Reference Number: *UHB 539* **Version Number:** 1	**Date of Next Review:** *30/01/2028* **Previous Trust/LHB Reference Number:** *n/a*

CMHT Standard Operating Procedure Treatment

Policy Statement

Even though all patient treatment is bespoke and individual to that person and their needs it is essential that the CMHT ensures that all teams are offering the same level of service and working to the same operating procedure around treatment within a CMHT. It is also important to clearly set out the expected practise and expectations around care received in particular how the CMHTs will provide treatment in line with the Welsh Government expectations and legislation in the Mental Health Measure (2010). This operating procedure looks to address these important factors and set out a standard operating procedure of treatment within a CMHT. This policy is focusing on treatment offered to patients referred to and allocated for treatment within a CMHT.

Policy Commitment

The purpose of this policy is to ensure that Treatment given from the CMHTs managed by the Cardiff and Vale UHB is effective, consistent and organised around the needs of individual service users and carers.

Supporting Procedures and Written Control Documents

Mental Health Measure (2010) and Mental Health Measure Code of Practise
Cardiff and Vale UHB Clinical risk assessment and management policy 2023
Other CMHT Standard Operating Procedures.

Scope

This document defines the procedure for treatment received whilst allocated under a worker from the community mental health teams, in Cardiff and the Vale of Glamorgan.

Equality Impact Assessment	An Equality Impact Assessment (EqIA) has not been completed as there were no identifiable impacts of this policy review/update.
Policy Approved by	Mental Health Clinical Board
Group with authority to approve procedures written to explain how this policy will be implemented	Mental Health Clinical Board
Accountable Executive or Clinical Board Director	Dr Rim Al-Samsam

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.

Summary of reviews/amendments			
Version Number	**Date Review Approved**	**Date Published**	**Summary of Amendments**
1	*30/01/2025*	*03/07/2025*	*Version 1*
2			

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1. Team allocation for treatment

1.1 The discussion around whether allocation is needed, and to which discipline or disciplines, will be decided when the assessment is fed back to the multi-disciplinary team (this may be the full MDT or a smaller MDT panel).

1.2 The MDT should consider what the person's needs are, and which staff member (or which disciplines) might be most helpful to the person's care and management at that time. As part of the process of allocating staff, a care co-ordinator should be identified, and that care coordinator will have the lead responsibility – along with their colleagues – for drawing up and for overseeing the Care and Treatment plan (see below).

1.3 Once the MDT has discussed which discipline(s) might usefully be involved the allocation request will go to the lead for the appropriate discipline(s) for them to allocate to specific staff members.

1.4 The allocated staff member(s) should receive the service user's details and also some feedback on the nature of support and input required. The allocated staff member(s) should make contact with the service user in the agreed timescale (timescale dependent on service user presentation and agreed between discipline lead and staff member). It is expected that contact is made within a maximum of five working days.

2. Initiating Treatment

2.1 It is good practice for the care coordinator to be the first member of staff to make telephone contact after allocation, and for this to happen

at the earliest possible time to introduce themselves, pass on information about the working plan for care, and to obtain any updates from the service user. It is expected that contact is made within a maximum of five working days. Sometimes several members of the team might be allocated to support a service user, and it might be agreed that – for example – the psychiatrist will act as care coordinator but that a nurse will initiate contact (for example to gather more information)

2.2 Whoever meets the service user initially should ensure that the service user (and family where applicable) is aware of how to contact the team, access to the duty system and the ability to contact 111 option 2 outside of hours.

3. Care and Treatment plans

3.1 The Mental Health Measure states that *'Care and Treatment plans should be provided as soon as is reasonably practicable after the individual has become a relevant patient and the care coordinator has been appointed.'* Even though a specific time frame is not specified it is best practise that this is completed within 6 weeks and then distributed within 2 weeks of the meeting.

3.2 Care and Treatment plans (hereafter CTPs) need to be coproduced by the care coordinator, the service user, and any other identified relevant parties by the service user ,such as family. The CTP should be an excellent opportunity to set out a service users needs, the best treatment and an understanding of the shared responsibility of these goals. The CTP provides an opportunity for there to be a clear and shared understanding of the service users needs, the treatment required and a shared responsibility to reach these goals.

3.3 The CTP should be a holistic approach to the service user's care. It is important that the CTP engages the service user in what changes they want to make and what steps can be made to achieve this. The CTP should be outcome focused and can provide an agreement to treatment clarifying purpose and focus. It is important that agreed outcomes are as far as possible SMART (Specific, Measurable, Achievable, Relevant and Timely) to help clarify purpose and focus and allow for clear review and working towards independence from the team and thinking about steps towards discharge from the beginning.

3.4 Every effort should be made to engage a service user and accommodate their views. However in rare cases there is disagreement or lack of engagement CTPs need to be created using

the information available and reviewed as relationships are built for further details please see The Code of Practise of Parts 2 and 3 of the Mental Health Measure 4.11.

3.5 CTPs should be reviewed and updated once a year as a minimum. A review should also be undertaken at the service user's request, and after any significant clinical change (e.g. admission; significant treatment change; change in psychological function or well-being etc).

4. Risk Assessment

4.1 All service users within the CMHT require a comprehensive risk assessment: the UHB uses the Wales Applied Risk Research Network assessment (hereafter WARRN) format, and all service users should have a WARRN. The WARRN includes a review of risks, and also identifies plans to mitigate those risks.

4.2 A WARRN is completed as part of the initial assessment, but will likely only offer an overview of risk, and the care coordinator should ensure that the WARRN as part of the care planning process and updated as needed.

4.3 WARRNs are best completed a multi-disciplinary team (so the care coordinator should discuss the plan with other staff members who have worked with/are working with the service user as part of the process). For people where there is current significant risk to self or others it might be necessary to convene an MDT meeting to agree the WARRN.

4.4 The WARRN should be reviewed at a minimum of once a year. A WARRN should also be revised after any significant clinical change (such as an admission, significant treatment change, change in psychological function or well-being etc) in line with the Cardiff and Vale UHB 'Mental Health Clinical Risk and Risk Mitigation Management Policy'.

4.5 WARRNs should be coproduced with the service user: if there is dispute over perceived risks then a discussion should be had but it is important for any identifiable risks to be documented in the WARRN. Families should be consulted around the WARRN especially if they have been identified as part of a risk management or safety plan. Where consent to share information with family has been declined but

a family member is expressing concerns about risk this should be listened to and considered as part of the WARRN.

5. Engagement with other services

5.1 When service users' care is delivered (on a temporary basis) by an inpatient service, the care coordinator will communicate with that service, and be updated about changes to the care and treatment plan, particularly during periods of transition between services.

5.2 If a service user is care coordinated within the CMHT, but the service user is receiving care from another diagnosis-focussed team (e.g. an eating disorders service) or tertiary service (e.g. Cynnwys), it is the responsibility of the specialist team to clearly communicate and discuss with the care coordinator any plans for care. The CMHT care coordinator has oversight and responsibility for the plan, and it is therefore important that ideas are discussed and agreed before they are implemented. They should also provide regular clear updates on the input for that service user so the care coordinator is able to have knowledge of all areas of the service users care. It is imperative that this is done prior to any major care changes such as discharge (please reference the Standard Operating Procedure for discharge from CMHTs) from the team, commencement of a specific therapy.

6. The role of the care coordinator

6.1 This is taken directly from the Mental Health Measure Parts 2 and 3 Code of Practise

The care coordinator is responsible for the following:–
• working collaboratively with the relevant patient and the relevant patient's mental health service providers with a view to agreeing the outcomes which the provision of mental health services are designed to achieve;
• ensuring that a care and treatment plan is developed and written;
• ensuring care and treatment plans are reviewed and revised;
• providing advice to service providers on the effective coordination of the care which is delivered;

• keeping in touch with the relevant patient. The care coordinator may also choose to keep in touch with family and carers where appropriate or necessary.

6.2 Care coordinators are the principle source of information for the relevant patient and are responsible for seeking their active involvement and engagement in the care planning process. They also have a significant role in managing relationships with a wider range of partners in the care and treatment process. The care coordinator may also deliver certain components of the care and treatment plan themselves.

7. Change or removal or allocated worker

7.1 There may be times in which due to unforeseen circumstances or service issues such as a staff member leaving that a service users allocated worker must be changed. There will also be times when due to clinical presentation and need one of a service users allocated workers may be removed or changed such as if a specific piece of work is completed. It is important that the impact on the service user is considered through this process and that it is done in a sensitive and careful manner. It is important that there is a clear rationale given for the change and as much notice is given as possible. Consideration needs to be given around endings particularly of more longer-term therapeutic relationships and how the service user can be supported with this. Where possible this should be done as part of a Care and Treatment plan review and always include the service user and where possible their family.

7.2 Vacancies: When a vacancy arises within any discipline in the multi-disciplinary team, the senior lead from each discipline will scrutinise and where appropriate re-allocate the absent member's caseload. They will have a sound clinical awareness of each patient's needs through regular clinical caseload supervision with the now absent individual. In all cases, the Clinical Lead and Consultant Psychiatrist will inform the Integrated Manager of contingencies being implemented. Where resources from within that specific discipline are exhausted and wider team reallocation is required, the Integrated Manager will take this requested need to the Multi-disciplinary Team and speak with the individual clinical leads to scope out further capacity. Patients and Carers will be informed of any changes in care co-ordination arrangements as soon as possible.

7.3 Sickness and other absence: When any member of the multi-disciplinary team has a period of extended sickness or absence over 28 days, the senior lead from each discipline will scrutinise and where appropriate re-allocate the absent member's caseload. They will have a sound clinical awareness of

each patient's needs through regular clinical caseload supervision with the now absent individual. The Clinical Lead and Consultant Psychiatrist will discuss and agree with the Integrated Manager any contingencies being implemented. Where resources from within that specific discipline are exhausted and wider team reallocation is required, the Integrated Manager will take this requested need to the Multi-Disciplinary Team and speak with the individual clinical leads to scope out further capacity. Patients and Carers will be informed of any changes in care co-ordination arrangements as soon as possible.

8. Frequency of contact

8.1 Frequency of contact with allocated workers needs to be negotiated and agreed between the service user and allocated workers and be in line with the CTP. Risk and clinical presentation need to dictate frequency of contact and consideration of increasing frequency of contact should be made.

9. Specific treatment pathways

9.1 If a service user is receiving some specific treatments, there may be a relevant treatment pathway for this element. The specific treatment pathways are to be found within the appendices of this procedure. Included in this is the treatment pathway for occupational therapy input, psychology input, and patient's prescribed antipsychotic medication.

Appendices:

1. Treatment under Psychological Therapies
2. Occupational therapy CMHT Map

1. Treatment under Psychological Therapies

Psychological Therapy: Psychologists in CMHTs most often offer therapy where people have more complex difficulties, usually as part of 'stepped care' once people have tried other sources of support such as therapy groups or guided self-help (e.g. www.stepiau.org). They almost always offer an assessment first to check that the person might benefit from therapy, rather than putting people directly onto a therapy waiting list: they use NICE and Matrics Cymru guidelines to inform evidence-based therapies for people in secondary mental health care.

Psychologists are trained in a number of different psychological therapies, and this range varies from psychologist to psychologist but always includes CBT. Psychologists often use an integrative approach (that is, combining different therapies to address a person's needs) to meet the complex needs of people in CMHTs.

Therapeutic groups: As well as individual therapy, psychologists run a number of cross-locality therapy groups alongside our nursing and support worker colleagues. Currently, these include the DBT Skills group and Hearing Voices group.

These groups are run in the service of CMHTs, and are not standalone or 'tier one-and a-half' services – as such all referrals for the groups need to remain open to and supported by the CMHT for the duration of the group. You can request more information about these groups from your team psychologist who will also be able to pass on information about making referrals.

Service users being referred for therapy (or assessment for therapy) should -

- ✓ be suitable for secondary care CMHT services (we do not provide a standalone therapy service)
- ✓ have an ability and willingness to observe/reflect on self, to explore personal issues and actively collaborate with a therapist to work towards a change in the target difficulty.
- ✓ have already attempted other therapy interventions in a 'stepped care approach' (e.g. having supported stabilisation work in the CMHT; doing CBT for Depression through the Hub before being referred for individual CBT in the CMHT). We recognise that sometimes people's needs do not map well onto primary care provision, and we are happy to discuss exceptions to this guidance.
- ✓ be able and willing to dedicate the time and personal resources required for therapy.

People who are unlikely to benefit from therapy include -

X those who have a recent history of persistent non-attendance or other indicators of ambivalence.

X those who are engaging in serious drug/alcohol use, which may interfere with ability to make use of psychological input.

X clients with serious contra-indicators (for example, living in insecure or unsafe conditions; where attending to a problem is likely to significantly increase risk; on-going legal proceedings).

X those whose primary presenting problems would be more appropriately cared for by another service (e.g. Eating Disorder),

X those who are on a waiting list for another form of psychological therapy (e.g. awaiting trauma therapy through TSS), or in receipt of therapy from other services (even if focussed on different issues). Please consider which type of support might be most useful rather than referring to multiple therapy/counselling services (we're very happy to offer advice on this).

X Those who have already completed several courses of psychosocial therapy. Re-referrals would usually only be considered a minimum of 6 months following completion of a psychological therapy, and with a change of circumstances that suggest further therapy may help.

Please note: We are unable to offer individual therapy on the basis that the person prefers individual input to group work unless there are good *clinical* reasons to do so (e.g. the person has difficulties with memory or attention that make a group setting difficult).

It is important to discuss the potential referral with the person, and to check that they are happy to meet with the psychologist.

Occupational Therapy CMHT Map

Referral to Occupational Therapy (PARIS checked several times a week)

Occupational Therapy Initial Assessment Period

Formulation of Occupational Goals & Care Planning

Occupational Therapy Interventions

Occupational therapy tools/resources that can be used within the occupational therapy process (based on c
necessary to use all

Referral via: MDT colleague, CMHT referral meeting, CMHT screening feedback meeting, CMHT allocation meeting, handovers from within OT service:
Discussion between referrer and an OT is essential
Referrer logs referral on PARIS
Review Clinical Information & Relevant Case Notes
An OT Screening Assessment arranged
Referral to be accepted/rejected on PARIS and

Initial Assessments to be completed as Appropriate and Relevant for the Individual:

- OCAIRS
- MOHOST
- Occupational Self-Assessment

Other Available Assessments:

- Meyers Lifestyle Questionnaire
- Interest Checklist
- ADL Assessment (of any relevant task)
- Home Visit
- MOCA/ACE III
- ACDM
- Sensory Profile

Complete Occupational Formulation in collaboration with Service User:

- Occupational Identity
- Occupational Competence
- Key Occupational Issues

Care Planning in collaboration with Service User:

- Aims
- Goals
- Interventions

Consider sustainability issues

Dependent on Individual Occupational Therapy Goals:

- 1:1 Therapy Sessions
- Recovery Through Activity
- Signposting to other organisations/ resources

This part of the process can involve an almost infinite number of intervention possibilities
OT Tech involvement could be considerable in this part of the process