

Llywodraeth Cynulliad Cymru
Welsh Assembly Government

THE ROLE OF COMMUNITY MENTAL HEALTH TEAMS IN DELIVERING COMMUNITY MENTAL HEALTH SERVICES

Interim Policy Implementation Guidance and Standards

[July 2010]

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1. Introduction

1. This guidance sets out the guiding principles for Community Mental Health Teams in delivering community mental health services in Wales. The guidance also stresses the importance of ensuring that services delivered by CMHTs are integrated and delivered in a co-ordinated way, and that services set out clear and transparent access and discharge criteria. This guidance is issued to support senior managers of mental health services working in Local Health Boards and Local Authorities in Wales. It should be read in conjunction with *Delivering the Care Programme Approach in Wales: Interim Policy Implementation Guidance*.¹

2. The guiding principles

2. The three guiding principles for planning and delivering secondary mental health services is set out in *Delivering the Care Programme Approach in Wales: Interim Policy Implementation Guidance*.² They are:
 - **Care and treatment will be holistic;** that is, addressing the medical, psychological, social, physical and spiritual needs of people accessing mental health services
 - **Care and treatment will be coordinated and integrated;** that is health, local authority, third sector and any other appropriate bodies working together in a co-ordinated way
 - **Individuals will be involved and engaged:** that is adopting a personalised approach that involves and engages with people who access mental health services to identify, plan, develop, deliver and evaluate a range of services to meet their needs.

3. Description of a tiered model of adult mental health services

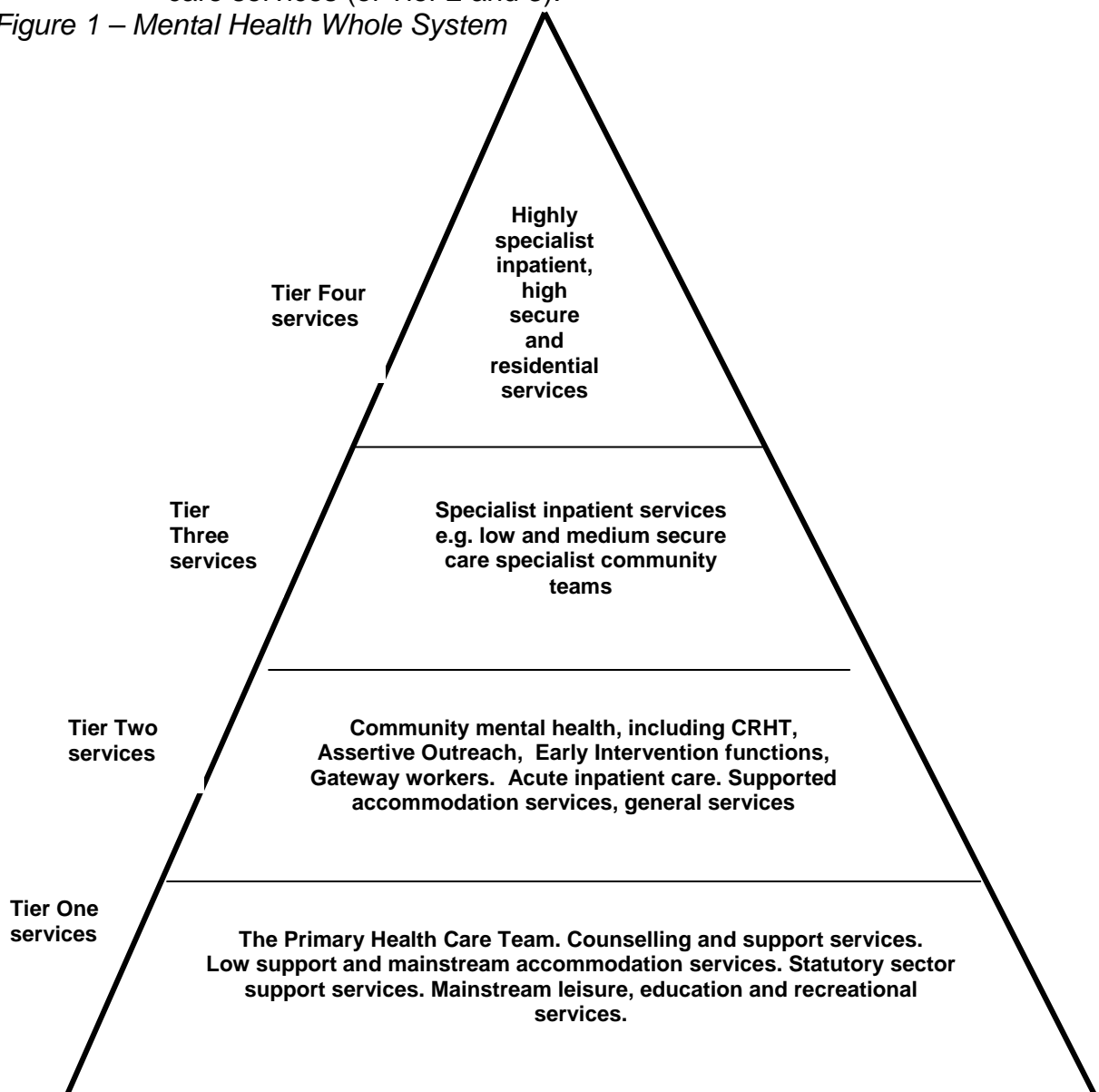
- **Tier 1 – primary mental health care**
The identification, assessment and treatment of common mental health problems, such as anxiety and mild to moderate depression, and monitoring the physical and mental healthcare needs of people with a severe and enduring mental health problem, along with the provision of good quality information and sign posting services.
- **Tier 2 – secondary mental health care**
CMHTs are at the heart of secondary care services in Tier 2. CMHTs receive referrals (at present mainly from primary care); undertake screening assessments and where allocation within the team is appropriate a range of more specialist assessments and interventions. Acute inpatient provision also comprises a part of Tier 2 services, with

¹ Welsh Assembly Government guidance (2010)

admission (as well as alternatives to admission) to hospital arranged by the crisis resolution home treatment (CRHT) service, outpatient clinics or assertive outreach services.

- **Tier 3 – specialist services, including specialist inpatient services**
Tier 3 community mental health services are supported by a range of more specialised services including specialist inpatient beds. Within this tier therapeutic intervention is more intensive with far higher levels of support and one to one contact time between service user and service provider. People within this tier are more likely to require low to medium secure services and present with more challenging behaviour that requires more intensive support.
- **Tier 4 – highly specialist inpatient, secure and residential services**
In Tier 4 highly specialist services provide aspects of mental health care that may not be able to be provided within community secondary care services (of Tier 2 and 3).

Figure 1 – Mental Health Whole System



4. Community Mental Health Services Delivered within Tier 2

3. CMHTs predominantly deliver community mental health services within Tier 2 of the whole system model. However, they also have clear links and responsibilities for ensuring the effective transition of people from and back to Tier 1, and to and back from Tier 3. CMHTs should be aware of all people who access secondary mental health services from whatever route, including people who are directly referred to Outpatient services.
4. CMHTs screen and assess people referred to Tier 2 services, and deliver a range of health, social care and psychological interventions, including medical treatment, having taken into account a person's range of needs. These services are planned, delivered and reviewed in an integrated and co-ordinated way through the framework of Care Programme Approach (CPA). This framework provides an organised and methodical way for CMHTs to assess the needs of people who experience mental distress, develop a vehicle for meeting those needs through a single care plan, and to regularly review those needs.
5. There are a range of specific and sometimes discrete mental health services delivered within community mental health services that have developed over the last few years. These include 'Crisis Resolution Home Treatment' (CRHT) services, 'Assertive Outreach' services (sometimes referred to as 'assertive community treatment' or 'intensive support' services), and Early Intervention in Psychosis (EIP) services (sometimes referred to as 'First Episode Psychosis' services).
6. There has been much discussion and debate as to whether these services should be delivered by separate and discrete teams or whether they should be part of a specialist service delivered within a generic CMHT. It is for each Local Health Board and Local Authority to determine how best to organise services to fully meet the needs of people with mental health problems.
7. Crucially, services delivered within Tier 2 must **not** be separate, distinct and apart from the CMHT. They should be integrated elements of a whole community mental health service, and delivered by teams, groups or individuals all operating within the sphere of the CMHT. Regardless of what setting an individual service user is receiving care within Tiers 2, 3 or 4 of the whole system of mental health, they must still remain known to the CMHT, either through the care coordinator or by having a formal nominated link person from within the CMHT.
8. Policy Implementation Guidance on the development of Crisis Resolution/Home Treatment services in Wales was published in 2005. This advised that;
9. *'Within urban areas the most appropriate model may be a discrete specialist CR/HT Team working alongside other services such as mainstream Community Mental Health Teams (CMHTs), day hospitals and acute inpatient units. In less densely populated or rural areas there may not be the need for a discrete CR/HT team, or it may not be a cost-effective option. In these circumstances it may be more appropriate for crisis resolution staff to be included within another service*

team. For example, one or more generic CMHTs may provide a crisis resolution service either through dedicated specialists within the team and/or a rota of staff. It may be necessary to undertake an in-depth audit of current service provision, care pathways and local epidemiology to identify and assess local need in order to inform the model of service developed.

10. *The CR/HT service should work as an integral part of the mental health system aiming to provide a safe and effective home based assessment and treatment service as an alternative to inpatient care, working in conjunction with other service elements. It is essential that the service acts as a bridge between community and inpatient care and not perceived as a “bolt on” but as an integral part of the whole system approach to mental health care in Wales.’*
11. Where discrete teams have been developed within Tier 2 services there must be clear protocols and agreements between teams to show how service users/patients can access those services as quickly and safely as possible.

5. Role and function of Community Mental Health Teams

Overview

12. CMHTs are the main source of community mental health services within Tier 2 and should target resources at those in the greatest need. They are at the centre of the system and are specialist, multi disciplinary, multi agency teams which provide expert mental health assessments and interventions to individuals accessing services (see Annex 2). CMHTs prioritise interventions based on an assessment of need, risk and vulnerability for individuals whose complexity of care cannot be met within primary care.
13. CMHTs must have clear, explicit integrated management arrangements between Health Boards and Local Social Services Authorities in order to deliver the statutory and other responsibilities of both agencies. Teams will normally share a common base between health and social care (see Section 6 of this guidance). The majority of referrals to a CMHT are likely to come via General Practitioners (GPs), and be usually based around primary care groupings (e.g. GP practices).
14. CMHTs deliver health, social care and psychological interventions together with medical treatment, which take account of an individual’s range of needs. Services must be planned, delivered and reviewed in an integrated and co-ordinated way through the framework of Care Programme Approach (CPA).
15. Managers of mental health and social care services must ensure that CMHTs:
 - Keep people who use mental health services informed of what to expect within services on a regular basis
 - Develop an agreed care plan in accordance with ‘*Delivering the Care Programme Approach in Wales: Interim Policy Implementation Guidance*’
 - Develop a more standardised approach that:

- Minimises bureaucracy and uses a single set of documentation
- Ensures risk assessment and risk management protocols and processes are in place
- Reduces duplication and ensures integrated information systems between Health and Social Care organisations are developed
- Integrates Health and Social Care performance management processes

CMHT provision

16. The focus on provision of services by the CMHT should be on those with a severe and/or enduring mental disorder, and within this focus the delivery of services should be prioritised on an assessment of need, risk and vulnerability. CMHTs need to work proactively and collaboratively with other elements of the mental health whole system, which includes acting as step down from more specialist care.

17. Managers of mental health and social care services should ensure that CMHTs are supported by the availability of:

- A comprehensive range of accessible services being available 24 hours a day, 365 days a year for all those who require it, including 24 hour access to emergency assessment under the Mental Health Act 1983.
- Care being provided within the least restrictive environment possible, consistent with ensuring the well being and safety of the individual and, where applicable, others;
- Interventions that are timely, evidence based, effective and delivered to ensure that inappropriate and unnecessary treatments are avoided; and
- Pro-active work undertaken to sustain those individuals within the community so far as is possible.

18. CMHTs may be involved in providing some or all of these functions.

Specific functions and role

19. The role and function of the CMHT team needs to be understood by all local agencies and stakeholders.

20. CMHTs must:

- Have clearly established principles for access to services with an appropriate mechanism for adjudication where there is a dispute over eligibility
- Use the CPA as the framework for assessing, delivering and reviewing care for individuals and, more widely, ensuring the effective targeting of its services;
- Have agreed processes in place to manage those who do not attend for assessment or other appointments (DNA);

- Provide a range of evidence based and effective short, medium and longer term interventions based on the demands of the identified needs of the individuals;
- Ensure access to comprehensive, multi-disciplinary, psychological therapy services and psycho-social interventions;
- Ensure the genuine and meaningful involve and engagement of service users and their carers in individual care planning and service delivery;
- Promote socially inclusive and culturally sensitive practice which impacts on stigma and discrimination, taking into account particular cultural, religious and gender needs to provide equitable access to services.

21. CMHTs must work closely with primary care services, including primary mental health services to ensure:

- A triage function operates between primary and secondary care so that safe, appropriate and effective care is provided to individuals;
- Advice and support is provided;
- There are effective medicine management systems in place;
- There is close liaison between primary care (Tier 1) and secondary care services delivered in Tiers 2 and above;

22. CMHTs must not operate in isolation from other components of the Tier 2 services and indeed all other Tiers of the whole mental health system. Effective partnership working is essential and helped by:

- Liaison and working in collaboration with other partners in care, for example inpatient services, third sector organisations, and where a person has co-morbidity working jointly with partners such as substance misuse or learning disability service providers;
- Providing continuity of care across services by working in an integrated manner with crisis resolution, assertive outreach, inpatient, outpatient and other community services;
- Developing and delivering integrated care pathways that ensure effective referral/liaison to and with other services, this includes protocols for ongoing support and re-referral pathways;
- Ensuring there is clarity of role and function not only of the CMHT but other components of the service delivery area;
- Working pro-actively to reach diverse and difficult to reach groups including individuals who are homeless or roofless, those from black and minority ethnic groups.

6. Integration of Health and Social Care within Community Mental Health Teams

23. Services have traditionally been organised through separate agencies with different accountability structures, funding sources and cultures. However, to deliver an effective, holistic service that addresses the medical, psychological, social, physical and spiritual needs of people accessing mental health services, a more integrated approach is required.
24. The provision of health and social care under an integrated management framework enables the sharing of expertise and resource, and to meet the changing and demanding nature of work within Tier 2, CMHTs must provide access to both NHS and Social Care services to improve service delivery, quality and outcomes to the services user.
25. Managers of mental health and social care services must ensure that CMHTs:
- Are co-located with health and social care staff working in and from the same premises, with integrated working practices and shared objectives;
 - Are jointly managed under a single line of management with appropriate supervision for the individual professions;
 - Have an organisation development plan that embraces all aspect of the health and social care interface, and has shared information management and data collection protocols;
 - Have regular team meetings with designated input for part of the meeting from other teams e.g. crisis/inpatient/assertive outreach etc.
 - Have effective working arrangements agreed with local criminal justice agencies and forensic services;
 - Have a core staff base that comes from the following areas:
 - Social care
 - Nursing
 - Psychiatry
 - Psychology
 - Occupational therapy
26. In addition access to other services such as pharmacy is essential, and there should be access to other therapies professionals as required. It is also important for CMHTs to have in place the right support and supervision for care co-ordinators and CMHT staff to enable the most effective use of expertise. Having a skilled, competent workforce, with effective management is an important aspect of a functional team.

7. Principles of access

27. Managers of mental health and social care services must ensure that people do not fall through gaps between services, and that CMHTs deliver services for

people with a mental disorder who are in most need, at most risk and who are the most vulnerable. They should take into account both health criteria based on prioritising those at highest levels of clinical need, and social care criteria based on local eligibility, with allowance made for vulnerability and other individual factors which make CMHT intervention appropriate. There must be a clear and appropriate mechanism for adjudication where there is a dispute over access to a service.

28. Examples of care which may be required within these access principles include:

- Individuals with severe and enduring mental disorders which are associated with significant disability and require proactive follow up, and may require other specialist input such as Eating Disorder services, personality disorder services, etc.;
- Individuals with any mental disorder where there is a significant risk of harm to self and/or others;
- Individuals with complex need which exceeds that which a primary care or Tier one service could offer;
- Individuals with disorders which require skilled or intensive treatments or medication monitoring/maintenance not available within primary care settings;
- Individuals with complex needs requiring treatment under the Mental Health Act 1983, including patients discharged under community treatment orders.

29. It is essential that where people are referred to CMHT services, but do not fall within these access principles, or it is more appropriate to be referred to another service, they are sign-posted to appropriate alternative services. The referrer must always be notified when this happens. See Action 4 in Annex 1. Annex 2 gives further guidance on the principles for accessing services.

8. Ongoing interventions and constructive discharge

Discharge from Tier 2 services

30. Community mental health teams must ensure that they have clear discharge processes in place that identify when service users no longer require the intervention of Tier 2 services. Discharge from the service should be sensitive to the needs of individual service users, and ensure that detailed care pathways are included in discharge plans. Such a pathway should include the options and choices available to service users and their carers should there be a concern about potential relapse, and what to do in crisis. The care plan should detail these arrangements on discharge. Appropriate discharge for most individuals should be seen as a positive outcome and part of the recovery process.

Transfers of care

31. There should be formal and agreed transfer of care arrangements between and across services at all points of transition. Where these are not possible (for example, with areas outside of the locality) the absence of such agreements should not delay, or adversely impact on the transfer of care for an individual.
32. Where an individual is moving between services, they will remain linked to the original service, for example, on transfer to specialist eating disorder services, there should be an identified person in the health and or social care team acting as a link for the CMHT. This remains the case even when the care coordinator function is handed over to the specialist service. All individuals with severe and enduring mental health needs who are accepted within Tiers 2, 3 and 4 of the mental health system should always be known to the CMHT wherever they may be within the system (e.g. high secure care or receiving treatment out of area).
33. Those who remain with the CMHTs for ongoing interventions and monitoring should have regular reviews as part of the CPA process. Local protocols should identify and clearly map out the referral pathways between primary and secondary care in order to enhance and strengthen the interface with the CMHT. Such protocols should include information on transition between service areas.

9. Key relationships

Liaison and links with services within Tier 2 services

34. Mutually agreed and documented responsibilities, liaison procedures and in particular transfer procedures need to be in place where discrete teams are established to deliver crisis resolutions/home treatment services, assertive outreach services and early intervention services. These arrangements must be subject to regular review and revision.

Liaison and links with more specialist services

35. In order for CMHTs to work effectively, links will need to be established with other services outside the realm of CMHTs to provide a holistic package of care. This includes links with:

Health and Social Care

- **Child and adolescent mental health (CAMHS)**

It is important that CMHTs act on the joint protocols established within the NSF Key Action 37 for engagement with CAMHS. The protocols must ensure planned and effective transitions between services, and clarify current service provision to reduce uncertainty and ensure potential gaps within local provision are minimised. Some service flexibility will need to be ensured as services must be delivered that are based on the needs of each young person whatever formal arrangements are in place.

- **Learning disability**
A learning disability should not be a barrier to accessing CMHT services if the CMHT is best placed to meet the presenting mental health need. Individuals whose main presenting need is related to a learning disability should be referred to specialist learning disability services, and services should collaborate to manage those who have co-morbid conditions effectively.
- **Substance misuse**
For those individuals with a dual diagnosis of substance misuse and mental disorder, where the primary issue is the mental disorder, mental health services will take the lead, but work closely with the substance misuse team who should continue to provide support.
- **Eating Disorder**
An eating disorder is not a barrier to accessing CMHT services if the CMHT is best placed to meet the presenting need. Individuals, whose clinical problems are complex and where more specialist advice would assist their management, should be referred to specialist eating disorder services, where the teams will work collaboratively as identified in the Eating Disorders Framework.
- **Personality Disorder**
A personality disorder should not be a barrier to accessing CMHT services where the person is likely to benefit generic CMHT support or treatment. Most individuals with a personality disorder are likely to be seen within Tier 2 services, and where Tier 3 or 4 services are required, close liaison with the CMHT must be maintained.
- **Older Persons Mental Health Teams**
In general the principles iterated above apply across all adult services. It is accepted that there are generally discrete Older Persons Mental Health Teams which cover both functional illnesses such as depression and organic conditions such as the dementias. Individuals should be cared for by the team that can most effectively meet the person's needs, rather than having arbitrary age boundaries. In particular, transfers from working age adults to older person's services should be due to a change in needs rather than an age based criteria, and wherever possible agreed with the individual and their carer. Mental health managers should set up mechanisms to arbitrate where there are disagreements.

Advocacy

36. The Welsh Assembly Government's 'Revised Adult Mental Health Services National Service Framework' (2005) recognised the need for a range of independent, trained and dedicated advocacy services to be made available and promoted across Wales. Links should be made with advocacy services to ensure that appropriate information and support is available.

Third Sector

37. Community Mental Health Teams function within local communities and as such are dependent on close working relationships with the non-statutory sector. Strong links and partnerships should be developed with the third sector to ensure that Tier 2 service provision is socially, culturally and economically relevant for all service users.

Standards for Community Mental Health Teams

To support the delivery of the policy implementation guidance, Community Mental Health Teams are expected to meet the following standards:-

Standard		Measure(s)
<i>Referrals and initial assessment</i>		
<p>1. The CMHT will produce and publish clear access criteria based on agreed principles for service provision.</p>	<p>Access criteria should be sensitive to local needs analysis and also take account of the principles set out in this policy implementation guidance and in Annex B</p>	<p>Access criteria, pathways and protocols available and reviewed as a minimum biennially. Published document(s) available to all users in each LHB and LSSA area. Information Leaflet available for individuals.</p>
<p>2. The CMHT will ensure that all relevant assessments are undertaken in accordance with clinical and legislative requirements (including statutory guidance).</p>		

Standard		Measure(s)
<p>3.</p> <p>The CMHT will offer timely assessment of the needs of people referred to the service. Assessments will be prioritised according to apparent need and risk and will be undertaken by appropriately competent and qualified staff in accordance with CPA guidance.</p> <p>A supervised triage approach to response times for assessments to be undertaken, namely:</p> <ul style="list-style-type: none"> - Emergency referrals will be seen within 1-4 hours; - Urgent referrals will be seen within 48 hours; - Routine referrals will be seen within a maximum of 4 weeks, but usually much sooner 	<p>Referrals to secondary care Mental Health should go through a single point of access within the CMHT.</p> <p>This initial assessment should have a focus on the whole person, including elements of daily life as well as their current presenting symptoms.</p> <p>Clear agreement with CRHT in place to avoid duplicate assessments and appropriate management of emergency and urgent referrals.</p>	<p>Single point identified, known to all agencies.</p> <p>Audit and reporting of waiting times from receipt of referral through each process.</p>
<p>4.</p> <p>The CMHT will ensure that for referrals that fall outside of any access criteria, prompt feedback to the referrer is given which includes alternative options signposted where appropriate.</p> <p>Outcome of initial assessment will be communicated to the service user and referrer as soon as practicable but no later than 10 working days of assessment</p>	<p>Alternative services clearly signposted with supported written information about contact details of alternatives.</p>	<p>Response to referrer within 10 working days of receipt of referral.</p> <p>Response to referrer within 10 working days.</p> <p>Response to service user within 10 working days.</p>

Standard		Measure(s)
<p>5. The CMHT will ensure that for initial referrals that appear appropriate, but where the individual does not attend for assessment, there are clear protocols in place to make contact and engage with that person as soon as possible either directly, or through the referrer.</p>	<p>Agreed actions commensurate with risk of need and vulnerability undertaken by teams.</p>	<p>Written protocols for DNA's in place that are consistent across Wales.</p>
<p><i>Caseload management</i></p>		
<p>6. The CMHT will discuss all referrals and all completed assessments at a weekly meeting.</p>	<p>The team will discuss and agree a consensus on the best management and interventions for all referrals.</p>	<p>Weekly meeting with records of agreed outcomes.</p>
<p>7. The CMHT will discuss people whose care and treatment is being managed by associated teams within the whole system.</p>	<p>Normally inpatient services and CRHT workers will attend the MDT for a period to discuss current cases held by that part of the team. For patients located distantly (e.g. within high or medium secure services), the care co-ordinator or key local contact will attend CPA meetings and report back to the CMHT on a 6-monthly basis.</p>	<p>All service users within Tiers 2, 3 and 4 will be known to the CMHT and be on their case management system. This includes people located distantly.</p>
<p>8. The CMHT will undertake multidisciplinary reviews, as a minimum once a year, of all people on its caseload, in accordance with CPA guidance.</p>	<p>The detailed planning in relation to individual cases will be undertaken in formal Care Programme Approach meetings arranged by care coordinator (see relevant CPA guidance).</p>	

Standard	Measure(s)	
<i>Interventions provided by CMHTS</i>		
<p>9. The CMHT will be able to provide general Tier 2 evidence based interventions for all those who need them in a timely manner. General Tier 2 interventions will include as a minimum:</p> <ul style="list-style-type: none"> • Effective medication arrangements³ including across primary and secondary care so that any changes are communicated appropriately; • Access to a range of core psychological therapies; • Access to psycho-social support and interventions (e.g. housing, employment, benefits, training/education and activities of daily living); • Relapse prevention interventions; • Substance misuse assessment including the delivery of basic harm minimisation interventions and motivational interviewing (more complex cases may need referral to specialist services); • Support to assure physical health needs met in primary care; • Relevant support to closely involved family and/or carer(s). 		<p>Outpatient waiting times audit.</p> <p>Quality of intervention as formal audit e.g. Lithium level monitoring.</p> <p>WARRN/other risk training numbers.</p>

³ Note that where an individual is subject to a community treatment order (within the meaning of the Mental Health Act 1983) the GP may not amend the medication for mental disorder without discussing this first with the approved clinician in charge of the treatment in question and ensuring that the relevant Part 4A certificate remains valid

Standard	Measure(s)	
Key relationships – links		
<p>10. The CMHT will establish links with other services to ensure that action is taken to update the risk assessment and care plan at points of transition. This includes links with:</p> <ul style="list-style-type: none"> • Inpatient care • Co-occurring substance misuse services • Rehabilitation services • Eating disorder services • Forensic services • CAMHS • Local primary mental health support services • Co-occurring learning disability services • Criminal justice agencies, including court diversion schemes • Independent advocacy services • Voluntary sector providers • Housing agencies 		<p>Agreed protocols for regular communication normally weekly in MDT.</p> <p>Formal CMHT records maintained annual audit is available.</p> <p>Care pathway agreed and signed up to.</p>

Standard		Measure(s)
<i>Constructive discharge</i>		
<p>11.</p> <p>The CMHT, including where appropriate AO, CRHT and EIP staff, should be fully involved in discharge planning, ensuring that Care Plans and Crisis Plans with relapse signature if appropriate are in place</p> <p>All individuals discharged from inpatient care should have a first follow up within 5 working days of discharge.</p>	<p>Appropriate agencies should be involved in discharge planning to ensure smooth transition.</p>	
<i>Integration of health and social care</i>		
<p>12.</p> <p>The CMHT will undertake a demand and capacity assessment taking into account the variation in demand over a 4 week period. This will help inform workforce requirements, and ensure that the appropriate numbers of professionals with the appropriate skills and competencies are in place to respond to local needs within the access criteria timescales.</p>		<p>Each CMHT to provide evidence that a demand capacity plan has been undertaken.</p> <p>Each CMHT to provide a workforce plan that informs on the workforce numbers and skills required to meet local need.</p> <p>Each CMHT to provide evidence on the actions taken / planned, that responds to the service demand identified</p>

Access principles for Adult Community Mental Health Teams (CMHTs) in Wales

Introduction

Establishing clear access criteria based on agreed principles for service provision is important in ensuring the prioritisation and targeting of resources to those people with the greatest and most immediate need. This will be determined primarily by the level of risk and need identified during screening and assessment processes in line with the Care Programme Approach (CPA). It will be a matter for professional judgement and will be determined on a case by case basis taking into account the summation of a variety of factors outlined below.

The majority of people engaged by adult CMHTs will be of working age. It should not exclude people of pensionable age where provision of their care is more appropriately delivered within an adult CMHT. Children (those under 18) will normally be looked after by CAMHS teams but support from specialist services and engagement for transition from within the CMHT may sometimes be helpful.

Transition into adult CMHTs and into older people's mental health services therefore needs to be negotiated with CAMHS and Older Adult teams respectively. This will require the use of clinical judgement on a case by case basis undertaken in consultation with the person receiving care and their family.

Duration of the Disorder

CMHTs deliver both short term and longer term interventions with the primary purpose of contributing to the person's optimal recovery. Many people treated by CMHTs will therefore be referred back to their GP following intervention, typically 5-6 contacts. The presence of short duration disorders does not prevent access if the severity of the disorder would warrant CMHT intervention.

Severe and persistent mental disorders associated with significant disability would normally indicate the need for services to be delivered by a CMHT. These mental disorders would predominantly be psychoses such as schizophrenia and bipolar disorder and longer term disorders of lesser severity but which may be characterised by poor treatment adherence requiring proactive follow up but not reaching the threshold for an assertive outreach service. Depending on level of severity, many mental disorders e.g. eating disorders, significant personality disorders etc. will need to access the CMHT and who may additionally need input from more specialist services.

The degree of distress arising from the disorder

Whilst diagnosis of psychosis and major affective disorders are indicative of heightened priority, consideration should be given to the degree of distress and the life limiting consequences arising from the presenting disorder regardless of

diagnosis. Some individuals may experience traumatic life events that will precipitate extreme distress and this may reach a level when it will become a mental disorder and may require CMHT input.

The presence of Co Morbid disorders

When establishing criteria for CMHT services interventions, care should be taken to consider the potential for any presenting disorder being accompanied by other mental and/or physical disorders. The presenting disorder may in itself not reach the threshold for access. However, when considered along side other secondary or tertiary conditions this may well raise the person's requirement for service. There are many such conditions including for example neuropsychiatric and other physical conditions that may require CMHT input.

In recent years the increased prevalence of co-occurring mental health and substance misuse and the risks associated with this presentation have become a highly significant issue in mental health services. A Service Framework to meet the needs of people with a co-occurring substance misuse and mental health problem was published by WAG in July 2007. Access principles should be considered taking into account that service framework. The service framework is clear that where a severe mental illness accompanies substance misuse problems, the mental health service will take the lead in service provision for the mental illness. However this does not negate the importance of collaborative intervention from substance misuse services.

Personality disorder can be accompanied by a mental illness which may be "masked" by the behaviour associated with the personality disorder. Care must be taken to ensure that the potential for a co morbid condition is adequately assessed and considered in exploring the impact of each condition and the consequent requirement for service provision.

People with a learning disability or who have autistic spectrum disorder may also have co-morbid mental health problems and as identified in the main document teams should work together to manage such cases with clear agreement about which service leads for which component of the illness.

Risk of Harm to Self

This includes consideration of risk of;

- Self harm (cutting, ingestion of harmful substances or other behaviours that have or are likely to lead to serious injury or death regardless of intent).
- Self neglect (an inability to carry out routine tasks necessary to sustain good physical and/or mental health)
- Vulnerability to physical and/or emotional abuse whether by act or omission
- Vulnerability to sexual and/or financial exploitation whether by act or omission.

Risk of Harm to Others

In individuals with a mental disorder this may include risk of:

- Actual or threatened physical violence
- Psychological harm
- Actual or threatened sexual violence
- Physical, sexual, emotional abuse or neglect of children
- Abuse of vulnerable adults including financial or sexual exploitation

Ability to care for ones self

This includes all areas of daily living, lack of social/community integration leading to social isolation/exclusion and lack of paid or voluntary work and maintaining family life. This could include self neglect and vulnerability to abuse and exploitation but has a broader threshold reflecting the potential loss of independence, employment and broader social relations.

Ability to care for dependant children and adults

Part 4 Sections 67 and 68 of the Children and Families (Wales) Measure place duties upon Local Authorities and Health Boards to meet the community care needs and health care needs of parents where these needs lead to a child or children to be in need within the meaning of Part 3 of the Children Act 1989. People being assessed for CMHT intervention may also provide care to adults. In determining access to services consideration of a persons ability to fulfil these caring roles should be fully considered.

Establishing access

In considering access to services, the range of factors outlined above and any other appropriate and relevant factors need to be considered together in line with the relevant legislation and the Care Programme Approach. Practitioners and clinicians have to apply careful professional judgement in the application of these criteria using evidence based tools to assess where appropriate.