

Reference Number: UHB 564 Version Number: 1	Date of Next Review: 27/06/2028 Previous Trust/LHB Reference Number: n/a
CMHT Standard Operating Procedure Discharge	
Policy Statement	
<p>It is essential that the CMHT maintains a capacity to undertake new assessments and take on work with new users. The CMHT must therefore be proactive in considering when a service user is ready for discharge back to the Primary Care Team.</p> <p>Within a Recovery Model of work the CMHT will assist the service user to maximise their potential for recovery and return to independence and discharge from the secondary services. In addition to this there will be a cohort of individuals who have a severe and enduring mental illness who will achieve relative stability. as guided by the Mental Health Measure it is appropriate to discharge these individuals to primary care, with the legal right to self-refer back into the CMHT within the following 3 years if required.</p>	
Policy Commitment	
<p>The purpose of this policy is to ensure that Discharges from CMHT managed by the Cardiff and Vale UHB is effective, consistent and organised around the needs of individual service users and carers.</p> <p>Not all clinical cases will align with the devised procedure. In instances where this is the case, clinical judgement and informed rationale will be required for actions taken in response to daily working tasks. Each time this is the case, safe care and individual service user need must be prioritised.</p>	
Supporting Procedures and Written Control Documents	
<p>117 Policy and code of practice Mental Health Measure Prudent healthcare Treatment SOP</p>	
Scope	
<p>This document defines the procedure for the discharge from community mental health teams care, in Cardiff and the Vale of Glamorgan.</p>	
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	MHCB Controlled Document Oversight Group
Accountable Executive or Clinical Board Director	Daniel Crossland

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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 Director](#)

Summary of reviews/amendments

Version Number	Date Review Approved	Date Published	Summary of Amendments
1	27/06/2025	Feb 2026	Version 1
2			

1.Introduction

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It is an essential requirement of good patient care that discharge is planned and co-ordinated on a multi-disciplinary basis and that patients and carers are involved in making decisions and kept informed of their discharge plans.

Clear expectations should be jointly agreed with the service user at the time of agreement of involvement with the CMHT, with an understanding of specific pieces of work that are required and achievable goals that need obtaining in order to support the identification of discharge. Discharge should be managed as a process and not an isolated event. Discharge planning should be considered throughout an individual's involvement with the CMHT.

The individuals concerned and their carers should be fully involved in this process and kept fully informed by regular reviews and updates of their care and treatment plans and be aware of an estimated date of discharge. Liaison with other involved agencies will take place early in any work undertaken to ensure continuity of care.

2. Discharge at point of End of Treatment

Where possible, discharges from Secondary Care if planned following a Care and Treatment Planning meeting involving multidisciplinary discussion and actively incorporating the views of patients, their family and carers and any voluntary or independent sector agencies providing care and support to the service user. Exceptions to this may occur if the service user disengages or moves away unexpectedly and without notification.

Discharge from the CMHT to the Primary Care Team will be considered when:

- Service users have achieved Care and Treatment goals and require only minimal intervention that can be offered in primary care service
- If there is no longer a meaningful or active intervention occurring e.g. seen at more than 3 monthly intervals with diagnosis and treatment plan established, stabilised and appropriate for management within a Primary Care provision.
- Care being delivered if no longer doing some measurable good.
- The diagnosis and treatment plan are suitable for continuation by the individuals Gp.
- Service users who have an established severe and enduring diagnosis with a period of recovery and mental stability (no relapse requiring significant intervention) for a period determined and agreed during MDT CTP reviews and no longer requiring specialist interventions/services
- Service users receiving commissioned care are not suitable for discharge as require ongoing review via the Complex Care and Commissioning Service in conjunction with the allocated Care Co-Ordinator.
- Service users in receipt of Local Authority Care Packages, managed within the CMHT are required to remain open to the CMHT pending discussions with Adult Services to agree appropriateness of transfer of this responsibility.

At the point where it is considered the service user has recovered and no longer requires specialist secondary mental health services discharge back to the Primary Care Team should take place via the CTP process under Part 3 of the Welsh Mental Health Measure.

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A CTP review meeting should be planned before discharge, which includes service users, carers, all involved staff and GP is invited to. The GP should be made aware if unable to attend the review meeting they are able to inform the care team of key considerations from their perspective.

3. Documentation

Prior to any discharge from the CMHT a relapse plan will be agreed with the service user and this will include a contingency plan identifying risk factors, warning signs and actions to be taken in the event of any difficulty occurring after the discharge back to the GP takes place in line with WARRN principles.

Patients discharged from CTP and CMHT should always receive a personalised and empathic discharge letter, with a copy sent to their GP. This letter should include; acknowledgement of problem received services for, action taken/interventions delivered (or offered if disengaged), progress made, reason for discharge, relapse indicators, and actions to take if becoming unwell in future. The patient should also be advised of the medication they are prescribed at point of discharge within their discharge advice letter. This should align to the Gp's discharge notification letter. Should the patient be discharged due to dis-engagement/In-absentia; medically led clinical advice as to the continuation of any medication specific to the case should be provided to both the patient and the Gp. This should be translated for the service user if identified that English is not their first/preferred language.

Service users should be reminded of their right to request an assessment under part 3 of the Welsh measure inclusive of the specific date Part 3 entitlement to self-refer ends.

Appropriate discharge information must be communicated to the GP (i.e. medication) and other appropriate agencies outlining explicitly that secondary care has now ended and moved to primary care provision.

Whenever possible WARRN risk formulations need to be updated collaboratively with service users. This is to reflect risks at point of discharge and management plan in relation to this. Of particular relevance sections outlining what signs, symptoms or circumstances would prompt a reassessment.

4. Disengagement/ In-Absentia

Should a service user refuse to engage with the CMHT or not actively participate in therapeutic interventions towards their goals. Dependant on the complexity and risk this may be appropriate to be discussed within the clinical team caring for the person or the multi-disciplinary team meeting.

Risks to self and others will be assessed and an action plan, dependent on risks and need, agreed prior to discharge. A desktop review of the clinical case prior to agreement of discharge must be completed prior to a decision to discharge to consider known current and historical risk factors.

All reasonable attempts at engaging a service user in their care are made and attempts to identify the reason for disengagement. It may be appropriate to consider contacting associated people for example carers, family or other professionals involved. A consideration needs to be given to any safeguarding concerns.

The decision and its rationale must be recorded in the patient's electronic record and the GP informed in a timely manner.

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For cases of in-absentia related to S117 the 117 policy guidelines must be followed.

5. Supporting carers at point of discharge

All regular and substantial carers should have their needs and views recorded throughout duration of care. They should be offered appropriate services including local authority assessments and/or use of 3rd sector agencies and charities that are available to support them.

Carers should be involved in discharge planning process where consent is in place and provided with written information that is pertinent to the patient's case for example – signs and symptoms/relapse indicators, or information on medication management.

If citing Carers as point of contact and support in a crisis/contingency plan they must be aware and agree in line with the expectations of WARRN. Their views and opinions are to be recognised and recorded appropriately. Carers should be made aware of how/where to access support if the person becomes unwell in future.

6. 117

- If service user is subject to 117 aftercare this must be reviewed and discharged before discharging from CMHT service
- 117 policy should be referred to for specific guidance on this.
- Discharge in cases of 117 must align to the statutory obligations of the Mental Health Act.

Appendices:

1. Mental Health Measure Discharge Letter Template (Part 3) example

Appendix 1

Dear

Further to our last meeting, I am now writing to inform you of the arrangements for your discharge from the

At your last review onwe agreed that you should now be discharged from the team as your mental health is stable.

We noted that the following signs may be indicators of you becoming unwell:

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If you notice these things, you can try

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..... as these things have been identified as helpful.

If you continue to experience difficulties you should speak to your GP as a matter of urgency, or alternatively, you or someone on your behalf can contact 111 option 2 which is a 24-hour phone line manned by mental health staff to provide advice and refer on to appropriate services if required

In addition to these arrangements you are also entitled to seek a reassessment by our service, within three years of this discharge date being

If you would like to seek a reassessment by our service then please contact your local CMHT, these are allocated by GP therefore if you have moved may differ to the one you last saw, if you are unsure call the team you are familiar with who can advise which team to call. The CMHT will discuss your current difficulties on the phone and may offer advice, arrange an appointment for a reassessment or assist with making further arrangements if another agency/service more appropriately meets your needs.

If you require support or advice outside of community mental health team working hours you are advised to contact the out of hours GP service or Community Advice Listening Line: 0800 132 737 or 111 service.

We hope you have found the care from (Specify Gp) CMHT helpful, whether positive or negative feedback is useful for us to shape future services and we are keen to hear from you. There are several ways you can do this; by phone or in writing to the manager of the team

Yours sincerely

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