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 developed by The 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

Young people with a learning disability (LD) are at an increased risk of mental health issues and/or behavioural problems (Emerson & Hatton, 2007). In addition, individuals with learning disabilities are additionally at higher risk of comorbidities such as ASD and ADHD. The mental health needs of young people with learning disabilities and ASDs are often not accurately noticed or understood due to diagnostic overshadowing and the young person’s LD/ASD being blamed for their presentations; this, and poor links with specialist educational provisions would act as a barrier to this population accessing services, which is not acceptable, considering the prevalence of mental health needs in the population.

2.0 Definitions and Diagnostic Criteria: Indicating Appropriateness for Pathway

Within HYM we currently aim to provide a comprehensive mental health service including child psychiatry, clinical psychology and learning disability nursing to children with severe learning disabilities and their families, children with moderate learning disabilities who attend a specialist school or college provision (Oakdale, Cromwell and Dovestones) or with a level of complexity that requires a specialist learning disability worker, and who are experiencing mental health issues. Having a learning disability refers to those individuals who have an IQ score of 70 or less alongside impairments of adaptive functioning that have been evident from childhood. Severe learning disability is defined as IQ 20-35 and moderate as an IQ
36-50, both with significant impairment in activities of adaptive functioning, including social functioning and daily living.

Where a child is identified as having a mild learning disability, their individual profile of strengths and needs may mean that they are able to access the core HYM care pathways for support with some adaptations. Generic case workers can seek additional support and/or consultation from the LD team.

See Appendix 2 for diagnostic criteria.

**3.0 Coping/Getting Advice**

CYP described as ‘Coping’ or ‘Getting Advice’ are supported to manage their mild or temporary mental health difficulties in the community, outside of a CAMH 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. There are many sources of support for young people currently provided by other agencies, including advice and monitoring of mental health by general practitioners and staff in education and early help support. HYM is able to support the work of other agencies, reaching down, in a way that helps the CYP to manage their difficulties without coming into HYM.

Types of support may include:

- Autistic Spectrum Disorders [www.nas.org.uk](http://www.nas.org.uk)
- Fragile X [www.fragilex.org.uk](http://www.fragilex.org.uk)
- Downs syndrome [www.downs-syndrome.org.uk](http://www.downs-syndrome.org.uk)
- Smith Magenis Syndrome [www.smith-magenis.co.uk](http://www.smith-magenis.co.uk)
- Prader Willi Syndrome [www.pwsa.co.uk](http://www.pwsa.co.uk)
- 22q 11 deletion syndrome [www.22q.org](http://www.22q.org)
- Phenylketonuria [www.nspku.org](http://www.nspku.org)
- Williams Syndrome [https://williams-syndrome.org/](https://williams-syndrome.org/)
- Fetal Alcohol Syndrome [www.nofas-uk.org](http://www.nofas-uk.org)
- Local charities according to young persons’ needs e.g.
  - Cerebra [http://w3.cerebra.org.uk](http://w3.cerebra.org.uk)
- Royal College of Psychiatrists [http://www.rcpsych.ac.uk/healthadvice/problemsdisorders/learningdisabilities.aspx](http://www.rcpsych.ac.uk/healthadvice/problemsdisorders/learningdisabilities.aspx)
- Respect for all (counselling) [http://www.respectforall.org.uk/counselling/](http://www.respectforall.org.uk/counselling/)
- Young Carers (siblings) [http://www.tameside.gov.uk/carers/young](http://www.tameside.gov.uk/carers/young)
- Relationship and sexuality groups [www.kids.org.uk](http://www.kids.org.uk)
• Signposting to services available
• Parent/carer support groups:
  • Tameside Action for Social Communication and Autism (T.A.S.C.A) www.freewebs.com/tasca4u 07931 466417
  • Our Kids Eyes (O.K.E.) www.ourkidseyes.org 0161 3712084/2087
  • Tameside Down Syndrome Support group http://tag-friends.org.uk/
• Consultation to professionals if comorbid ASD is suspected. Referrals are initially made to Communication Language and Autistic Spectrum Services (C.L.A.S.S) (then follow the neurodevelopmental pathway into the Multi Agency Autism Assessment Team) – their assessment includes observations and developmental history taking (if family has consented to an ASD assessment) and interventions in schools; Early Help Team; Child and Adolescent Behaviour Service (CABS).
• Advice/training to professionals around detection, assessment and monitoring of symptoms including risk around challenging behaviour
• Training to professional groups e.g. Early Help, PSS, CLASS, schools, school nurses, health visitors, Paediatricians
• Consultation to other agencies/charities/3rd sector offering support
• Joint assessments with Child and Adolescent Behaviour Team (CABS) and Supporting CABS in functional analyses
• Resources developed by the LD team to support the skilling up of tier 1/2 professionals to set up and deliver their own education-based groups in the community
  o Soiling/toiletting
  o Sleep
  o Feeding
  o Low level anxiety groups
  o Emotions groups
  o Resources to help support teams to set up groups
• Supervision to other professionals

3.1 Consultation

Consultation is offered to the special schools and college (Oakdale, Cromwell, Dovestones) and to other professional groups as and when required.

Psychological consultations will be provided half termly in each setting, jointly with the LD HYM nurse who also represents CABS. Consultation to schools is a vital component of providing early help and prevention to those in contact with children and families with learning disabilities. If psychological knowledge and useful strategies can be accessed early, this is likely to prevent future referrals to LD HYM describing families in crisis or extreme behaviour. This is particularly the case for
challenging behaviour presentations whereby families may wait until crisis point before attending HYM requesting medications.

Typically, consultation involves thinking broadly about the child and their circumstances in light of presenting difficulties. The person requesting consultation will be encouraged to consider the impact of contextual factors in order to collaboratively devise an adequate working formulation.

**RISK:** Risk must always be assessed carefully when a low mood or risk-taking behaviours are present, regardless of the duration of symptoms. At this stage the responsibility for risk management, including the monitoring of non-attendance of follow-up appointments, lies with the professionals working directly with families and young people; and risk issues should be assessed and managed by the LD social care team.

### 4.0 Getting Help

Professionals in our partner agencies with concerns about a CYP with a diagnosis of a learning disability who require support for co-morbid mental health difficulties can make a referral/re-referral into HYM.

### 4.1 Referral

There are several routes into HYM for assessment of a mental health difficulty for CYP with a diagnosis of a learning disability. If a child is identified as having a mild or moderate learning disability, their individual profile of strengths and needs may mean that they are able to access the core HYM care pathways for support with some adaptations.

- **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).

- **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, the CYP. Young people with a diagnosis of moderate/severe LD and a comorbid mental health issue will be seen for an LD HYM assessment appointment.

Following this assessment, case management would generally be undertaken by this worker. Following an initial assessment the HYM LD team meet to discuss an initial formulation of the young person’s needs. At this stage if it is felt appropriate, and it fits with the young person’s formulation it may be appropriate to complete a more in depth assessment or to pass on to
psychiatry for medication, or to clinical psychology for individual psychological therapy.

- **Inter-pathway Transfer**: Some CYP may transition to the LD care pathway from other pathways, for example, due to identification of a moderate to severe LD beyond the initial assessment. Children with milder LD would remain in the appropriate alternative pathway, such as the EBD or MED pathways supported by members of the generic HYM team.

### 4.2 Assessment

For CYP with a diagnosis of an LD and referred to HYM in relation to co-morbid mental health difficulties, there will be possible courses of action, items 4.2.1 and/or 4.2.2.

#### 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 without the need to see the CYP in person. Occasionally it might be necessary to involve the CYP themselves in this process.

#### 4.2.2 Initial Assessment

When 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. Careful consideration will be given to whether the CYP should be involved in the first appointment. If the child/young person is to attend the appointment there will be an emphasis on identifying appropriate communication strategies, and exploration of ways of gaining information from the child (gaining their perspective). The HYM LD team consider what might be needed to support individuals attending appointments, e.g. Picture Exchange Communication System (PECS), timelines, sand timers; and/or would a home visit be more helpful.

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 mental health difficulties in the LD population. The team seek to understand the wider systems around the young person and find out more about the services involved in supporting them; to consider the impact of environmental
changes on the young person’s presentation, and possible underlying genetic causes, and genetic and behavioural phenotypes. 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 the 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 when a mood disorder and/or risk-taking behaviours are present, regardless of the duration of symptoms.

CYP with a diagnosis of a moderate to severe LD and evidence of a co-morbid mental health difficulty will enter on to this care pathway after referral screening and offer of a consultation intervention, or post-initial assessment. CYP with mild mental health difficulties will move into ‘Getting Advice/Coping’ with identified support in the community and advice and risk monitoring and management and consultation support from HYM as needed.

### 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. 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 the 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 care co-ordinator will develop an individual care plan with the CYP and their family and liaise with other professionals involved. Thereafter, a range of possible interventions may be offered including:

- Psycho-education around mental health needs in this population to help the young person, their family and school understand the young person and their presenting problems better
  - This may include management of symptoms such as sleep problems, behavioural activation, goal setting, enhancing emotional literacy, problem-solving and worry management
- Active case management and care coordination including crisis and risk management
- Signposting and referrals to other agencies
- Consultant child and adolescent psychiatry overview
- Parenting support, including referrals to adult mental health services where appropriate
- Play therapy
- Creative approaches
- Psychometric assessment of cognitive profile (assessment of a potential learning disability diagnosis should routinely be undertaken by Educational Psychologists within schools)
4.5.1 Psychological Therapy

A range of psychological therapies are available within the HYM service, and will be appropriately adapted by experienced clinicians for CYP with LD. Examples of such therapies include:

- Behaviour therapy
- Cognitive-behaviour therapy
- Family therapy and systemic approaches, including narrative approaches
- Non-specific therapies

Some therapies may also be offered in a group format.

4.5.2 16-18 Year Age Group

The HYM LD team provide a service to young people with severe LD who remain open to HYM at their 16th birthday and require ongoing support up to the age of 18.

The HYM LD team also take referrals from the Child and Adolescent Behaviour Service (CABS) for the 16-18 age group if they have been previously been known to HYM and they have received behavioural interventions but there are concerns regarding possible mental health difficulties, or they request an assessment to consider medication for challenging behaviour.

If the needs of these young people are better met by other services e.g. adult services, adult ASD nursing team they will be signposted to these services.

Urgent/emergency presentations in this age group e.g. young people aged 16-18 presenting at A&E need assessment by adult services.

5.0 Getting More Help

This summarises what we are able to offer young people who have presentations which are likely to require extensive or intensive interventions for them to feel benefit, for example young people with psychosis, eating disorders, emotional dysregulation issues, and complex comorbid mood disorders with additional risk issues. As such, these CYP will require longer-term provision. For the population of CYP with severe learning disabilities, treatment plans are often led by the outcomes of functional analyses. A functional analysis involves thorough assessment of a specific behaviour: clearly defining the behaviour; understanding the history of the problem; analysis of the potential triggers to and consequences of the behaviour; analysis of reinforcers/motivators that maintain behaviour; an ecological analysis of physical, interpersonal and activity related environments and factors; and a mediator analysis.
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 and/or co-morbidity (adapted cognitive-behaviour therapy, behaviour therapy, family therapy and systemic work, narrative approaches. These may be in individual or group formats.
- Transfer to alternative therapy and risk management
- Ongoing case and risk management (including Inreach/Outreach provision where necessary)

Functional analyses will be undertaken by the HYM LD team when CYP present with severe challenging behaviours e.g. severe self-injurious behaviour or severe aggression and an underlying mental health issue is suspected. A functional analysis may not be warranted when CYP are not believed to have an underlying mental health issue; these CYP will be supported by CABS.

**Pharmacotherapy**

If pharmacological treatment is considered appropriate – full physical examination including height, weight, blood pressure and pulse rate using standard monitoring forms would be completed before initiation of treatment if appropriate; and any family history of physical health difficulties would be explored. Medication trials may include Stimulants for ADHD, SSRI’s for mood disorders, OCD, etc. The relevant care pathway should be followed for the young person’s presentation e.g. ADHD pathway, Mood and Emotional Disorders Pathway etc. Medication may need to be initiated at a lower dose and may require additional monitoring due to the risk of side effects in this cohort of young people. Shared care guidelines are in place with GP’s across Greater Manchester for most medications.

Where medication is required on a long term basis to manage a long standing condition or mood difficulty, cases remain open to LD HYM. In such instances, cases would be allocated a case manager within LD HYM who promotes effective behaviour management and change in addition to the use of medication. The LD psychiatrist will review medication periodically jointly with the case manager but will not generally be part of any other aspects of the child’s care plan at LD HYM. In such cases, close communication and working between the LD psychiatrist and the case manager is required. The role of psychological intervention in such cases
should be considered regularly; i.e. it may be possible to undertake short pieces of psychological work periodically.

Once intervention work is complete families are discharged back to their GP, however they are likely to need on-going support from services to help prevent relapse.

**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 Inpatient Psychiatric Unit, Fairfield General Hospital.

### 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.

### 6.0 Getting Risk Support

Risk management is a consideration in every level of the LD Care Pathway, both physical and psychological risk. An increase in deliberate self-harm, suicidal thoughts and intentions 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.

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.

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:

- Young people being seen within HYM would receive risk management via case manager or multi-agency team; duty (emergency and overdose) rota within HYM.
- Support in multiagency risk management
- Signposting
- Input into inter-agency work
- Consultation/liaison to other professionals
- To access urgent assessment if there are concerns around significant deterioration in mood or there are significant thoughts of, or there have been attempts at suicide (e.g. overdose), or significant self-harm then the young person should present to A&E for assessment where HYM may be asked to support around issues of assessment and admission.
- Supporting local safeguarding work alongside Children’s Social Care

### 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 audits will be undertaken to help develop and improve the HYM LD service. These may include audits of adherence to and helpfulness of pathways, adherence to NICE guidance, use of psychological therapy prior to medication (unless contraindicated), outcome measures and young people’s outcomes when using specific treatments.

### 8.0 Staffing

#### 8.1 Training
All staff to have the core skills necessary to identify, assess, case manage and offer basic interventions to CYP with LD. The HYM LD team is staffed by a Consultant Psychiatrist and Clinical Psychologist with a special interest and experience in LD. An LD nurse is also part of the team. Where appropriate, CYP on this pathway will be offered a psychological therapy by a suitably qualified therapist, and may include behaviour therapy, cognitive-behaviour therapy and family therapy, adapted for CYP with LD, for example. CBT staff are trained to either a certificate or diploma level. Interventions for the most complex presentations will be seen by clinicians qualified to diploma level and eligible for BABCP accreditation. FT practitioners all have specialist post-graduate level training in their field.

Regular training to the CORE HYM team will be offered to develop and enhance core skills in working with CYP with LD (for example, assessment, intervention and diagnostic overshadowing issues).

8.2 Supervision

All staff offering assessment and interventions on this pathway will receive monthly clinical supervision in line with the Trust supervision policy. The LD HYM team should also be able to access LD specific supervision. 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. Specific LD supervision can also be offered by the LD HYM team to the rest of the team.

9.0 Discharge/Transition

CYP making progress with a psychological therapy as evidenced by movement towards goals and/or routine outcome measures will be moved out of the HYM service into ‘Coping’. This may involve signposting to local voluntary or charitable organisations that can provide support, or to adult services. Some CYP may be moved into 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. There should be ongoing liaison with families, education and social care in relation to discharge. If appropriate, and where cases have been open to LD HYM for a long period, a discharge planning meeting with relevant professionals is important.

For any CYP who fail to engage with the service, the standard Trust DNA Policy will be followed, and any medication discontinued. A discharge letter will be sent to the GP and the referring agent, and any other involved professionals as appropriate and without exception when there remain issues of significant risk.

9.1 Transition
“...a purposeful, planned process that addresses the medical, psychosocial and educational/vocational needs of adolescents and young adults ... as they move from child-centred to adult-orientated healthcare systems” (Blum, Garell and Hodgman, 1993).

Young people who require a mental health service into adulthood should be supported to access Adult Learning Disability Mental Health Services. Referrals to the Clinical Psychologist team are only considered following an initial consultation. A referral to adult services will be made when young people reach the age of 17 years and six months. However, the young person can be seen in child services until the age of 18.

All professionals involved with the child (including education) should be involved in the young person’s transition. Approximately one month before the child’s 18th birthday, a meeting between the LD HYM case manager, adult transition social worker and the family should take place. All professionals involved with the child and family should be invited to attend.
References


Appendices

APPENDIX 1

- **Coping/Getting Advice**
  - Signposting
    - Supervision/one-off consultations
    - Regular consults to SLD schools
    - Consultation and liaison including advice around referrals into CAMHS/ASD assessment pathways
    - Advice around education based support groups
    - Advice around bibliotherapy, online self-help resources
    - Training to professional groups (detection and monitoring mental health issues and risks)

- **Getting Help**
  - S/T intervention if appropriate
  - Initial assessment (including risk assessment) joint assessment with CAMHS if unclear: re: appropriate service
  - Consideration of most appropriate worker (generic/specialist LD)
  - Signposting/liaison with other services if not mental health
  - Use of LD ROMS and goal based measures
  - Multi-agency meetings for complex cases; ongoing consultation

- **Getting Risk Support**
  - Risk management in complex LD cases generally needs to be multi-disciplinary: regular meetings as appropriate. Risk management plans: clear documentation and sharing of risk issues.
  - Consultation and advice to other agencies as requested.
  - Challenging behaviour leading to risk issues needs CAHS involvement and referral to CAMHS LD if concerns re: MH issue/consideration of medication.
  - Ideally previous functional analysis by CAHS prior to CAMHS referral.

- **Getting More Help**
  - Longer term interventions e.g. functional analysis for severe challenging behaviour.
  - Pharmacotherapy e.g. for ADHD, severe CBT, major mental illness
  - Evidence-based treatment interventions, e.g. family therapy, adapted CBT, narrative approaches, medication etc.
  - Need to provide ongoing monitoring of risk and contribute to multi-agency planning around complex cases.
APPENDIX 2

Diagnostic criteria for a learning disability / mental retardation - ICD-10 criteria


**Mental retardation**
*(F70-F79)*

**Definition**

A condition of arrested or incomplete development of the mind, which is especially characterized by impairment of skills manifested during the developmental period, skills which contribute to the overall level of intelligence, i.e. cognitive, language, motor, and social abilities. Retardation can occur with or without any other mental or physical condition.

Degrees of mental retardation are conventionally estimated by standardized intelligence tests. These can be supplemented by scales assessing social adaptation in a given environment. These measures provide an approximate indication of the degree of mental retardation. The diagnosis will also depend on the overall assessment of intellectual functioning by a skilled diagnostician.

Intellectual abilities and social adaptation may change over time, and, however poor, may improve as a result of training and rehabilitation. Diagnosis should be based on the current levels of functioning.

**Coding-Hint**

Use additional code, if desired, to identify associated conditions such as autism, other developmental disorders, epilepsy, conduct disorders, or severe physical handicap.

**Modifiers**

The following fourth-character subdivisions are for use with categories F70-F79 to identify the extent of impairment of behaviour:

.0 With the statement of no, or minimal, impairment of behaviour

.1 Significant impairment of behaviour requiring attention or treatment

.8 Other impairments of behaviour

.9 Without mention of impairment of behaviour
### Mild mental retardation
**Definition**
Approximate IQ range of 50 to 69 (in adults, mental age from 9 to under 12 years). Likely to result in some learning difficulties in school. Many adults will be able to work and maintain good social relationships and contribute to society.

### Moderate mental retardation
**Definition**
Approximate IQ range of 35 to 49 (in adults, mental age from 6 to under 9 years). Likely to result in marked developmental delays in childhood but most can learn to develop some degree of independence in self-care and acquire adequate communication and academic skills. Adults will need varying degrees of support to live and work in the community.

### Severe mental retardation
**Definition**
Approximate IQ range of 20 to 34 (in adults, mental age from 3 to under 6 years). Likely to result in continuous need of support.

### Profound mental retardation
**Definition**
IQ under 20 (in adults, mental age below 3 years). Results in severe limitation in self-care, continence, communication and mobility.

### Other mental retardation

### Unspecified mental retardation
APPENDIX 3

Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges (NG 11, 2015). This guideline offers evidence-based advice on prevention and interventions for children, young people and adults with a learning disability and behaviour that challenges. (See following page).
Patient Journey/Pathway

School Consultations
- Initial advice
- Brief systemic work
- Formulation meeting
- CAF meeting
- If problem remains and meet HYM criteria request

Referral

Case seen by CABS assessed as requiring Mental Health Service

Single Point of Entry to HYM
- Urgency and risk assessed
- Assess if appropriate for young person to attend or just parents/carers
- Consider if assessment should be joint with CABS team

Risk assessed as urgent

Access next duty slot available
- Seek consultation with LD

Severe LD
(attending Oakdale, Cromwell, Dovestones)

Risk assessed as not urgent

Mild/moderate LD

Access next available appointment with LD team member

Access next available appointment with generic team member (consultation available from LD team)

Initial assessment

Problem appears to be behavioural and does not meet threshold for mental health service.

Pass referral to CABS

Complex learning and mental health needs requiring specialist or systemic intervention

Extended assessment and intervention by LD team