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**OPERATIONAL POLICY  
FOR  
INTEGRATED COMMUNITY MENTAL HEALTH TEAMS**

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**OPERATIONAL POLICY  
FOR  
INTEGRATED COMMUNITY MENTAL HEALTH TEAMS**

## **1. INTRODUCTION**

Community Mental Health Teams (CMHTs) in Cardiff & Vale are jointly operated by Cardiff & Vale University Health Board (UHB), in partnership with Cardiff County Council and Vale of Glamorgan Council. They offer a specialist multi-disciplinary service for individuals suffering with mental ill health. CMHTs form part of an integrated whole system approach that is delivered in conjunction with inpatient, crisis and specialist mental health services.

Within Cardiff & Vale the modernisation agenda and wider system changes will all have an impact of the operation of CMHTs. In particular, the introduction of Primary Care Mental Health Liaison Workers through the Mental Health Measure and 'New Ways of Working' should lead to CMHTs being primarily involved with service users most requiring the assistance of the secondary services.

This Operational Policy outlines the role and function of CMHTs based on Welsh Assembly Government Guidelines and will be subject to continuing review and development.

The service offered by the CMHTs is based on good practice guidelines outlined in the National Service Framework (NSF), Cardiff & Vale UHB policy on the Care Programme Approach (CPA) and the Department of Health Mental Health Policy Implementation Guide and will embrace the principles of the Recovery Charter (Charter for Mental Health, C&V).

People referred to a CMHT will receive a comprehensive assessment taking into account their mental health, physical health and social care needs. Carers may also be offered a carers assessment which may enable them to receive additional support in their role. Following assessment, appropriate services are offered if needs for mental health services, including social care services, are identified. There will therefore be a need for people assessed by the CMHT to sign a disclosure agreement that allows the sharing of confidential information gathered at assessment and during ongoing interventions with other members of the multi-disciplinary team and wider mental health and social services where appropriate. This confidentiality restriction does not apply when a criminal act is disclosed.

## **2. PURPOSE AND AIMS**

Community Mental Health Teams are committed to:

- Ensuring all health and social care needs and risk are assessed and that service users are managed within the Care Programme Approach and an appropriate treatment / care plan and risk management plan agreed. The plan will include the views of the service user and relevant carers and a copy will be provided for them.

- Providing services that are accessible to all sections of the local population in compliance with equality and diversity principles and relevant legislation.
- Working with service users within a model of care that aids recovery and enables them to return to their full potential in day to day life and, when appropriate, discharge from the secondary services.
- Working collaboratively with and referring appropriately to other Cardiff & Vale services such as Crisis Resolution & Home Treatment Teams (CRHTT), Inpatient services, Assertive Outreach services, Drug and Alcohol services, Forensic Services, Accident and Emergency (A&E) Liaison Services, Community Support teams, Older Peoples Mental Health Services, Primary Care Gateway Services, Community Learning Disability Teams (CLDTs), Specialist Learning Disability Services and Child and Adolescent Mental Health Services and any new services that are developed.
- Enabling service users to have access to local advocacy services.
- Assessing the needs of carers and ensuring appropriate support is given within available resources.
- Actively involving service users and carers in planning and delivering mental health services.
- Promoting the needs of people with mental health problems and reducing the stigma associated with mental health care.
- Working in collaboration with other statutory and voluntary agencies and ensuring the needs of the service user are taken into account.

### **3. TEAM MEMBERSHIP**

The CMHT core team unites specialist Medical, Nursing, Occupational Therapy, Psychology, Social Work, Support Workers and Administrative staff within a team base and a single Integrated Management structure. This group of professionals are listed as core staff according to WAG guidelines. The Integrated Manager represents the authority of the partner organisations that make up the composition of the CMHT and may be from a Health or Social Work background.

The Integrated Team Manager is responsible for the day to day operation of the CMHT, for the delivery of the services it provides and to ensure the delivery of an effective clinical pathway for the individual service user through the efficient coordination of the constituent members of the CMHT. This includes the day to day line management of the constituent team members of all disciplines although each discipline will continue have its own professional lines of accountability.

The Integrated Manager will have responsibility for ensuring effective waiting list management of all parts of the CMHT business and reporting on performance management to the relevant host organisation.

All disciplines will contribute both professional and generic skills to their team. Each team member is professionally responsible for clients under their care and for recognising the limits of their own competence and job description. This includes the responsibility to seek appropriate supervision both within the team and within their professional structure.

Non-registered staff will work under the clinical guidance and direction of appropriate professionals.

Some CMHTs also have the support of specialist workers from other agencies such as employment support workers who can provide practical help in maintaining or securing meaningful employment. It is intended that there will be equity of service provision across all CMHTs as to provision of services through future service developments.

#### **4. TEAM LOCATIONS AND OPENING HOURS**

CMHTs are open to the public between 9.0am – 5.00pm Monday to Thursday and 9am – to 4.30 pm on Friday.

All CMHTs have an answer phone message giving details of emergency contact numbers out of hours.

Service Users known to the CMHT who require a higher level of support from a CMHT (but not at the point of needing admission) could be referred to the weekend CPN service who operate between 9.00am and 5pm weekends and bank holidays. If it is deemed that the service users needs exceed that of the weekend CPN service, i.e. admission is required, a referral to the CRHTT would be appropriate.

If a service user known to the CMHT is assessed out of hours by the CRHTT, and deemed to need extra support but not admission, a referral should be made to the weekend CPN service.

#### **5. PRIMARY CARE ALIGNMENT**

Access to CMHTs is based on the alignment with GP practices in Cardiff and the Vale. Each CMHT is aligned to a number of Primary Care Practices in a defined geographical locality. There are 7 CMHTs based across Cardiff and Vale.

- Cardiff North West, Gabalfa Clinic

Bishops Road Medical Centre, Birchgrove Surgery, Llwynbedw Medical Centre, Llanishen Court Surgery, Meddygfa Llwyncelyn Practice, Whitchurch Village Practice, North Cardiff Medical Centre, North Road Medical Practice, Llandaff North Medical Centre, Whitchurch Road Surgery, St Isan Road Surgery, Taffs Well Health Centre.

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- Cardiff North East, Pentwyn Health Centre

Cyncoed Surgery, Pontprennau Medical Centre, Llanedeyrn Health Centre, St.Davids Medical Centre, Llanrumney Medical Group, Wellwood Surgery, Brynderwen Surgery, Trowbridge Health Centre, Daintree Surgery, Willowbrook Surgery, Rumney Medical Practice.

- Cardiff South East, Links Centre,

Meddygfa Albany Surgery, Four Elms Medical Centre, Branch Surgery (Sterling Close), Crwys Medical Centre, The City Surgery, Clifton Surgery, Salisbury Road Surgery, Cardiff Health Access Practice, Cloughmore Surgery, Roathwell Surgery, New Moors Surgery, Cathays Surgery, Penylan Surgery, Roath House Surgery, Minster Surgery.

- Cardiff South, Hamadryad Centre

Riverside Health Centre, Penhill Surgery, Kings Road Surgery, Meddygfa Canna Surgery, St David's Court Surgery, Meddygfa Lansdown Surgery, Saltmead Medical Centre, Grange Surgery, The Surgery (Corporation Road), Clare Road Medical Centre, Grangetown Health Centre, Grange Medical Practice, Butetown Health Centre.

- Cardiff West, Pendine Centre

Fairwater Health Centre, Westways Surgery, Woodlands Medical Centre, Llandaff Surgery, Greenmount Surgery, Ely Bridge Surgery, Danescourt Surgery, Radyr Health Centre, Caerau Lane Surgery, Byways Surgery

- Barry, Vale of Glamorgan, Amy Evans Centre

Eryl Surgery, Rhoose, Waterfront Medical Centre, Barry, Court Road Surgery, Barry, Vale Family Practice, Barry, West Quay Medical Centre, Barry, Ravenscourt Surgery, Barry, Practice of Health, Barry, Highlight Park Medical Centre, Barry

- Eastern Vale, Hafan Dawel

Station Road Surgery, Penarth, The Health Centre, Penarth, Albert Road Surgery, Penarth, Redlands Surgery, Penarth, Dinas Powys Group Practice, The Family Practice Health Centre, Dinas Powys, Sully Surgery, Sully.

Meetings should take place between senior CMHT members including the Integrated Manager and Consultant Psychiatrist and their Primary Care Practice at least 6 monthly. Good communication links between Primary and Secondary Care Services should be maintained and this forum should provide an opportunity for local resolution of discussion of interface problems. Most GP Practices have regular business meetings which could be used for this purpose.

### **Homeless People**

Usually people of no fixed abode are registered with a local GP and these should be allocated to the appropriate CMHT as above.

Service users not registered with a GP practice who appear to require access to services from the CMHT will be allocated to their nearest CMHT based on proximity to their home address. This also applies to asylum seekers and refugees.

If a person does not normally reside in Cardiff & Vale ordinarily, CMHT access is determined by the GP practice in the County where they are registered. In such cases any referral should be assessed, treatment arranged by the CMHT receiving the referral, if this is required and a plan agreed to ensure any risks are managed until they return to their home area. The home area GP and other involved mental health professionals should be informed of any assessment and treatment.

If a person not usually resident in Cardiff & Vale requires admission to a Mental Health Unit they may be admitted in an emergency, under the out of area treatment ruling (OATS). Following admission they should be transferred, as soon as is reasonable, to the area responsible for their care.

If a period of treatment is commenced, a Care Co-coordinator should be allocated and when / if transfer is agreed this should be via the CPA process (see Care Programme Approach).

Specialist GP services; Safehaven (secure GP practice) and Cardiff Health Access (Asylum Seekers) will be allocated to a CMHT based on the nearest one to their home address. The Atrium (Cardiff University) will be allocated to Pentwyn CMHT as per contractual agreement.

People who were homeless prior to an inpatient admission should be allocated to a CMHT based on their GP or home address on discharge.

### **Transfer between CMHTs**

Transfer between CMHTs can be an issue when a service user moves address and or GP practice. This often coincides with discharge from hospital after an inpatient admission and can lead to problems in continuity of care. In the event that a service user needs to transfer from the care of one CMHT to another, communication should be sought at an early a date a possible to arrange transfer via the CPA process. Ideally, if possible the care coordinator should arrange a meeting with the new care coordinator and the service user to handover care.

In the event of specialist 24 hour placements, where there is a strong likelihood of the placement breaking down, a period of three months should elapse before handing over the care to another CMHT. Otherwise transfer should take place as soon as possible.

### **Interface with Primary Care**

The Integrated Manager and a Senior Clinician will meet with their Primary Care Practices at six monthly intervals to discuss operational issues at the Primary Care business meetings.

## 6. SERVICE USER PROFILE

The CMHT services are offered according to need and primarily, but not exclusively, to adults of working age (18-65), who require assessment by a specialist mental health professional. This would include people, who after screening may be referred on to specialist services such as the Eating Disorder Service, or Crisis Resolution & Home Treatment Team (CRHTT), be taken on by the CMHT or referred back to Primary Care.

Referrals for service users under the age of 18 and in full time education should be referred to the Community Adolescent Mental Health Services (CAMHS). Referrals for people over the age of 16 and under the age of 18 will be assessed by the CMHT. People in the care of CAMHS who are likely to need ongoing care from an adult CMHT should be subject to robust handover processes to ensure effective transfer to adult mental health services. This will change in April 2012 when all referrals under the age of 18 will be assessed by CAMHS. If a service user first presents at the age of 17 and six months, they should be taken on by an adult CMHT directly rather waiting for six months till they become 18.

Service users who have reached the age of 65 years will continue to receive mental health services from the CMHT until such a time as their needs are assessed as having changed, due to their age, and adult services are less able to meet their needs. Transition of care to Mental Health Services for Older People will then be planned via the CPA process according to the following criteria:

- First presentation of severe functional mental illness over the age of 65 or people over 65 who have been closed to the CMHT for a period in excess of five years should be referred to Mental Health Services for Older People.
- People suffering from an established primary progressive dementia related illness (including alcohol related) of any age with behavioural and psychological symptoms of dementia should be referred to Mental Health Services for Older People.

### **Learning Disability**

Learning disability should not act as a barrier to acceptance by the CMHT as long as the CMHT is best placed to meet their individual needs. In cases where this is not immediately clear, assessments should be carried out jointly by representatives of both CMHT and Learning Disability Services.

### **Co-occurring Alcohol / Substance use**

Service users with co-occurring alcohol /substance misuse problems are defined as those with severe mental illness and drug and / or alcohol problems. This group are likely to meet the eligibility criteria for services from a CMHT.

It is acknowledged that they may often present particular risks to themselves or others, and require good care co-ordination. Those with a dual diagnosis as defined will be the primary responsibility of the CMHT. (Mental Health Policy Implementation Guide: Dual

Diagnosis – Good Practice Guide, May 2002 and the Interagency Protocol for Mental Health and Substance Misuse 2011).

Such individuals should be referred as necessary by CMHTs to Community Drug and Alcohol Services for expert advice or a specific treatment package. Community Drug and Alcohol Services will also give advice as necessary to those providing medically assisted withdrawal programmes to service users with a dual diagnosis on acute inpatient units.

Disputes over case responsibility will be rare if full information is shared and if both services are willing to operate with some flexibility in the interests of the service user. Guidance should be sought from the Interagency Protocol for Mental Health and Substance Misuse as to which agency takes the lead role in care coordination and treatment. Each CMHT should have an identified link worker for alcohol and substance misuse to provide advice and support to other team members for this client group. The incidence of this service user group becoming involved in serious adverse incidents is high. It is therefore vital that mental health and addiction services work closely and constructively together. The effectiveness of services for people with co-occurring alcohol / substance use and mental illness will be monitored through close scrutiny of serious and adverse incidents (SAI) data on an ongoing basis.

Members of staff, or their close relatives, requiring mental health services will normally be offered a service out of the area in which they work.

## **7. CMHT ENTRY CRITERIA**

Referral for assessment should be made to the CMHT if the following conditions apply:

- Severe mental disorder
- Diagnostic uncertainty
- Complex mental disorder or severe psychological disturbance including eating disorders such as anorexia and bulimia where significant risk is a factor.
- When the GP requires a second opinion in the context of a complex to treat mental disorder or severe psychological disturbance
- Mental disorder associated with significant and / or urgent risk
- Complex needs and significant deterioration of mental state

Circumstances and symptoms associated with significant risk include:

- Severe depression
- Clear suicidal intent / hopelessness in the context of a mental illness.

- Recurrent or severe self harming behaviour in the context of a mental illness.
- Mental disorder in the context of chronic / painful physical illness
- Psychotic symptoms
- Elevated mood associated with behavioural disturbance/lack of judgement
- Mental disorder associated with a vulnerable dependent. e.g. child
- Puerperal mental disorder or a history of mental disorder in pregnant women
- Mental disorder associated with violent and impulsive behaviour
- Vulnerability to abuse, exploitation or neglect leading to substantial or critical risk

Referrals are received from a variety of sources, predominantly from primary care but also from a range of agencies such as: Other secondary care services, Police and Criminal Justice agencies, Housing Officers, Social Services, non-statutory partner agencies such as Mind, Gofal and Hafal.

Self referrals are discouraged. Potential service users should ideally participate in the Primary Care pathway in the first instance, however, should someone present at the CMHT they must receive a mental health assessment to ascertain what their mental health needs are (if any) and be directed to the appropriate service.

Under the Mental Health (Wales) Measure 2010, from January 2012, it is likely that people who have been discharged from secondary mental health services, but who subsequently believe that their mental health is deteriorating to such a point as to require such care and treatment again, to refer themselves back to secondary services directly, without necessarily needing to first go to their general practitioner or elsewhere for a referral.

Self referrals should be prioritised in the same way as any other referrals and an assessment made as to the urgency of the response required according to WAG guidelines to be determined by the duty worker in discussion with the Integrated Manager and / or Senior Clinician (see referral process).

## **8. ELIGIBILITY FOR SERVICES**

Decisions on whether someone should be accepted for services should always be based on their health and social care needs as a whole and not on diagnosis alone. However following an assessment of need, priority for services will be given as shown below:

- Service users with severe, difficult to manage and persistent mental illness, such as schizophrenia severe depression or bipolar disorder

- Longer term disorders of lesser severity but which are characterised by poor treatment adherence requiring proactive follow up
- Any disorder where there is significant risk of self harm or harm to others (e.g. acute depression, anorexia, high levels of anxiety) where the level of support exceeds that which the primary care team can offer.
- Pregnant mothers suffering any type of mental disorder.

## **9. CMHT DUTY SYSTEM**

A professionally qualified Duty Worker is available in the office to receive and screen new referrals, to see people who drop-in, to offer advice and to be involved in any activity deemed to be an appropriate task for a Duty Worker between the hours of 9 - 5pm and 4.30pm on Fridays.

On receipt of complex new referrals, especially those who may be actively psychotic, the duty worker will seek advice from a psychiatrist in the team or in the Integrated Team Manager.

## **10. REFERRAL PROCESS**

There are three categories of referral according to Welsh Assembly Government Guidelines:

- Emergency: Assessed within 1-4 hours.
- Urgent: Assessed within 48 hours.
- Routine: Assessed within 4 weeks.

CMHTs are the main point of entry to the secondary mental health services. Referrals can be made by letter, fax, or telephone. Following a telephone referral, a confirmation letter / fax will be requested.

Most referrals received will usually be assessed; exceptions would be those when, after discussion and agreement with the referrer, another type of service is considered more appropriate.

Referrals that indicate various interconnecting difficulties exist, such as mental health problems and learning disability or mental health problems and substance misuse, will be dealt with according to the local policies on delivering care across service boundaries.

Following the initial screening by the Duty Worker a level of priority for assessment will be decided at a CMHT screening meeting. Membership of this group is made up of senior clinicians and practitioners from a range of disciplines.

Individuals who present at the CMHT and have no fixed abode will be assisted in returning to their district of origin unless their mental state requires immediate assessment and treatment.

Emergency referrals will be seen and assessed on the same day and by definition should be made directly by the referrer by telephone and routed to the duty worker. An emergency referral will always be discussed with the Integrated Team Manager or senior clinician on the day of receipt and will be co-managed by appropriate members of the CMHT until the emergency is passed or averted. If a Mental Health Act assessment is requested, this should be passed to the Social Work Team Manager or Duty Approved Mental Health Act Professional (AMHP).

WAG guidance suggests that urgent referrals will be seen and assessed within a maximum of 48 hours. An urgent referral should therefore be made by telephone to the duty worker and for both an Emergency or Urgent referral a mutually agreed appointment must be mutually agreed between the GP and the duty worker that must be no longer than five working days.

Requests for emergency referrals received should be received by the duty worker based in the CMHT who will undertake a triage assessment to ascertain the appropriate level of response. Screening the referral will include examination of any old notes, face to face, or telephone contact with the person referred or contact with the GP and the carer. The information gathered must be sufficient to identify risks. If it is deemed that admission to hospital is required the duty worker will pass the details on to the CRHTT who will take over the management of the care.

Requests for emergency or urgent assessment will be screened by the CMHT Duty Worker. Normally an emergency request would be passed directly to the duty worker who will discuss the referral with the referrer. For both emergency and urgent referrals, if unable to take the call at the time, the referrer will be contacted by telephone by the Duty Worker to gather further information and ensure that appropriate priority is allocated. It may be that after discussion the priority could be upgraded or downgraded in priority by mutual agreement.

Requests for assessments that are not deemed to be emergency or urgent who are deemed to meet the eligibility for access to the CMHT will be offered an assessment by an appropriate team member following initial screening by the MDT within a target of four weeks. A letter will be sent to the service user asking them to contact the CMHT with two weeks of referral asking them to arrange a mutually agreeable appointment.

If the service user fails to attend an initial appointment, they will be closed to the CMHT and asked to contact their GP if they wish to be seen again. The GP will be involved of

this. Individual services users may lack the ability to respond to this approach in which case this should be indicated by the referrer and a more proactive approach taken by the CMHT to engage the service user. The decision to close a service user to the CMHT in this way should be passed via the MDT for approval.

Increasingly service users may wish to exercise choice in where they receive their care. They should always be given full information about the range of services available, and their expressed preferences should always be carefully considered in line with equal opportunities legislation. If it is decided that that their choices cannot be provided - either for practical reasons or because it is not in their best interests, the reasons should be recorded (Cardiff and Vale Mental Health Service User and Carer Involvement Framework, 2011).

Useful information to be included in the Referral:

- Service user identification details including mobile telephone number.
- Ethnic origin and language. Please state whether an interpreter will be required.
- Reasons for referral and why now?
- Any significant life events.
- Working diagnosis and treatments already tried.
- Previous psychiatric history.
- Relevant personal and family history.
- Co-existing medical conditions including co-occurring alcohol / substance use / learning disability including details of medication.
- History of risk to self and others including forensic history.
- Existing support networks already in place.
- Carer details (NB Where a carer of some one with a mental illness has been identified, that carer has a right to an assessment of their needs as a carer regardless of whether or not the service user accepts a service from the CMHT)

## **11. REFERRAL AND ALLOCATION MEETINGS**

Referrals are discussed in a multi-disciplinary meeting attended by a range of professionals including the Consultant Psychiatrist. This is held weekly to discuss new referrals, assessments undertaken and team discussion of any current risk issues. A decision is made about the most suitable person to assess any new referrals is made by

the MDT. All assessments of people who are thought to have a serious mental illness will normally involve assessment by a psychiatrist. The Integrated Manager's role is to chair the meeting and ensure the effective running of the meeting including allocation of new referrals and service users taken on by the team.

## **12. ASSESSMENT PROCEDURES**

Following allocation, the named professional worker(s) will offer an appointment. Generally this will be in the CMHT base but in some cases a home visit can be arranged. If the referrer has any reason to believe a home assessment is necessary it is useful to explain this when making a referral. Home assessments of new service users are carried out by two workers, in accordance with lone working and risk management policies.

If appropriate, CMHTs will offer joint assessments by two different disciplines from within the team. CMHTs would anticipate that joint assessments would always occur when a new assessor required greater experience or in situations that indicate the assessment will be complex and / or high risk.

A comprehensive assessment of health and social care needs will be undertaken within the framework of the Care Programme Approach (CPA) and Unified Assessment (UA). The assessment includes consideration of physical health needs and also takes into account any family, housing or occupational difficulties.

During the assessment process the views of appropriate carers will be taken into consideration. Any child care issues will be identified and if appropriate a referral will be made to Children's Services Intake and Assessment.

If the assessment suggests other professional advice / assessment is required this will be arranged. This would include onward referral to the specialist Eating Disorder Service, Borderline Personality Disorder, Traumatic Stress Disorder or other Specialist Mental Health Services.

It is usual that service users receiving services from specialist such services including Eating Disorder Services, Traumatic Stress Services, Borderline Personality Services and Assertive Outreach Services will continue to receive support from the CMHT particularly in respect of care co-ordination under CPA.

WAG guidelines suggest that services users involved in the specialist Eating Disorder services have a designated link worker identified within each CMHT to work with the Specialist Eating Disorder services in supporting this client group in secondary care.

The Local Authority can provide services to meet eligible needs identified via the Unified Assessment process including domiciliary care packages and outreach support workers.

Following assessment, the GP and the service user will be sent a copy of the assessment within 10 working days unless there are specific reasons to suggest this is inappropriate.

The service user will be given an opportunity to comment on the assessment and these comments will be recorded.

Following a comprehensive health and social care assessment and a risk assessment, if a continuing service is offered, the service user will receive a package of care based on the Care Programme Approach.

The Mental Health (Wales) Measure (WAG 2010) places duties on Local Health Boards and Local Authorities to appoint an eligible care coordinator for someone for whom secondary care mental health services are being provided. The care coordinator must work with service user and service user providers to agree and achieve outcomes with a view to agreeing a care plan aimed at achieving those outcomes.

If following assessment, a continuing service is not offered by the CMHT the reasons for this will be explained to the person and will be recorded on the assessment. The GP and original referrer will be informed.

### **13. ASSESSMENTS UNDER THE MENTAL HEALTH ACT 1983**

Requests for an assessment under the Mental Health Act for clients open to CMHTs will be managed during normal office hours by the CMHT social work manager or deputy. If there is no AMHP available, the CMHT can elect to ascertain whether the CRHT AMHP is on duty and available to manage the assessment. If not, the assessment will default to the Duty AMHP Rota.

If the client is not currently open to a CMHT, in the first instance the CRHT AMHP, if on duty and available, will manage the assessment. If there is no CRHT AMHP available, then as above it will default to the Duty AMHP Rota.

Mental Health Act assessments that are commenced during office hours remain the responsibility of the AMHP until the assessment is completed, even if this is outside normal office hours. It is only in exceptional circumstances that the Emergency Duty Team will take over the assessment.

Outside office hours and at Bank Holidays assessments under the Mental Health Act will be coordinated by the Emergency Duty Team in conjunction with the Crisis resolution & Home Treatment Teams.

Whenever possible, requests for a Mental Health Assessment should be communicated at the earliest part of the day so that the assessment can be completed during the working day. In all instances the CRHTT will attend assessments under the Mental Health Act in order to ascertain whether hospital admission is appropriate or whether a package of home treatment can be provided.

#### **14. LINKS WITH THE CRISIS RESOLUTION AND HOME TREATMENT TEAM**

The CRHTT aims to provide a service for adults who appear to have severe and enduring mental illness who are experiencing acute psychiatric mental health crisis that would otherwise require admission. The CRHTT will provide an alternative to admission where safe and appropriate, in a flexible and responsive manner, in the most appropriate setting.

The CRHTT will promote continuity and consistency of care and intervention for service users and carers, offering a range of approaches and skills for usually no more than 8 weeks. If CRHTT input is indicated beyond this, weekly CPA meetings between CRHTT, client and CMHT/GP should take place to ensure the right focus of care.

A service user would be referred to the CRHT if it is clear that admission is required to continue to safely manage risks. Any individual referral passed to the Crisis Team must have been assessed face to face by a mental health professional during the previous 24 hour period.

The CMHT will provide sufficient information for the CRHTT to plan appropriate intervention with particular consideration to issues relating to risk assessment, gender preference and specific clinical information. If a full assessment has been undertaken it is imperative that this be faxed to the CRHT or made available on Paris. The CRHTT will make a decision on the appropriateness of the referral based on the information given. They may request further information before proceeding, or they may suggest signposting to other services, or they may accept the referral as appropriate for their service.

The outcome of the assessment will be fully discussed with the referrer and the Responsible Clinician, if available, and a plan agreed upon with shared responsibility. Where ambiguity exists around the outcome of an assessment, a discussion between the CRHTT, the referrer and the client would be indicated to ascertain the best course of action.

Service users receiving home treatment also need the full support of community staff during the home treatment episode. The Care Coordinator retains responsibility throughout the home treatment spell and will undertake to liaise weekly with a CRHT member regarding the plan of care, preferably undertaking joint visits to review the service user in their care setting. The Care-Co-ordinator will also facilitate CPA reviews for their clients whilst under the care of the Crisis Team.

Clients discharged from the Crisis Team will be offered a follow-up community appointment within 5 days of that discharge. This will be in accordance with Best Practice Guidelines.

If a service user known to the CMHT is assessed and taken on for home treatment out of hours, the CRHTT will contact the care co-ordinator the next working day to agree a plan of care. Alternatively an out of hours assessment may not require home treatment, but is suitable for further assessment at the CMHT. In this instance, the CRHTT will inform pass

the details on to the CMHT as soon as practicable and ask the service user to make contact with the CMHT care coordinator to arrange a mutually agreeable appointment.

If a service user not currently subject to CPA (not in the care of the mental health services) is assessed and taken on for home treatment out of hours, the CRHTT will assume care co-ordination responsibilities whilst actively seeking the appointment of a care co-ordinator from the CMHT. The Integrated Team Manager of the CMHT will ensure that a care coordinator is allocated at the earliest opportunity.

Whenever possible a member of the CRHTT staff will accompany CMHT staff on the assessment.

## **15. CARE PROGRAMME APPROACH (CPA)**

The Care Programme Approach (CPA) is the framework for care co-ordination and resource allocation within mental health and should be an effective, efficient and transparent process of care co-ordination and care delivery that encompasses all the relevant responsibilities of the NHS and the local authority.

Following a comprehensive assessment of health and social care needs and a risk assessment all service users requiring a service will be allocated a named Care Co-ordinator and a level of CPA, Standard or Enhanced, agreed. A care plan will be formulated

The Care Plan will include details of services required to meet need and manage the assessed risk, and Contingency Plans which will identify risk factors, early warning signs and actions to be taken in any crisis.

It should be recognised that risk cannot be eliminated; only managed. An integral part of the management process should be for the service user to accept responsibility for their own actions and associated risks supported by the Care Plan and the team's interventions based on the principles of positive risk management.

During any assessment process care must be taken to ensure any previously held information is identified and that the service user is not subjected to having the same information requested time and time again.

The comprehensive assessment will be recorded on form CPA1 which will be entered onto Care Notes within the PARIS electronic record system and held on file. The risk assessment and Care Plan will be recorded on the relevant CPA documentation for Standard or Enhanced level and this will also be entered onto Care Notes within PARIS and held on file. When service users have been seen at an outpatient clinic the assessment and Care Plan is likely to be in the form of a letter.

The service user and relevant carers (if agreed) will receive a copy of the care plan and the risk management plan. They will be encouraged to be involved in the planning process and express their views on the content of the Care Plan

Some service users, previously unknown to the CMHT, may be an inpatient in the Mental Health Unit or be receiving a service from CRHTT. In these cases the Integrated Manager CMHT will identify a care co-coordinator within 5 working days of notification from the other service, in order that a safe and sound transfer of responsibilities.

During any inpatient admission the service user will be allocated a named nurse on the ward who will work with the Care Co-coordinator to ensure needs, identified on the Care Plan are met

CPA and risk assessment reviews will be held at regular intervals, according to need, and at no less than annual intervals. GP's are invited to all CPA meetings and their attendance at critical meetings essential

The needs of carers will be identified and a Carers Assessment offered and arranged by the Care Co-coordinator if this is required and desired

If a service user moves to another area and registers with a GP practice covered by a different CMHT. Transfer of the care should be made to the appropriate CMHT in a timely fashion through the CPA process.

## **16. SUPPORT FOR SERVICE USERS IN HOSPITAL**

Service users who require admission to an acute inpatient unit or a secure setting need the full support of community staff during the inpatient episode. Ensuring the service user and relevant carers receive appropriate support is seen as high priority by CMHT staff

Whilst an inpatient on an acute ward the community Care Co-coordinator will ensure the service user is visited in hospital regularly and at least once every two 2 weeks and also discuss progress with the Named Nurse and attend CPA reviews held in the inpatient unit.

The community Care Co-coordinator and the Named Nurse will ensure the multi-disciplinary team are advised of any issues that may effect progress towards discharge. In particular any housing, welfare benefits or family relationship and child care difficulties will be identified, discussed with the service user and the care team and addressed within the care plan

CMHT staff will attend, or feedback information, to the weekly ward rounds in the Mental Health Unit and pro-actively seek to assist the service user and relevant carers in identifying plans which will support them on discharge from inpatient care. Whenever possible the Care Co-coordinator (or delegated representative should be present when the discussion takes place on the service user for whom they are Care Co-coordinator

At the meeting prior to the inpatient's planned discharge date, the CPA care-plan and risk assessment will be reviewed. Indicators of relapse will be identified and recorded on the care-plan and a crisis contingency plan / relapse plan (should difficulties arise) will be agreed. A date for the next CPA review meeting will be set. The Service user, relevant carers and the GP will be sent a copy of the documentation of these plans. This meeting will also consider and agree the appropriate level of CPA for the service user post discharge.

Inpatients discharged on Enhanced CPA to the care of the CMHT or when a recent account of non fatal deliberate self harm is recorded, a date, time and place for a follow-up community appointment within 5 days of discharge will be arranged. This will be in accordance with best practice guidelines on the follow up after discharge from mental health in-patient units.

When any unplanned discharge from the Mental Health Unit occurs a pre-discharge CPA review will not have occurred. The CMHT Care Co-coordinator must arrange an early CPA review and contact within 5 days of the discharge taking place.

If the service user has to be placed in an acute or Psychiatric Intensive Care Unit (PICU) away from the local area the Care Co-coordinator will ensure that the service user's views on returning to the local Mental Health Unit are known to the multi-disciplinary team. Transfer back will be effected as soon as clinically possible.

## **17. THE RANGE OF INTERVENTIONS PROVIDED IN A CMHT**

Professional staff and support workers deliver a range of interventions to assist the service user recover and maintain stability. The interventions include:

- Psychological therapies.
- Appropriate Medication and medication management.
- Ensuring physical health needs are addressed.
- Psychosocial and Occupational interventions.
- Signposting to Welfare Benefit advisory services.
- Assistance in accessing suitable accommodation.
- Help in accessing local opportunities for work and education.
- Relapse prevention.
- Support for carers.

- Support and advice for families.
- Information regarding Advocacy Services.
- Advice and access to treatment for substance misuse.

There are a number of key components relating to work within CMHTs. They include:

- A team approach to the assessment of health and social care needs and risk.
- The allocation of a named care co-coordinator for all service users receiving an on-going service.
- Priority allocation, within 5 working days, of a Care Co-coordinator for In-patients and those receiving a service from CRHTT.
- Close Liaison and working with the Primary Care Team including the GP.
- Regular review, at no more than annual intervals of the Care Plan for both Standard and Enhanced CPA.
- Ensuring all service users are involved in the development of and have a copy of the CPA Care plan.
- Record keeping.
- Weekly team meetings to offer an opportunity to consider and discuss clinical issues such as treatment outcomes, practice issues and new developments.
- Information from Executive and Senior Management cascaded to all levels of staff as outlined in the Communications Strategy.
- Vulnerable people are monitored through regular Protection of Vulnerable Adult (POVA) processes. Where there are concerns relating to a vulnerable adult in the community, the lead agency is the Local Authority, in a hospital setting the lead agency is the UHB.
- CMHTs liaise and work with other statutory and voluntary agencies to promote the development and access of services for those with mental ill health. This work could include:
  - Working with the local Housing Department in relation to the development of supported accommodation
  - Working with the police to help maintain community safety and reduction of crime and disorder to individuals irrespective of age, gender, race or disability

- Working with local voluntary agencies to support and assist in the development of community activities
- Visits from the care co-coordinator should occur within 5 working days of the admission and thereafter a visit should occur at least every two weeks.

## **18. ADVANCE DIRECTIVES**

Service users will be encouraged to complete an Advance Directive identifying a range of different things they may wish to be taken into consideration should they become mentally unwell.

Advance Directives can only be completed when a service user is sufficiently well, and has the capacity to make the Directive.

The Care Co-coordinator, the Responsible Clinician or an advocate will assist the service users discuss and complete the directive.

Advance Directives will be identified on Care Notes held on the service users file within the PARIS information system.

## **19. WORKING PROCEDURES**

CMHTs are committed to a recovery model of work that builds on the personal strengths and resilience of the service user. Encouraging hope and respecting diversity the service user, their family and support networks are central to the process of any work undertaken by CMHT staff. Goal planning for service users will be outcome focused and collaborative.

Assessments, whenever possible, will include the views of family and friends and they will be offered support and information about the illness and the care process.

The needs of any children in the family must be considered. Children's welfare and safety is paramount and it is the responsibility of all staff to ensure they identify and respond to concerns. Where concerns have been identified a written referral to Children's Services must be made in line with Local Authority and Health Safeguarding Procedures.

Staff should seek to discuss concerns about child welfare and safety with the service user and relevant family members, unless to do so would place the child at increased risk of harm. Disclosure of relevant information for the purposes of referral may need to take place against the wishes of the service user if the child is considered to be at risk of harm.

## **20. PSYCHIATRIC OUTPATIENT CLINICS**

Psychiatric outpatient clinics are a Consultant Psychiatrist led service and operate in all Cardiff & Vale CMHTs.

Service users are offered an appointment to see a doctor, for the purpose of specialist psychiatric assessment and treatment of a mental health disorder

Psychiatric outpatient clinics offer a service to a wide range of service users, including the assessment of new referrals, follow-up appointments following an inpatient episode and the monitoring and re-assessment of mental state when this is required.

If a service user fails to attend any psychiatric outpatient appointment the following actions will occur:

- When any outpatient appointment is missed the junior doctor should always discuss with the Consultant Psychiatrist to assess risk and agree next actions. This to be recorded on Care Notes.
- If the appointment missed is a first appointment following discharge from inpatient care or a first appointment for a person not previously known to services the Consultant Psychiatrist will discuss the situation with the Integrated Manager and agree next actions.
- Any failure to attend 2 outpatient appointments must be discussed by the Consultant Psychiatrist with the multi-disciplinary team. A decision regarding further action will be taken based upon assessed risks to self or others. If the decision is to discharge, the service user and the GP will be informed immediately
- Routine referrals of new cases, usually from Primary Care, will be discharged following one non attendance (DNA), in line with Welsh Assembly Government policy, unless there are extenuating circumstance or higher risk factors evident.

## **21. PSYCHOLOGICAL TREATMENTS**

Psychological treatments are available and provided by CMHT psychologists along with other staff within clear clinical supervision arrangements.

Various specialist services providing psychological therapy are available, e.g. Eating Disorders Service, Panic Treatment Project, Borderline Personality Disorder Service and Traumatic Stress Service. The psychological treatment care pathways, referral and discharge criteria are available from these specialist services on request.

## **22. CMHT DISCHARGE GUIDELINES**

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

Within a Recovery Model of work the CMHT will assist the service user maximize their potential for recovery and return to independence and discharge from the secondary services

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

- Service users are on Standard CPA and require only minimal intervention and:
- They require to be seen at less than 3 monthly intervals The diagnosis and treatment plan are clearly established They can attend their GP for follow-up
- Service users with major mental disorder (e.g. schizophrenia / bipolar disorder / personality disorder / recurrent depression) and:
- There is evidence of mental stability (no relapse requiring significant intervention) for a period of at least 1 – years They do not require specialist interventions They will be able to attend their primary care clinician for review and treatment They are believed to be compliant with treatment There are no significant risk factors Key stakeholders (GP/ service user / carer) have agreed to the discharge as part of the CPA process

It is acknowledged that some service users, because of the nature and complexity of their mental illness, may require on-going treatment and support for many years and long term assistance will be offered when this is the case

Discharge planning will form an integral part of the service users Care Plan. Liaison with other involved agencies will take place early in any work undertaken to ensure continuity of care

The CPA review meeting is where the service user and the care team meet to discuss the Care Plan and this will be the venue in which both the tier of CPA (Enhanced or Standard) and changes to the Care Plan and discharge from the mental health services will be discussed

At the point where it is considered the service user has recovered to a degree they no longer require specialist secondary mental health services discharge back to the Primary Care Team via the CPA process will be agreed with the service user and the Primary Care Team. If this occurs any responsibilities held under Section 117 of the Mental Health Act will also be discharged.

Prior to any discharge from the CMHT an aftercare 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.

Should a service user refuse to engage with the CMHT or refuse to continue to accept services the situation will be discussed within a multi-disciplinary team meeting. Risks to self and others will be assessed and an action plan, dependent on risks and need, agreed. The GP will be informed immediately

Discharge from services may occur following non-attendance at outpatient clinics. Procedures are identified above.

### **23. SERVICES FOR CARERS**

All regular and substantial carers will be offered an assessment of their own needs. They will be offered appropriate services within resources available and will have a written care plan, which will be reviewed no less than once annually.

Carers and relatives will be consulted about the service user's care, with the clients consent. Where consent to consent or share information is refused, information can still be provided to the CMHT by carers and relatives and generic information about care provide to CMHT clients also given by the team to the carers or relatives. Where issues of risk are high and consultation and information sharing is refused, discussion should take place at an MDT meeting about this issue and the outcome documented.

### **24. TEAM SAFETY & MANAGING CLINICAL RISK**

Individuals, whose behaviour is likely to put the safety of others at risk, should they attend the CMHT base, may be seen at Whitchurch Hospital, where safe facilities exist to minimise risk.

A decision to exclude an individual from the CMHT base can only be made after a full discussion is held by the CMHT. This should be recorded. The patient must be informed in writing of any such decision.

The right to appeal should be made via the UHB complaints procedure.

Team members should comply with the UHB 'Lone Worker Policy', have access to mobile telephones and be able to raise any concerns about lone visiting with their manager or at the regular multidisciplinary Team meetings.

Information regarding the whereabouts in the community and contact details of all staff will be kept by team administrative staff. Appropriate and comprehensive risk assessment will be used to maintain safety and also ensure treatment is not withdrawn inappropriately. The UHB operates a zero tolerance policy ('Prevention & Management of Violence of Aggression Policy') regarding racial, physical or verbal abuse towards its staff.

## **25. SUPERVISION ARRANGEMENTS**

A range of supervision is required to meet the needs of staff in a multidisciplinary Community Mental Health Team.

All staff should have supervision at least monthly with their clinical line manager; this should provide ongoing guidance on the management of complex cases, caseload management and monitoring of practice.

### **Clinical Supervision**

Best practice would be that all CMHT staff should have access to clinical supervision. This should be with a professional not necessarily from the CMHT or the same professional background, but mutual agreement to support and guide them in their clinical practice.

CMHT members who are managed by a member of a discipline other than their own should receive additional or joint supervision provided by an appropriate member of their own discipline.

### **Specialist Supervision**

For some psychosocial interventions such as cognitive behavioural therapy (CBT), Behavioural Family Therapy and some approaches to working with substance misuse, there is a requirement that the staff member receive formal specialised supervision to ensure services are developing and staff are maintaining these skills appropriately.

## **26. CASELOAD MANAGEMENT & CAPACITY**

Capacity will be monitored by CMHT managers to ensure the appropriate management of caseload allocation and use of skills. It is planned to move towards an indicative maximum team case load to ensure adequate care and team review where each whole time equivalent care co-ordinator other than medical staff, should have a maximum of 35 clients on their caseload dependant on their professional background and statutory responsibilities.

CMHT and individual caseloads will be regularly monitored and reviewed to ensure CMHT members are able to provide immediate effective care (without the use of waiting lists) for new referrals with severe mental health problems, and a flexible capacity to increase contact during crisis.

## **27. ACCESS TO HEALTH RECORDS**

Clients wishing to access their own clinical notes will be provided with support within the UHB's 'Access to Health Records' Policy. Clients requesting copies of notes will receive these in accordance with this policy.

## **28. TRAINING & DEVELOPMENT**

Training and development will reflect the needs of the UHB and of the individual, as described in their personal development plan develop as part of the Knowledge & Skills Framework, to include their profession specific needs. The UHB recognises that Continuing Professional Development is a key element of ensuring the delivery of the highest possible quality of service. Role development and scope of practice is also increasingly relevant to the provision of staff training and supervision. All staff will be appraised annually via the KSF, with a six-month review. Where there is only one member of a discipline in a team, professional support and supervision must be provided. All new staff will attend an induction programme.

Induction programmes will be prepared for all Locum staff to include reference to the appropriate policies and procedures such as CPA and Risk Management. Staff will attend statutory/mandatory training sessions appropriate to their individual professional status and including Fire, Health and Safety, Assessment and Management of Risk, Cultural Awareness, and Breakaway. Training will also focus on the development of psychotherapeutic competences integral to the care delivery of all staff.

The CMHT will have annual team away days for the purpose of reviewing activities, policies and team building.

## **29. EQUALITY IMPACT ASSESSMENT**

Cardiff & Vale NHS UHB is committed to providing an environment where all staff, service users and carers enjoy equality of opportunity.

The UHB works to eliminate all forms of discrimination and recognises that this requires, not only a commitment to remove discrimination, but also action through positive policies to redress inequalities.

Providing equality of opportunity means understanding and appreciating the diversity of our staff, service users & carers and ensuring a supportive environment free from harassment. Because of this Cardiff & Vale NHS UHB actively encourages its staff to challenge discrimination and promote equality of opportunity for all.

## References

- Mental Health (Wales) Measure 2010, Welsh Assembly Government.
- Mental Health Policy Implementation Guide: Dual Diagnosis – Good Practice Guide, May 2002.
- An Interagency Protocol for Mental Health and Substance Misuse with Cardiff and the Vale of Glamorgan.
- Cardiff and Vale Charter for Mental Health, 2011.
- The Cardiff and Vale Mental Health Service User and Carer Involvement Framework, 2011
- The Role of Community Mental Health Teams in Delivering Community Mental Health Services Interim Policy Implementation Guidance and Standards, Welsh Assembly Government, 2010.

## Appendices

### 1. Referral classification for Mental Health Assessments

**Referral classification for Mental Health Assessments**

Priority	DEFINITION	ACTION	TIME SCALE
<b>Emergency</b>	<p>The referrer feels that an individual is in need of a mental health assessment <b>that day</b> due to the level of risk that person may be presenting to themselves or others due to a perceived mental health problem.</p>	<p><b>Contact the host CMHT by phone</b> and ask to speak to the duty worker who will receive the call, discuss the concerns and arrange an emergency assessment that day.</p> <p>Out of hours, the request for emergency assessments should be directed to the appropriate Crisis Resolution and Home Treatment Team.</p> <p>It is helpful to make the referral in the presence of the person being referred so that the duty worker can inform them of an appointment time. Part of the discussion, should include an agreement as to the safe transportation of the person from the practice to the CMHT.</p> <p>An emergency referral should be followed up by a faxed referral form summarising the reasons for the request to assess urgently.</p>	<p>Assessment undertaken within <b>4 hours</b> of referral.</p> <p>If this falls outside of the working hours of the CMHT, then the referral may be passed to the appropriate Crisis Resolution and Home Treatment Team to assess.</p>
<b>Urgent</b>	<p>The referrer feels that an individual is in need of a mental health assessment but is not an immediate risk to themselves or others to the point that they need to be seen that day.</p>	<p><b>Contact the host CMHT by phone</b> ask to speak to the duty worker who will receive the call, discuss the concerns and agree an appropriate timeframe for an assessment to take place. This may be within the 48 hour timeframe, or if it is agreed between referrer and the duty worker, a longer or shorter timeframe could be agreed that is mutually acceptable.</p> <p>It is helpful to make the referral in the presence of the person being referred so that the duty worker can inform them of an appointment date and time.</p> <p>An Urgent referral should be followed up by a faxed referral form summarising the reasons for the request to assess urgently.</p>	<p>Assess within <b>48 hours</b> from receipt of referral or within a mutually agreed timeframe.</p>
<b>Routine</b>	<p>The referrer feels that an individual is in need of a mental health specialist assessment and there are no significant risk factors that would suggest that an emergency or urgent response was required.</p>	<p>Having reviewed the clinical picture based on the referral letter, an appropriate action should be prescribed which may include assessing the patient within 4 weeks of receipt of referral. It is possible that on receipt of the referral, the MDT might suggest that the person is seen in a much shorter timeframe.</p>	<p>Assess within <b>4 weeks</b> of receipt of referral</p>
<p>If in doubt, contact the CMHT duty worker to discuss the referral</p>			