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 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 developed by The Tavistock and The Anna Freud Centre (Wolpert et al., 2014).

The THRIVE model (see fig 1) 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

Young people who present with high risk, impulsive behaviours are likely to be in a state of emotional/psychological turmoil, requiring emotional containment and
regulation. The Emotional and Behavioural Dysregulation Care Pathway is a treatment pathway for young people with such difficulties.

Young people on this pathway can be extremely challenging to work with, and are likely to harbour a fragmented and largely negative sense of self and other, often associated with a complex trauma history and attachment difficulties. Providing appropriate and robust services for young people who experience problems resulting in emotional dysregulation is a priority for CAMHS services, and requires a highly coordinated and comprehensive care pathway.

2.0 Definitions and Diagnostic Criteria: Indicating Appropriateness for Pathway

The following ‘Red Flag’ indicators can be used to consider the appropriateness of the CYP for the EBD pathway. The referral and screening tool (Appendix: Document 2) can be used to aid this process:

Repeated crisis intervention, numerous professional involved, long standing difficulties, splitting of staff group, high levels of risk, difficulty engaging YP or Family, standard treatment not helping, pervasive interpersonal problems, impulsive risk takings, difficulty monitoring own emotions, complex trauma history, limited emotional maturity (insight, tolerance, regulation), risk interfered with treatment.

The ICD 10 diagnostic criteria for unstable personality disorder may also act as a guide to considering whether a YP is appropriate for the pathway:

<table>
<thead>
<tr>
<th>1. Unpredictable</th>
<th>Marked tendency to act unexpectedly and without consideration of the consequences</th>
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<tbody>
<tr>
<td>2. Quarrelsome</td>
<td>Marked tendency to quarrelsome behaviour and to conflicts with others, especially when impulsive acts are thwarted or criticized</td>
</tr>
<tr>
<td>3. Explosive</td>
<td>Liability to outbursts of anger or violence, with inability to control the resulting behavioural explosions</td>
</tr>
<tr>
<td>4. Desultory</td>
<td>Difficulty in maintaining any course of action that offers no immediate reward</td>
</tr>
<tr>
<td>5. Capricious</td>
<td>Unstable and capricious mood</td>
</tr>
</tbody>
</table>

2.1 Borderline Type

<table>
<thead>
<tr>
<th>1. Poor self image</th>
<th>Disturbances in and uncertainty about self-image, aims and internal preferences (including sexual)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Relationship crisis</td>
<td>Liability to become involved in intense and unstable relationships, often leading to emotional crises</td>
</tr>
<tr>
<td>3. Fear of abandonment</td>
<td>Excessive efforts to avoid abandonment</td>
</tr>
<tr>
<td>4. Self-harm</td>
<td>Recurrent threats or acts of self harm</td>
</tr>
<tr>
<td>5. Feelings of emptiness</td>
<td>Chronic feelings of emptiness</td>
</tr>
</tbody>
</table>
Allocation to this pathway will not be appropriate for young people with moderate to severe learning difficulties, or moderate to severe deficits in social cognition, who require specialist input on care pathways for CYP with Learning Disabilities and/or Autistic Spectrum Disorders. Young people sixteen and above with very entrenched and risky behaviours may require exclusive input from Adult Mental Health Services, or be in receipt of a joint approach whereby case management and psychiatry input is provided by adult services, and therapy is provided by HYM.

### 3.0 Coping/Getting Advice

CYP described as ‘Coping’ are supported to manage their mild or temporary mental health difficulties in the community, outside of a CAMHS service. There may also be CYP with chronic, fluctuating or ongoing severe difficulties who are choosing to manage their own mental health and/or are on the road to recovery.

Young people with evidence of mild emotional dysregulation difficulties, in the context of life stressors, who are deemed able to access and potentially benefit from a counselling approach, will be classified in the THRIVE’S ‘coping’ quadrant, and signposted to local 3rd Sector Counselling services.

Alternative sources of support for young people currently provided by other agencies, include advice and monitoring of mental health by general practitioners and staff in education, non-directive supportive counselling services, early help support, and programmes to increase resilience in education. HYM can support other professionals within an educational or community setting in working with these CYP as follows:

- Consultation and liaison, including advice on when a referral might be necessary
- Advice around education-based support/therapeutic groups and parent skills groups
- Guidance around accessing psycho-education including self-help resources, including both bibliotherapy and online materials
- Advice around guided self-help
- Signposting, for example to counselling services outside of HYM
- Supervision
- Advice and training around detection, assessment and active monitoring of symptoms of mental health difficulties, including risk around self-harm and suicidality

**RISK:** Risk must always be assessed carefully when there is evidence of emotional and behavioural dysregulation, regardless of the duration of symptoms. Where there are concerns about deteriorating mood, self-harm and/or suicidality, professionals are advised to contact clients who do not attend follow-up appointments, or are otherwise failing to attend services/provisions, e.g. school.
4.0 Getting Help

Professionals with concerns about a CYP considered to have moderate to severe emotional and behavioural dysregulation difficulties, 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 into HYM.

4.1 Referral

There are several routes in to HYM for assessment of difficulties associated with emotional and/or behavioural dysregulation:

- **Emergency Referral**: Following an emergency assessment in the context of a crisis involving self-harm and/or suicidality by a core HYM duty professional with support from a senior member of staff where appropriate, often after admission via Accident & Emergency (A&E).

  The 16+ Young People who present at A&E in a mental health crisis are assessed by the adult RAID team. This is followed up by a HYM RAID worker, following which, allocation to this pathway may be warranted.

- **Urgent/Routine Referral**: A routine referral is considered in our multi-professional, single point of entry referrals meeting. More urgent referrals will sometimes follow an emergency consultation from the previous working day. Additional information is sometimes sought from the referrer or family to aid decision-making and to determine the level of urgency. If the referral meets the criteria for a service and the concerns include possible moderate to severe emotional and behavioural dysregulation difficulties, the CYP is allocated for an initial assessment, including risk assessment, by a HYM professional. Where there is an indication of risk, all CYP will be seen in person.

  For routine referrals of young people who are 16 or over, triaging decisions about appropriate pathways are made within the Adult Access team, supported by a HYM liaison practitioner. All routine GP referrals for the 16+ age group will be triaged through the Adult Access Team. The EBD pathway is the only care pathway within HYM for 16+ young people – alternative pathways lie outside of HYM, such as those provided by Primary and Secondary Care Mental Health Services and 3rd Sector Counselling services.

- **Inter-pathway Transfer**: Most CYP will transition to the emotional and behavioural dysregulation care pathway from other pathways. For example, as time passes, it becomes apparent that a presentation of low mood is within the context of longer standing patterns of dysregulated emotions, problematic interpersonal patterns and impulsive risk taking.
4.2 Assessment

Many CYP entered onto this care pathway will be transferred from other pathways and as such will have had significant HYM assessment and intervention. For CYP referred directly into HYM in relation to emotional and behavioural dysregulation difficulties, there will be two possible courses of action:

4.2.1 Consultation Intervention

A consultation intervention involves three consultative sessions with members of the CYPs system (e.g. carer, professional from another service etc.). This is provided by a specialist HYM worker, and does not involve direct contact with the CYP. Consultation for EBD related difficulties will often involve supporting carers and other professional to work on their ability to ‘validate’ the CYPs experiences, whilst also maintaining boundaries and expectations of the CYP in the household.

A consultation intervention may be less likely for CYP with EBD difficulties, as compared to children on other pathways, due to the inherent risk taking that is normally associated with their referral, meaning that direct contact with the CYP is required.

However, in some instances a consultation intervention may be indicated. For example, a CYP may refuse contact with HYM. In this instance, a three
session consultation can be offered to support adults in the system to support the CYP more effectively.

Furthermore, if the CYP has presented with superficial self-harm, and a 3rd Sector counselling approach is felt to be adequate, then the addition of a consultative intervention for carers may be indicated.

### 4.2.2 Initial Assessment

Where there is an indication of moderate to severe emotional and behavioural dysregulation issues, or a consultation intervention is deemed insufficient due to the severity and/or complexity, or has already been tried, 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 such EBD issues (for example, significant attachment difficulties, childhood adversity). 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 assessment will encompass 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 when a mood disorder is present, regardless of the duration of symptoms, including exploration of themes of hopelessness for the future and personal helplessness. Some CYP with moderate to severe emotional and behavioural dysregulation difficulties will enter onto this care pathway after referral screening and offer of a consultation intervention, or post-initial assessment. Many will be transferred onto this pathway from other care pathways as difficulties become more apparent over time. CYP identified as having mild difficulties with no other mental health difficulties will move into ‘Coping’ with identified support in the community and advice around risk monitoring and management. Following any consultation interventions, CYP will either move back to ‘Coping’, or will receive a thorough initial assessment and remain in ‘Getting Help’ or ‘Getting More Help’.

### 4.3 Documentation and Correspondence Points

Client records to be kept in accordance with Trust policy and to include case notes, completion of PAD and the 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.

Most CYP on the EBD pathway will be required to be on the Care Programme Approach (CPA). Documentation should be completed and managed by the case manager who will take responsibility for care coordination and adherence to CPA protocols. 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), outcome and relapse prevention plans and be sent within 10 days of 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 care co-ordinator will develop an individual care plan with the CYP and their family and liaise with other professionals involved.

Due to the often longstanding nature of difficulties, most CYP on this care pathway will receive care within the ‘Getting More Help’ quadrant of the Thrive Model. However, some CYP, with less severe EBD related difficulties, may find that their
needs are met within the ‘Getting Help’ quadrant, or be seen within this quadrant with a view to accessing a more intensive intervention within ‘Getting More Help’. Interventions at the ‘Getting Help’ level will be time-limited, formulation driven and goal-focussed, and may involve:

4.5.1 Formal Psychological Therapy

- Interpersonal Therapy for Adolescents (IPT-A)
- Cognitive-Behaviour Therapy (CBT) typically to address co-morbid difficulties such as anxiety and low mood
- Family Therapy to address familial factors which may be indicated in the maintenance of the difficulties

4.5.2 Other Interventions for Emotional and Behavioural Dysregulation Difficulties

For some CYP, a formal therapy as listed above may not be indicated by the formulation of their difficulties. Other CYP may not be in a position to access one of the therapies presented above for a variety of reasons, including age, complexity with co-morbidity and fluctuating risk, unwillingness to engage, lack of support at home etc. It might also be that there is a wait for a given therapy. As such a variety of other approaches might be taken:

- Active case management and care coordination, including crisis and risk management
- Motivational Enhancement Therapy / Motivational Interviewing to increase motivation to engage and address difficulties
- Psycho-education and advice around managing symptoms such as distress tolerance, enhancing emotional literacy, behavioural activation, goal setting, problem-solving and worry management
- Parenting support, including referrals to adult mental health services where appropriate
- Consultant child and adolescent psychiatry overview
- ‘Managing Emotions Group’
- Creative approaches

4.5.3 Case Management

The case manager should consider crisis management plans that are consistent with the young person’s formulation. For example, using behavioural principles to reinforce more positive care seeking behaviours from the young person, or coordinating multi-professional / multi-agency crisis response plans may be required. The case manager may wish to consult with the EBD consultation group for formulating care plans and crisis response strategies.
Case management for young people on this pathway is typically challenging and highly time demanding. Case management should be distinct from formal therapy, and provided by a different worker whenever possible.

5.0 Getting More Help

Due to the nature of their difficulties, most CYP on this care pathway will receive care within the ‘Getting More Help’ quadrant of the Thrive Model. These CYP are described as those who would “benefit from extensive long-term treatment which may include inpatient care, but may also include extensive outpatient provision” (Thrive, Wolpart et al. 2014, pg 9).

5.1 Interventions

**Extensive Outpatient Provision**

Some CYP will need longer-term involvement with the outpatient HYM service, which could involve:

- Ongoing pharmacotherapy management and review
- Ongoing psychological therapy for complex presentations, typically Dialectical Behaviour Therapy (DBT) and/or for co-morbid presentations (CBT/IPT/FT)
- DBT allocation is agreed via the DBT pathway group, and involves both group and 1:1 intervention, provided by DBT therapists. It is resource intensive but is expected to reduce crisis presentations and the demand placed on the case manager. There may be a waiting list for DBT; if so, alternative therapies may be offered in the interim, providing they are consistent with the formulation and care plan.
- Transfer to alternative therapy and risk management
- Ongoing case and risk management (including Inreach/Outreach provision where necessary)
- CYP moving onto the EBD pathway from an alternative pathway following re-formulation, changes in presentation etc.

**Pharmacotherapy**

There are no specific medications used in the management of emotional and behavioural dysregulation difficulties, however, CYP may require pharmacotherapy for the management of other co-morbid presentations, for example low mood (see relevant care pathway).

**Inpatient Provision**

If it becomes unsafe to manage the CYP within the community due to the severity of their presentation and/or risk, an inpatient intervention might be required at the Hope/Horizon Inpatient Psychiatric Unit, Fairfield General Hospital. DBT aims to reduce crisis admission, however there will be times
when an inpatient admission is unavoidable. It is important that the implications of an admission are fully considered, with recognition that for some young people admission may be attractive, but can be unhelpful and contra-indicated, particularly for those young people with multiple previous admissions. Agreements may have to be made between the young person, carers, care coordinator, Hope Unit and the InReach/OutReach Team as to what is in the young person’s best interest following a crisis presentation.

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. 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 in every level of the EBD care pathway, both physical and psychological risk. An increase in deliberate self-harm, suicidal thoughts and intentions are particularly relevant.

Due to the nature of their difficulties, it is crucial that a CYP is offered sufficient support and flexibility within the EBD pathway, to facilitate intervention at the ‘Getting More Help’ rather than ‘Getting Risk Support’ level as far as possible. Engagement will take time, consistency and perseverance. This is essentially a ‘getting to know each other’ process, which we believe is an important ‘pre-treatment’ component to effective mental health intervention for young people on the EBD Pathway.

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.

Some CYP will fail to benefit from interventions offered at the ‘Getting Help’ and ‘Getting More Help’ stages due to a wide range of factors, for example, difficult family circumstances and interpersonal factors. The degree of engagement, alongside other contextual factors, such as the CYP’s age and the availability of other support mechanisms, will determine the exact procedure for working with CYP at the ‘Getting Risk Support’ level. 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).
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. Case management of CYP on the EBD getting risk support quadrant will involve primarily 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.

CYP not engaged in an active health service treatment at this stage, and who are unwilling or unable to accept case management by HYM, but for whom 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’
- 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 Emotional and Behavioural Dysregulation Disorders Pathway. Some examples of proposed audits on this pathway include:

- Monitoring of referrals into the EBD pathway, including source of referral, demographics of CYP, and outcomes of referral
- Monitoring of treatments offered, and clinical outcomes, including symptom tracker scores and number of crisis presentations
- Monitoring of contact with case manager once a CYP has commenced DBT treatment
8.0 Staffing

8.1 Training

All staff are to have the core skills necessary to accurately identify, assess, case manage and offer basic interventions to CYP with issues around emotional and/or behavioural dysregulation. These core skills include the following:

- Identify and assess the issues most commonly associated with EBD difficulties
- Basic understanding of the underlying emotional mechanisms driving EBD related difficulties
- Ability to follow and implement CPA protocols including risk assessment
- Awareness of the importance of multi-professional / multi-agency communication when working with CYP on this pathway
- Basic skills in coping strategies and emotional containment for young people with emotional dysregulation difficulties
- Basic skills in DBT
- Awareness of how systemic and social factors can impact on CYP functioning and a willingness and intervene on a systemic level.

Continued Professional Development (CPD) and other training needs can be identified in supervision and internal or external training should be made available to support the development of core skills.

Most CYP on this pathway will be offered Dialectical Behaviour Therapy (DBT) by suitably qualified members of staff who have completed training, and receive ongoing team consultation in this approach. Some CYP might be offered Cognitive-Behaviour Therapy (CBT), Interpersonal Therapy (IPT) or Family Therapy (FT) by a suitably qualified therapist. CBT staff are trained to either a certificate or diploma level. CBT interventions for the most complex presentations will be seen by clinicians qualified to diploma level and eligible for BABCP accreditation. IPT and FT practitioners all have specialist post-graduate level training in their field.

8.2 Supervision

Working with this client group can be particularly demanding, both emotionally and practically. All staff offering interventions on this pathway will receive monthly clinical and management 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

Young people on this pathway may have an insecure attachment style or interpersonal sensitivities, making the prospect of discharge feel overwhelming, resulting in avoidance of discharge on behalf of the worker and client. Clinical and management supervision should directly address these potential difficulties.

9.1 Intervention Complete

CYP making progress with a psychological therapy as evidenced by movement towards goals and/or routine outcome measures and the level of risk reduced to an acceptable level, will be moved out of the HYM service into ‘Coping’. What represents ‘recovery’ should be carefully considered for young people on this pathway, as there is a risk of retaining young people in the service for longer than is necessary. For example, it is unlikely that the end goal will be a problem free life or complete cessation of self-harm. Some CYP may be moved in to Coping where it is agreed to manage their own ongoing chronic needs, or ‘Getting Risk Support’ where there is significant ongoing risk, with advice from HYM to the support system around them. Occasionally, CYP may be moved from the EBD care pathway to another more appropriate pathway as their needs change, although for most CYP being on multiple care pathways is more likely.

9.2 Disengagement

There is a marked risk of poor engagement and frequent non-attendance for CYP on this pathway. Disengaging young people may be considered for the ‘Getting Risk Support’ care outlined below. Careful thought must be given to how we attempt to engage hard to reach young people, and what we do when our attempts have failed. However, for CYP who fail to engage with the service, the standard Trust DNA policy (policy of non-attendance) will be followed, and any medication discontinued (unless Consultant Psychiatry consultation has been provided to a GP regarding the prescribing of medication to a young person, and the continuation of this is deemed appropriate). A discharge letter will be sent to the G.P. and the referring agent, and other involved professionals as appropriate and without exception when there remain issues of significant risk (a ‘DNA discharge with concerns’ letter).

In certain circumstances, extra consideration must be given to how the policy of non-attendance is applied. For example, a particularly challenging sub-group to work with will be those young people who present with some or all of the following:

- high risk behaviours
- have very poor engagement
- live on their own
- not in college
- no other statutory services involved

For these CYP, the emphasis in the DNA policy on the young person ‘opting in’ may be insufficient to ensure an adequate standard of risk management prior to
discharge. Cases such as these must be taken to clinical and management supervision, with a clear and flexible engagement plan evidenced prior to implementation of the DNA policy. Attempts should be made to involve other services that may be better placed to minimise risk (e.g. Children’s Social Care).

9.3 Transfer to Adult Services

Consideration should be given as to whether the CYP’s needs can be adequately met by HYM or whether exclusive input from an Adult mental Health Service is more appropriate when difficulties are very entrenched and/or are high risk. Possibilities for co-working should also be considered for CYP 16 years and over. For example, case management, crisis support and psychiatry input might be provided by adult services, while age appropriate and systemically orientated therapeutic input might be provided by HYM.
References


Appendices

APPENDIX 1

1. Routes into the Pathway

1a. CHOICE ASSESSMENT 1b. URGENT ASSESSMENT 1c. OTHER PATHWAY

2. Red flags indicating appropriateness for Pathway

Repeated crisis intervention, numerous professionals involved, long standing difficulties, splitting of staff group, high levels of risk, difficulty engaging YP or Family, standard treatment not helping, pervasive interpersonal problems, impulsive risk takings, difficulty monitoring own emotions, complex trauma history, limited emotional maturity (insight, tolerance regulation), risk interferes with treatment.

3. CASE MANAGER

4. EBD PATHWAY GROUP

4a. Screens referrals for pathway
4b. Provides consultation to CM
4c. Considers additional assessment requirements
4d. Contributes to formulation
4e. Advises on treatment options and care plan

10. INTERVENTION

10a. Getting Help
Self Harm Group
IPT-A
Consultation to others
Family Therapy
Coping skills
Emotional containment
Parenting support
Medical Input
CBT for co-morbid symptoms

10b. Getting More Help
DBT
Admission
Active Case Management

10c. Getting Risk Support
Active Case Management
APPENDIX 2

EBD Pathway Document 1

Tameside & Glossop CAMHS Screening & Referral Form

Emotional & Behavioural Dysregulation Pathway

Name of person making the referral…………………………………………………………

Date attended pathway meeting…………………………………………………………

Child/Young Person’s name ……………………………………………………………

Age and date of birth ………………………………………………………………………

School/College………………………………………………………………………………

Other services involved……………………………………………………………………

Are any of the below factors known or believed to be evident?

• Repeated crisis presentations
• Long standing difficulties
• High levels of risk
• Recurrent threats or acts of self harm
• Poor outcomes of previous interventions
• Intense relationships often resulting crises
• Impulsive risk taking as form of emotional regulation
• Complex trauma history
• Unusual perceptual experiences
• Deficits in emotional regulation and distress tolerance
• Poor or uncertain self image
• Fear of abandonment
• Feelings of emptiness
• Previous contact with CAMHS

Frequency of contact with your client:
Presenting problems:

Form received by on (date and time)………………………………………………

Outcome & Actions
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Care Coordinator Name __________________ Signed _______________

Pathway group member____________________ Signed_______________