromal illness or acute psychotic presentation. We would offer consultation and liaison if the quality of the symptoms is not indicative of psychotic illness with the aim of offering reassurance, signposting, referral to drug and alcohol services and access to other care pathways if necessary.

3.2 Bipolar Illness

In most cases, children and young people with such a presentation would usually come to the SMI pathway via other pathways within the service. However, with normal mood swings of adolescence, some professionals and parents would benefit from consultation and liaison with HYM. Very rarely, the presentation can happen for
the first time or known HYM clients may present to A&E out of hours, which would be dealt with by the on call/duty team processes.

All the above presentations would include risk assessment to evaluate the risk of self harm, suicide and harm to others which would inform the consultation to other professionals.

4.0 Getting Help

Professionals with concerns about a CYP considered to have features of a serious mental illness, or those with chronic and/or fluctuating difficulties where there are concerns about a deterioration in presentation and/or where there is an increase in self-harm/ suicidality (especially with features of hopelessness/ helplessness) can make a referral/re-referral, or request a consultation with HYM.

4.1 Referral

There are several routes in to HYM in relation to the presentation of severe mental illness.

- **From HYM Consultation:** This would be if there are any concerns from the initial consultation or increased risk around presentation.

- **Referral:** All agencies can refer to HYM with full, clear information around the presenting concerns. We do get referrals from a wide range of agencies, including drug and alcohol services, A&E and schools.

- **Inter-pathway Transfer:** Some CYP will transition to this pathway from other pathways within the service, mostly from the mood and emotional disorders and emotional and behavioural dysregulation care pathways.

4.2 Assessment

For CYP referred in relation to non-psychotic symptoms or other emotional difficulties, a consultation intervention may be considered.

As outlined above, if there are clear symptoms of severe mental illness, an initial assessment would be offered urgently within 2 weeks or sooner as an emergency depending upon the presentation.

4.2.1 Consultation Intervention

A consultation intervention may be offered to professionals and/or carers around the CYP. This will be offered by an experienced HYM professional and will involve up to 3 sessions of advice to members of the system around the CYP to help move things forward, usually without the need to see the CYP in person. For example, consultation intervention might be considered for referrals of typical mood changes in adolescence and non-psychotic
symptoms which might include dealing with any underlying mild anxiety, mild low mood or uncomplicated grief and consider suitable support to parents and families up to 3 sessions.

Whether this is pursued will depend on several factors including the carer’s ability to implement the advice given, complexity and severity of the presentation.

4.2.2 Initial Assessment

Where a consultation intervention is deemed insufficient due to the severity and/or complexity, or has already been tried, or due to clear psychotic presentation or increased risk, a full initial assessment will be undertaken directly with the CYP, by a HYM professional. This will usually involve carer(s) except in exceptional circumstances.

The assessment will involve an exploration of recent and past psychosocial risk factors, including age, gender, family context and relationships, history of bullying and/or abuse, educational context, social functioning, drug and alcohol use, family mental health history, significant life events, ethnic and cultural factors, and factors known to be associated with an increased risk of a mood or psychotic disorder (for example, significant losses, adjustment to major life changes, family discord). Assessment will be sensitive and respectful of cultural, ethnic and religious backgrounds. An assessment of risk in terms of suicidality and/or harm to self, harm to others, exploitation and neglect will also be undertaken at this stage.

The outcome of assessment will include a consideration of the diagnosis and severity of the presentation, development of a formulation and care plan with goals and completion of routine outcome measures, routine documentation and correspondence. At this stage referrals to other allied agencies for concurrent support might be made, for example, Branching Out and Children’s Social Care.

RISK: Risk must always be assessed carefully regardless of the duration of symptoms, including exploration of themes of psychotic delusions or significant mood changes.

CYP with symptoms suggestive of severe mental illness will enter onto this care pathway after referral screening and offer of a consultation intervention, or post-initial assessment. CYP identified as having a non-psychotic presentation with other non-specific mental health difficulties will move into ‘Coping/Getting Advice’ with identified support in the community and advice around risk monitoring and management. Following a consultation intervention, CYP will either move back to ‘Coping/Getting Advice’, or will receive a thorough initial assessment and remain in ‘Getting Help’.
4.3 Documentation and Correspondence Points

Client records are to be kept in accordance with Trust policy and include case notes, completion of the PAD and Trust approved risk assessment documentation, the TARA. Written client notes should include a formulation summary in the form of a diagram and/or narrative on completion of the initial assessment. Where relevant, Care Programme Approach (CPA) documentation should be completed and managed by the case manager. Referring agents, the General Practitioner and CYP and their carer(s) are to receive a post-initial assessment letter within 10 days. If the assessment is incomplete, a brief letter to note that the CYP is being assessed should be sent within 10 days, followed by a detailed letter as soon as possible post-assessment. Letters will include details of presenting problems and formulation, assessed risk, care plans with goals and plans for review.

Follow-up correspondence with a progress summary will be sent after a further 3 months, and 6 monthly thereafter, or when significant changes are made to the care plan. At discharge, a letter will be sent and should summarise the original presenting difficulties, interventions offered, progress made (including reference to goals at outset), outcomes and relapse prevention plans and be sent within 10 days after the final contact.

4.4 Reviewing Service Effectiveness

Mandatory ‘Routine Outcome Measures’ (ROMs) will be administered at initial assessment, mid-way (at least 6 monthly) and at the end point of any therapeutic intervention. These typically include:

- The Revised Children's Anxiety and Depression Scale (RCADS, Chorpita, Yim, Moffitt, Umemoto & Francis, 2000)
- The Strengths and Difficulties Questionnaire (SDQ, Goodman, 2001)
- The Outcome rating scale (ORS; Miller & Duncan, 2000)
- The session rating scale (SRS, Miller, Duncan & Johnson, 2002)
- The CHI Experience of Service Questionnaire (CHI ESQ, Astride-Stirling, 2002)

CYP will set their own goals (‘Goal Based Outcomes’) and progress towards these will be reviewed ideally at every session, but as a minimum every 3-4 sessions. Clients should be given an opportunity to complete session rating scales, and the CHI Experience of Service questionnaire should be routinely given out post-treatment. Supplementary measures may sometimes be useful clinically.

4.5 Interventions

The interventions are described under the two main conditions in this pathway.
4.5.1 Psychotic Illness

**Urgent initial assessment**

Acute presentation or psychotic illness and indications of significant symptoms would normally lead to a rapid assessment alongside a Consultant Psychiatrist. Joint assessment or co-working with the Early Intervention team will need to be considered on almost all occasions. The complete assessment will establish the full symptom severity and nature, alongside a comprehensive risk assessment. The options of outpatient and inpatient assessment will be considered depending upon the presentation. Full physical investigations including a referral to Paediatricians to rule out organic causes for the presentation will be considered. If symptoms are not acute, usually a wait and watch approach is advised with very close monitoring and assessments and occasionally longer term follow up to identify early prodromal stages of psychotic illness.

**Pharmacological interventions**

The use of antipsychotics will be discussed with the young person and their family and all investigations will be considered. The type of antipsychotics prescribed will depend on the side effect profile and the young person. Starting with a low dose and monitoring would be priority. The shared care guidelines around the use of these medications and investigations must be followed through.

**Non-Pharmacological intervention**

Psycho-education, relapse prevention work and cognitive-behaviour therapy (CBT) could be considered. Evidence suggests that managing expressed emotions is also key to sustaining improvement.

**Drug Induced Psychosis**

The main focus would be to establish the causation of the psychotic symptoms either as an outpatient with the help of urine drug screen/further assessments or as an inpatient. A referral to the Lifeline team and a safeguarding referral would be considered.

4.5.2 Bipolar Disorder

As outlined above, such a presentation would most often be in the context of a young person already accessing other pathways within HYM. The focus would be the completion of a detailed assessment by the case manager
alongside a Consultant Psychiatrist to establish clear symptomatology of manic episodes and depressive symptomatology. Joint working with the Early Intervention Team would be a good option to consider joint assessment and interventions. If there are no co-existing psychotic symptoms, the Early Intervention Team may not be part of the assessment or intervention. Extensive information gathering around the level of input already received, medication use, drug use, physical health investigations and second opinion should be considered. If the symptoms are quite severe, an inpatient admission might be useful for full assessment and risk management. Intensive monitoring at home via the Inreach/Outreach Service is also an option.

Pharmacological interventions

This will depend upon clinical presentation and would include the consideration of mood stabilisers, antipsychotics and antidepressants if necessary. The shared care guidelines around use of these medications and investigations must be followed through.

Non-Pharmacological interventions

Psycho-education, relapse prevention, and psychological therapies including CBT and family therapy might be considered. The CBT sessions would be particularly helpful in managing depressive episodes and to develop coping strategies. Interpersonal Psychotherapy (IPT) if indicated is also available within the service.

Important issues to consider in this pathway:

1. The Early Intervention team are available to join an initial assessment and if suitable can co-work with HYM until the age of 19. The EIT can participate in regular meetings, correspondence and can jointly offer interventions working with the HYM team.

2. Care Programme Approach - All patients on this pathway need to be on care programme approach (CPA), which would ensure regular multi agency meetings, including school, to update on information sharing, risk management and further courses of action. These meetings should happen every 6 weeks.

4.6 Review

Progress, including goal based outcomes, will be reviewed every 4-6 sessions, with administration of ROM’s at the mid-point and end of therapy.

Across all disorders on the pathway, based on the outcome of the review, 3 actions will be possible:
• CYP who no longer meet the criteria to be on this pathway, and are on the road to recovery will be discharged for support at 'Coping/Getting Advice'
• Continuation of therapy at 'Getting Help', followed by a review after 6 further sessions will continue to take place. As most of the young people on this pathway would need pharmacological interventions, there will be continued support from HYM in monitoring the side effects, completing annual physical health checks and relapse prevention work. These young people will move on to "Getting more Help"
• Severe and/or complex presentations where there are co-morbidities may require inpatient admissions and support through the Inreach and Outreach Service.

5.0 Getting More Help

CYP at this stage of the pathway are able to access longer-term monitoring and support. This may include additional help due to complex and risky presentations and/or poor response to treatment.

5.1 Extended Management

For both psychotic illness and bipolar disorder, patients would require clear care-coordination, CPA meetings, monitoring of medications, thorough investigations and relapse management and prevention. The care-coordination and joint working with a Consultant Psychiatrist would continue up to transition into the Early Intervention Team when the CYP reaches 16 years of age. However, for CYP with Bipolar presentations, if there are no co-existing psychotic symptoms, the Adult Community Mental Health Team (CMHT) may become involved in the transition process.

5.2 Review

For CYP in 'Getting More Help', a joint review with all professionals involved will be helpful on a 3 monthly basis. For clients coming up to their 12th session, progress will be discussed in supervision and at the monthly case review meetings within HYM. At these meetings it can be considered what, if any, further work is required, whether a change in therapy is advisable, and whether there is a need for ongoing case and/or risk management on the same or another care pathway, for example.

6.0 Getting Risk Support

Risk management is a consideration at every level of the severe mental Illness pathway, both physical and psychological risk. An increase in deliberate self-harm, suicidal thoughts and intentions and thoughts of harming others are particularly relevant.

The THRIVE model emphasises several important points with regards to CYP whose care needs are best met by ‘Getting Risk Support’ (Thrive, Wolpert et al., 2014):
Supporting these young people should involve close inter-agency working, often with Children’s Social Care taking a leading role.

There should be clarity over which service is leading the support package offered.

The language used should communicate clearly that a health treatment is NOT being offered.

Indeed, for some CYP “there is no current health treatment available, but they remain a risk to themselves or others” (Wolpert et al., 2014, pg 2). Such an example would be a situation of drug induced psychosis, where although under remission, due to lack of supervision and further use of drugs the CYP may become unwell again and demonstrate high risk. For some CYP there will be ongoing case management within the service due to the level of risk and complexity of presentation necessitating the level of mental health expertise offered by HYM.

For the ‘getting risk support’ group, obviously the main remit of this role will be risk management and liaison with other services. In line with the THIVE principle, care at this level should not be considered a ‘health’ intervention/treatment, so a case manager should be working towards involving more appropriate support services, and increasing the likelihood of a relatively safe discharge away from specialist mental health services.

Other CYP not engaged in an active health service treatment at this stage, or requiring ongoing case management by HYM due to the level of risk and complexity, but where there are ongoing significant concerns around risk can be supported by HYM as follows:

- Support for multi-agency risk management strategies
- Consultation and liaison to other professionals
- Input to inter-agency work
- Signposting
- Supporting local safeguarding work alongside Children’s Social Care
- Ongoing risk support with another partner agency leading
- Support to Accident & Emergency around assessment and admission

### 6.1 Review

CYP accessing ‘risk support’ should be reviewed on a 3 monthly basis. Outcomes may be as follows:

- CYP who have made progress and are on the road to recovery will be moved into support at ‘Coping/Getting Advice’
- CYP demonstrating readiness to make use of therapy can be moved back into one of the ‘Getting Help’ stages
- Ongoing risk support
7.0 Audit

Regular audit will be undertaken to monitor the quality of the service on the severe mental illness pathway.

Priorities for audit around accessibility and quality, to include:

- That treatment options are appropriately offered and provided as set out in the pathway. Are treatments on offer evidence-based, goal focussed and outcome measured?
- Minimum training criteria for professionals audited by a survey of staff and monitoring CPD and supervision arrangements

8.0 Staffing

8.1 Training

All staff within HYM to have the basic core skills necessary to accurately identify, assess, case manage and offer basic interventions to CYP with serious mental illness. Some CYP on this pathway might be offered a psychological therapy by a suitably qualified therapist as part of any intervention. CBT staff involved in the treatment of CYP on this pathway will be trained to diploma level and eligible for BABCP accreditation. FT and IPT practitioners all have specialist post-graduate level training in their field.

8.2 Supervision

All staff offering interventions on this pathway will receive monthly clinical supervision in line with the Trust supervision policy. Therapy-specific supervision will be provided for staff qualified in a particular psychological therapy, and will meet criteria to maintain accreditation where necessary. A hierarchy model of supervision will ensure that all staff practicing a particular therapy are supervised by a clinician of higher level of qualification and/or experience. For senior clinicians this may take the form of peer supervision. Supervision paperwork will be maintained as per policy with particular attention to safeguarding and risk.

9.0 Discharge/Transition

CYP with diagnosed Psychosis or Bipolar illness are likely to continue with treatment into late adolescence and early adult life. Therefore, a carefully planned transition to the Early Intervention Team (Psychotic illness and Bipolar Illness with psychotic symptoms) or the local Adult Mental Health Team will most often be necessary.

The Trust DNA (Did Not Attend) policy will be followed in cases of missed appointments. This will be accompanied by an intensive outreach process in an attempt to engage with the family through local safeguarding processes. For CYP with prodromal phase symptoms who don’t develop psychotic illness, a clear plan of
re-referral into the Early Intervention Team and contingency plans would be developed before moving to Coping/Getting Advice and discharge from HYM. For CYP with presentations of drug induced psychosis, who are free of drug use and symptoms, discharge could also be considered with clear contingency plans.

10.0 Provision for 16+

For CYP within the HYM service approaching their 16th birthday, treatment will be continued and a carefully planned transition to the Adult Mental Health or Early Intervention Team will be made. If new CYP are referred to HYM post 16, these will be signposted to Adult Mental Health Services through the Access and Liaison Team who could also refer to the Early Intervention Team for further assessment and intervention.

References


