Generic Integrated Care Pathway

For use by all professionals working in Mental Health Services and Partner Agencies for all people coming into mental health services in Lanarkshire
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1. Generic Patient Journey

1.1 Introduction

“Our mental health is important to all of us as it affects every aspect of our lives. There is no health without mental health.” (Towards a Mentally Flourishing Scotland Policy and Action Plan 2009-11)

Mental health is about how people think and feel. How we think and feel affects our overall health and well-being and quality of life. It is estimated that there are up to 850,000 people with mental health problems at any one time in Scotland. Mental health problems can include a wide range of conditions with varying symptoms and severity, for example, depression, eating disorders, bipolar disorder and schizophrenia. Mental health problems cause considerable poor health in Scotland. Rates of suicide in Scotland are higher than in England and Wales. Mental health problems can affect anyone but people who are likely to be socially excluded, such as people living in deprived areas, are at higher risk (Overview of Mental Health Services, Audit Scotland, May 2009).

In Lanarkshire, the Mental Health Strategy aims to create a multi-agency mental health model that is embedded in each natural community in Lanarkshire. This approach will influence the promotion of positive mental health and well-being and will deliver a range of services including treatment, care and support to those who encounter mental health problems.

Services will be locality based (in 10 localities in the four units which make up the North and South Community Health Partnerships [CHPs]). Specialist interventions and hospital treatment will be available but used only where necessary. These services will be accessible to local communities and access to services will be based on the needs and preferences of those receiving the service. Services will promote recovery using a model of social inclusion. (NHS Lanarkshire Mental Health Strategy, 2006 – 2011).

1.2 Rational for Developing the ICP

NHS Quality Improvement Scotland (QIS) (an organisation which helps health boards to improve the quality of care and treatment provided by the NHS in Scotland), is helping health boards to develop Integrated Care Pathways (ICPs) for mental health services. An Integrated Care Pathway is a tool that allows the,

“comparison of planned care with care actually given” (Standards for Integrated Care Pathways for Mental Health, NHS QIS, 2007)

For people using these services, this means the right care and interventions at the right time, in the right place. ICPs are much more than a document of care given; they also embody a system of care planning, organisation, co-ordination and governance. To achieve this NHS QIS has published standards for the development of ICPs detailing:

♦ how ICPs should be developed;
♦ the general care and interventions which should be offered to people coming into mental health services and specific care and interventions for five conditions (bipolar disorder, borderline personality disorder, dementia, depression and schizophrenia);
♦ how ICPs should be monitored.
In Lanarkshire these standards have been incorporated into the development of this Generic ICP and into five condition-specific ICPs which can be added to the Generic ICP when required for people with these conditions. In Lanarkshire various terms are used to describe the people who use mental health services which include, “clients”, “patients” and “service users” and to simplify this we have used the single term “patients” in this Generic ICP and the condition-specific ICPs. These ICPs have been put together by local development groups consisting of NHS staff, patients and carers, local authorities, voluntary organisations and the independent sector (see Appendix 1, Generic ICP development group members).

1.3 How to use the Lanarkshire Generic ICP

The Generic ICP will automatically be used for people accessing mental health services in Lanarkshire (with the exception of those people with depression who do not require specialist assessment and treatment in which case only the condition-specific ICP for depression will be used). For all others the Generic ICP will apply and if appropriate, the condition specific ICPs will be used as required. This ICP is designed to be used for any person over the age of 16. Additionally, people with learning disabilities can access services via the Lanarkshire Learning Disabilities Service. For young people aged 16 or under services can be accessed through the Lanarkshire Child and Adolescent Mental Health Service.

The Lanarkshire Generic ICP is based on a stepped model of care as described in the Lanarkshire Mental Health Strategy. The focus is on the patient journey across various service elements taking into account the different care and treatment needs the patient may have at different times and how these needs can best be met by health and partner agency services. The ICP documents this journey of care across all of the service elements, forming part of the care record. Staff involved in delivering each episode of care will contribute to completing the ICP documentation.

This model should place the emphasis on the whole person, rather than just their symptoms and view the patient as the ‘expert’ in their experience (Rights, Relationships and Recovery, the Report of the National Review of Mental Health Nursing in Scotland. Scottish Executive April 2006). The ICP encompasses a culture and values which aim to enable person-centred recovery and strengths-based focus with a move towards positive management of individual risk, maximising choice and access to evidence-based interventions (see Appendix 2, Guidance and Policy Base).

The ICP is intended to provide a standard model of good care based on the current evidence base and expert opinion. It is important to note that the ICP is a guide to good care but it should never replace sound professional judgement. The professionals’ assessment and judgement will always override the advice of the tool where this is necessary. The ICP is part of the patient record and as with all such records, it will be private and confidential with access governed by the usual rules of confidentiality.

By using this ICP we will be able to produce data about the care and interventions provided to people in Lanarkshire with borderline personality disorder/complex trauma. This information (variance data), will allow us to compare the actual care and interventions given with those planned in the ICP and enable us to identify areas where the ICP should be modified to improve the quality of care provided. The variance information will also identify resource issues, gaps in service availability and future staff training and supervision requirements.
1.4 Tiered Model

The Tiered Model illustrates the matched approach to care across the various levels or tiers of service. This means that the interventions and services provided match the level of need of the patient. Table 1 shows the services provided in each tier.

**TABLE 1 Description of Tiers**

| Tier 0 - Community Health and Wellbeing | Generic services providing education, health improvement and preventative approaches | voluntary services, public health services, local authority education and leisure services |
| Tier 1 - Primary Care and Mental Health Services | Entry level for care where professionals will seek to address issues before they may require referral on to more specialised and focussed services | general practitioner, public health nurse, long term conditions nurse, midwife, allied health professionals, e.g. dietetics, physiotherapy, occupational therapy |
| Tier 2 - Secondary Care Community Mental Health Services | Specialist community and inpatient based structured treatment service accessed by referral from Tier 1 | community and inpatient mental health services – incorporating crisis response and intensive home treatment and locality based psychological therapies, addiction services |
| Tier 3 - Tertiary Care | Specialist and high intensity treatment services. Access by referral from Tier 2 | intensive psychiatric care units, low secure forensic unit, eating disorder service, mother and baby mental health unit, complex needs, specialist addiction services |

All available services are included within the Generic ICP (as illustrated in Chart 1), but will be used as required by each individual patient. Once a person has been assessed by a health professional and a mental health need identified, a decision in collaboration with the patient (and carer where appropriate) will be reached on the most appropriate care and interventions. This will inform which pathway the patient will follow.

**CHART 1 Generic Patient Journey**
2. Mental Health and Wellbeing Services (Tier 0)

2.1 Introduction

Mental health is a term used to describe emotional, psychological and spiritual wellbeing and has been defined as,
“the emotional and spiritual resilience which enables us to survive pain, disappointment and sadness. It is a fundamental belief in our own and others’ dignity and worth.”

Health Education Authority, 1997

For individuals, mental health is how a person thinks, feels, and acts when faced with different situations. It is affected by factors that promote or demote peoples’ sense of wellbeing either individually or at population level. Mental health improvement is an inclusive term that may include action to promote mental health and wellbeing, to prevent mental health problems and to improve quality of life for people with a diagnosed mental health problem.

2.2 Social Prescribing

Social Prescribing is the term used to describe the non-medical sources of support available in the community for people with or who are at risk of developing mental health problems. These might include opportunities for arts and creativity, physical activity, learning, volunteering, mutual aid, befriending and self help, as well as support with, for example, benefits, debt, legal advice and parenting problems (Developing social prescribing and community referrals for mental health in Scotland, Scottish Development Centre for Mental Health, November 2007).

In Lanarkshire the services available at Tier 0 to promote or improve a person’s mental health and wellbeing are referred to as ‘Gateway Services’ and include services such as carer’s organisations; housing, homeless and tenancy support; volunteer services; leisure and sports facilities and counselling services. A comprehensive list of services has been put together in the North and South Lanarkshire Directories of Services which are available via the NHS Lanarkshire intranet (in the Mental Health Section) or on the Elament website and which are updated on a 6-monthly basis.

The Lanarkshire Healthy Reading Programme launched in 2010 as part of this social prescribing agenda, makes it easier for people to access mental health and well-being leaflets, books, CDs, DVDs and web-based support, through visiting the library or referral from GPs and other services in the community. All 50 libraries across Lanarkshire now have resources aimed at helping people get the most from life, such as living life to the full, sleeping better and becoming more confident and assertive.

Healthy reading can be helpful for people to overcome and cope with mental health problems such as anxiety, depression, stress, dementia, eating disorders, bereavement and panic. There are also resources for all ages including supporting young people, adults and older people as well as items on positive parenting. More information on how to access this support is on the Elament website (details below).
As part of this programme, Elament (Lanarkshire’s Mental Health and Well-being Website) has also been re-launched, with a full range of self-help materials for everyone to use. It also includes an improved service directory with maps built in to help people access services more easily. In addition, a self-help CD called “Mind to Listen” has been produced, with advice on stress, low mood, bereavement, sleep and includes relaxation exercises. This is available from every library or can be downloaded from ‘Elament’, http://www.lanarkshirementalhealth.org.uk/.

2.3 Access to Services

Services can generally be accessed by individuals without going through a GP first, (although people may be referred to them from primary care and specialist mental health services) and include services provided by health, local authorities, voluntary organisations and independent providers.

We record the use of Tier 0 care and interventions in relation to the add-on condition specific ICP for Depression. When a person attends their GP or primary care mental health services and initial assessment indicates suitability for self help treatment, direction to the ‘Healthy Reading Scheme’ or other options as described above, we can record the use of these services as part of that ICP. Services such as these may also be used in conjunction with treatment given at different Tiers of the service and this can also be recorded as part of other condition specific ICPs. (See the Depression ICP and other condition specific ICPs.)
3. Primary Care Services (Tier 1)

3.1 Introduction
Approximately 90% of mental health problems are identified, assessed and managed within primary care. Primary care services cover the mental health needs of people from the antenatal period to the end stages of life. A person centred, socially inclusive focus is at the heart of all assessments, care planning and care delivery ensuring that actions are based on recovery, value based approaches and outcomes identified by the patient rather than on the availability of services and treatments.

3.2 Primary Care Services
Services provided at Tier 1 in primary care are based on assessment and diagnosis made using clinical judgement and the use of standardised assessment tools such as PHQ9 or other appropriate tools. Services include:
♦ Assessment and diagnosis
♦ Risk assessment
♦ Primary Care Treatment
♦ Information and advice
♦ Monitoring, relapse prevention and review
♦ Onward referral to specialist mental health services, local authority services and other agencies.

3.3 Locality Based Service Provision for Mild to Moderate Mental Health Problems
The Psychological Therapies Implementation Plan for Lanarkshire (May 2010) states that, “Each locality will have a multidisciplinary team of clinicians providing psychological therapies to adults, offering a variety of evidence-based interventions at a level appropriate to the need of the client”.
Part of this service provision includes the use of Clinical Associates in Applied Psychology (CAAPs) as an integral part of the locality psychological therapies team to address mild to moderate mental health problems. Equitable and effective provision will be provided for people with mild to moderate health problems in primary care, with services primarily provided by CAAPs, Counsellors and Gateway Workers.
3.4 Living Better National Programme Pilot

Living Better North Lanarkshire Pilot - is part of a national programme to improve the mental health and well-being of people with long term conditions such as diabetes, coronary heart disease (CHD) and chronic obstructive pulmonary disorder (COPD). It is currently taking place in Bellshill and aims to assess, detect and manage psychological stresses that living with a long term condition can sometimes cause. Health service staff screen people known to the service for anxiety and depression and can take the following actions:

♦ Review after 2 weeks
♦ Signpost people to services such as those described in Tier O (see Point 2.2)
♦ Refer onto the GP for further assessment and treatment if required (linking into the mental health ICPs as appropriate).

The project is due to end in December 2010 and will be evaluated to determine any future roll out of the service.

3.5 Access to Services

The most usual method of accessing services is through the GP practice. As with Tier 0 services we record the use of Tier 1 care and intervention in relation to the add-on ICP for Depression or when these services are used in conjunction with treatment given at different tiers of the service as part of other condition specific ICPs. (See the Depression ICP and other condition specific ICPs.)
4. Secondary Care Services (Tier 2)

4.1 Introduction
Most people treated by secondary care community mental health services will have
time limited disorders and be referred back to their GPs after a period of treatment
(which will usually last for weeks or months), when their condition improves or secondary
care community services are not the most appropriate way of receiving care and
interventions. Some people will require care and intervention for a longer period of
time. This includes people with:

- Severe and persistent mental disorders with significant effects on day to day
  functioning. This will predominately be people with psychotic illness such as
  schizophrenia, bipolar disorder and other types of psychosis.
- Other long term non-psychotic disorders which require care and treatment that
  require a level of support and expertise that cannot be delivered by the primary
  care team alone.
- Any disorder where there is also a significant risk of self harm, harm to others or risk of
  suicide.
- Severe disorders of personality where these can be shown to benefit from a care
  package involving secondary care mental health services.

(Mental Health Policy Implementation Guide, Community Mental Health Teams,
Department of Health, June 2002)

4.2 Functions Provided by Secondary Care Services
1. Giving advice on the management of mental health problems by other
   professionals, in particular advice to colleagues in primary care and a triage and
   assessment function enabling appropriate referral and intervention matched to
   need.
2. Providing care and interventions for those people with time limited disorders who
   can benefit from specialist interventions.
3. Providing care and interventions for those people with more complex and enduring
   needs.

4.3 Secondary Care Community Mental Health Service Delivery Model
The model of secondary care community mental health services has been based on
the Resource Network model. A key part of this network is locality based health and
social work community mental health services working in partnership with other
statutory and voluntary service providers to deliver a variety of services for the residents
of Lanarkshire. Chart 2 shows the patient journey through secondary care services.
Secondary Care Community Mental Health Service Patient Journey

July 2010

Referral from:
- GP (other routes via GP), other professions
- Emergency Department
- NHS 24/Out of Hours Service
- Care Homes
- Non-mental health inpatient services
- Police/Court Services
- Social Work Reception Services

Referral discussed with patient (and carer if appropriate) by referrer before referral made

Referral Criteria met
- URGENT
  - Follow Crisis Service Model
- ROUTINE
  - Standardised Referral Form or eReferral completed and sent to Locality Mental Health Service patient's GP practice area
  - Multidisciplinary Vetting/Screening/Allocation

Acceptance for Assessment:
- Appropriate person appointed within 2 days to carry out assessment
- Appointment letter sent or phone call to patient
- Appointment date made for within 8 weeks of referral date

Initial Assessment carried out:
- Core mental health assessment
- Multi-agency risk assessment

Suitable for other secondary care community mental health service or inpatient services – discussion with referrer and patient and onward referral made same day as screening

Further Intervention Required
- Case allocation
- Complete required/specialist assessments (as detailed in narrative)
- Measure of needs and outcomes: patient, carer needs assessment, e.g. AVON; professionally rated validated measure of outcome, e.g. HoNOS
- Initial Care Plan formulation agreed in collaboration with patient and relevant others
- Care and Intervention Plan agreed with patient and referrer informed
- Discharge Planning commenced

Case Holder actions:
- Continuity of care via home visits, repeat appointments, etc.
- Clear instructions to patient for contact out of hours or when case holder away
- Maintain communication with primary care

Initial Review at 8 weeks after initial assessment (or sooner if required):
- Agreement with patient (and carer if appropriate) on action and outcome of review

Agreed Outcomes Achieved?
- NO
  - Ongoing Care, Interventions and Review:
    - 4 monthly reviews carried out and reported to local primary care team by case holder
    - Further actions identified as per specific conditions
    - Annual health check carried out
    - Ongoing discharge planning

  - If needs cannot be met by locality mental health team:
    - Consider referral to appropriate service/agency, e.g. crisis services, inpatient services, local authority services

- YES
  - Discharge Letter sent within 10 working days which includes:
    - Care and interventions received
    - Previous and current pharmacological treatment
    - Other agencies involved
    - Outcomes achieved
    - Current Care Plan
    - Risk Assessment
    - Staying Well Plan
    - Arrangements for re-referral if required

  - Summary Care Plan agreed with patient, copy provided (with Emergency Info Card) to patient and other relevant parties

  - Verbal discussion on hand over

  - Onward Referral to primary care, other secondary care mental health services, and agencies
4.4 Referral

ICP Standard 9a: There is an agreed decision-making system to support referrals into mental health services.

ICP Standard 9b: Service care providers have an agreed system on how referrals are managed within their mental health services, including: initial screening, triage assessment and signposting to required service according to complexity of need.

♦ All referrals must be discussed with the patient and carer (as appropriate) by the referrer before a referral is made.

♦ The referrer must identify whether the referral meets the criteria for routine consideration by the locality mental health service and should be made to a single point of access to the service. People requiring urgent assessment will follow the Crisis Service Model. The Crisis Service in Lanarkshire operates as a function of the CMHT and offers assessment and resolution for people in mental health crisis, where the person is at risk of admission to hospital. Alternatives to a mental health hospital admission are always considered first (see Appendix 3).

♦ Referral to the locality mental health service will involve the completion of a Standardised Referral Form/eReferral* sent to the team for the GP practice area.

♦ Referrals are screened initially on receipt, followed by a multidisciplinary vetting/screening/allocation meeting where the most appropriate action is agreed:
  i. Not appropriate – a discussion is held with the referrer on the same day as the screening/allocation meeting.
  ii. Suitable for other secondary care community mental health services. A discussion is held with the referrer and the patient and onward referral is made by the secondary care community mental health team as appropriate on the same day as the screening meeting.
  iii. Accepted for assessment – an appropriate person is identified within 2 days to carry out this assessment.

♦ An appointment letter is sent to the patient with a Patient Service Information Leaflet* or is contacted by phone with the date, time and venue for the appointment. The person should be seen within 8 weeks of the date of receipt of the referral in line with the 18 weeks waiting times target (or as per condition-specific ICP standards).

♦ If the person does not attend, their GP should be notified and a second appointment sent out. A discussion should be held with the multidisciplinary team and a decision made regarding further assertive action. If the person does not attend the second appointment, discussion should take place with the GP and further actions agreed and documented.

*To be agreed as part of ongoing development work.
4.5 Assessment

ICP Standard 10a: A holistic assessment is carried out with the service user and identifies: current and past mental health problems (including the informal carer's perspective); current and past interventions for these problems (including outcomes, adverse reactions and side-effects); personal, family and social circumstances; strengths and aspirations; physical health problems; functioning (e.g. life skills assessment); patient needs assessment (e.g. Avon) and where appropriate, informal carer needs assessment; capacity to consent to care and treatment, and drug and alcohol use and misuse.

ICP Standard 10b: A target time for completion of the holistic assessment is recorded.

ICP Standard 11a: There is a record of the service user's vulnerabilities and risks, including: self harm; suicide; harm to others; finance; occupation; social vulnerability; sexual vulnerability; abuse; neglect, and informal carer risk assessment, where relevant.

ICP Standard 11b: The risk assessment leads to the generation of a risk management plan that is: developed with the service user; communicated to all those involved and identifies roles and responsibilities; reviewed at regular intervals, and amended as necessary.

ICP Standard 12a: There is a record of a risk assessment and management plan for women of childbearing age which includes: advice and explanation of risks of becoming pregnant during treatment; access to contraceptive advice; the considered involvement of a partner; previous history of puerperal psychosis; suitability of current medication while pregnant and in the postnatal period; the effects of medication on the foetus and on the woman, and the risk of relapse if medication needs to be withdrawn or changed.

ICP Standard 21a: The care record includes a needs assessment scale which is rated by service users and informal carers, e.g. Avon Mental Health Measure.

ICP Standard 21b: The care record includes a professionally rated assessment tool which is validated for the relevant client group to monitor outcome.

♦ A Core Mental Health Assessment and Multi-agency Risk Assessment as per the Generic Mental Health ICP documentation (electronic or paper based) are carried out which includes an assessment of cultural and spiritual needs. If appropriate, use the Lanarkshire Suicide Assessment and Treatment Pathway to assess suicide risk (see Appendix 4).

♦ For women who are pregnant also follow the Antenatal and Postnatal Mental Health and Wellbeing Pathway (see Appendix 5).

♦ The outcome of this initial assessment is:
  i. No further intervention required by locality mental health service. A No Further Intervention Letter* is sent to the referrer and patient (patient and referrer versions as appropriate).
  ii. Further intervention required.

♦ Case allocation (Key Worker) then takes place and the patient, GP and other relevant agencies contacted. Further assessments are carried out as required including alternative/additional assessments for specific conditions (see condition-specific ICPs).

*To be agreed as part of ongoing development work.
ICP Standard 14a: The care record shows: the diagnosis or diagnoses; information on how the diagnosis or diagnoses was reached following evidence based guidelines or established diagnostic criteria, where available confirmation that the diagnosis or diagnoses has been explained to the service user and informal carer, and post-diagnosis support is offered.

ICP Standard 16a: The care record shows that care is planned and agreed with the service user and informal carer in a format that is accessible and takes into account personal values and beliefs.

ICP Standard 16b: The care record shows that advice has been provided to the service user and their informal carer on sources of further information and support, for example voluntary organisations and advocacy services.

ICP Standard 17a: The single care plan records a nominated co-ordinator who has been identified and agreed with the involvement of the service user.

ICP Standard 17b: The single care plan operates across all service care providers and: is based on the assessment of needs, strengths and past experience; identifies goals and aspirations; specifies tasks, treatment and interventions (including risk management); records roles and responsibilities of all individuals and agencies involved; includes a record of service user desired outcome (self-directed outcome); includes a system to record disagreement; records that service users are invited to hold a copy of the care plan, and records unmet needs since the last assessment.

♦ An initial Single Care Plan/Formulation is agreed with the patient and relevant others, the referrer informed and discharge planning commenced (including condition-specific ICP requirements).

4.6 Management in Secondary Care Community Services

ICP Standard 11c: Serious incidents or near misses are reported in accordance with local governance arrangements.

ICP Standard 12b: There is a record that practitioners follow a local treatment algorithm for the management of women who are pregnant and being cared for through the ICP process.

♦ The Key Worker ensures continuity of care by using repeat appointments, home visits, etc. Clear instructions are provided to the patient for contact out of hours and who to contact when the case holder is away. Contact and communication should be maintained with primary care.

ICP Standard 18a: The care record shows the decision-making process, including when to initiate, change, maintain or end medication.

♦ Medication treatment decisions are recorded throughout the episode of care.

ICP Standard 19a: When substance misuse is identified in a service user with a mental illness, there is a record that matched care appropriate to each person’s level of need is offered.

♦ For patients who also have substance misuse issues, appropriate care is offered.
ICP Standard 17c: The single care plan is reviewed regularly (annually, or for dementia at least every 6 months).

ICP Standard 13a: The care record shows that physical health needs are assessed at least annually using the following features: the completion of a physical health assessment; the provision of health promotion advice, and service users receiving medication should have side-effects and physical health assessed and managed according to the appropriate algorithm for that medication.

ICP Standard 13b: The care record shows information on the management of physical health needs, including: information on who is responsible for the physical health assessment (primary care or specialist services); evidence that results have been shared; evidence that results have been acted upon, and evidence that information and / or advice on promoting a healthy lifestyle has been provided.

ICP Standard 17d: The single care plan includes: a record of the service user's named person, where applicable; the offer of an advance statement; a crisis plan drawn up by the service user and care team, and a staying-well plan.

An initial review is carried out 8 weeks after the initial assessment or sooner and agreement reached with the Key Worker, patient and carer if appropriate on onward action. If outcomes have been achieved the patient is discharged from the service, a Summary Care Plan is agreed and given to all relevant parties, and a discharge letter sent to the GP within 10 working days. Verbal discussion on hand-over of care should take place before discharge and appropriate documentation completed (e.g. Summary Care Plan*, Discharge letter to Referrer/Primary Care Team*, Emergency Info Card*).

If care and interventions are ongoing, 4 monthly reviews are carried out and reported to the local primary care team by the Key Worker. Ongoing review and further actions are identified (including care and interventions as per condition-specific ICPs), health checks carried out as required (minimum annual physical health check or as per condition specific ICPs) and discharge planning is ongoing.

As the Scottish Recovery Network points out, “People can and do recover from serious and long-term mental health problems.” This network is designed to raise awareness and promote the issue of recovery and their tools and advice have been promoted by NHS Lanarkshire for some time. To assist people in Lanarkshire with recovery we have a number of support methods and tools available (should the person wish to choose them) which include:

- **Elament** - an online mental health and wellbeing information website: [http://www.lanarkshirementalhealth.org.uk/](http://www.lanarkshirementalhealth.org.uk/).
- Recovery Plans and self help/self management workbooks such as My RAP (available on Elament) to help identify strengths and build on them with practical help
- Advance Statement
- Medication management/monitoring
- Patient and Carer support networks such as Lanarkshire Links.

If needs cannot be met by the locality mental health team, referral to other services/agencies should be considered.

*To be agreed as part of ongoing development work.
4.7 Management in Secondary Care Inpatient Services

**ICP Standard 20a:** When a service user is admitted to hospital, the care record shows: the reasons for inpatient admission; any alternative options considered; the aims of admission, in accordance with the recommendations of Bateman & Tyrer and Fagin for the borderline personality disorder client group; the expected and actual length of the inpatient stay; the plan for discharge.

Across Lanarkshire there are a variety of adult and older peoples’ inpatient wards including complex needs, rehabilitation, continuing care (including contracted beds in nursing homes) and secure accommodation.

Access to inpatient services is via community mental health teams (including the Crisis Service) and acute hospital emergency department mental health services using the Generic ICP documentation currently in use in acute admission wards and includes a requirement to pursue alternatives to admission. The reasons for and aims of admission, expected length of stay and plan for discharge are all documented for these admissions. Following discharge a community visit will take place within 7 days.

4.8 Psychological and Psychosocial Interventions

**ICP Standard 15a:** Psychological therapies are delivered by appropriately trained and accredited staff under practice supervision.

**ICP Standard 15b:** The assessed need for psychological and / or psychosocial interventions is recorded.

**ICP Standard 15c:** Where needs have been identified, there is a record that the service user has been offered a range of therapies, including educational, social and lifestyle advice as well as psychological and / or psychosocial therapies.

**ICP Standard 15d:** There are systems for the provision of psychological and / or psychosocial therapies, including: delivery within 3 months of referral; review of individual patient progress, and recording of outcome.

The need for Psychological Therapies is assessed, offered, and delivered within nationally agreed timescales, by a locality based multidisciplinary team of trained staff as per the NHS Lanarkshire Psychological Therapies Implementation Plan (May 2010). These teams also have direct access to area based providers of psychological services including:

- Psychotherapy
- Addictions Service
- Psychological Therapies for Older People
- Child and Adolescent Mental Health Service
- Eating Disorders Service
- Learning Disabilities Service
- Forensic Service

The delivery of Psychological Therapies in Lanarkshire is based on the principle of matched care, whereby individuals referred into the service are matched to the appropriate level of treatment for the level of complexity of their difficulties (NHS Lanarkshire Psychological Therapies Strategy, August 2009). This includes services for both people living in the community and hospital inpatients.
In addition the recently published Matrix document from the Scottish Government provides health boards with a comprehensive review of the evidence base for psychological therapies and guidance as to how these should be delivered (i.e. level of training required to deliver therapy, amount of supervision required).

Before any psychological or psychosocial therapy is undertaken a comprehensive psychological assessment and formulation should be carried out by an appropriately trained professional and recorded as per agreed recording procedures. Where needs have been identified a selection can be made from a Comprehensive List of Therapies/Interventions based on patient need and preferences. This is recorded via the multidisciplinary team as per agreed recording procedures. These therapies/interventions will be delivered within 3 months or as per agreed timescales. Management, review of progress, and outcome measurement as per points 4.6, 4.7.

**To be agreed as part of the ongoing Psychological Therapies Implementation.**
5. Tertiary Care (Tier 3)

5.1 Introduction
People are referred to Tier 3 services in Lanarkshire when specialist and high intensity care and interventions are required due to the severity and/or complexity of their condition. NHS Lanarkshire is currently expanding the range of specialist services currently offered to provide appropriate levels of community based treatments and skilled staff, aligned to commitments outlined in national policies and strategies. These services include:
- Forensic Service
- Addiction Service
- Eating Disorder Service
- Complex Needs.

5.2 Access to Tertiary Care Services
Referrals to these services are normally made by professionals working in Tier 2 services. The use of Tier 3 care and interventions are recorded in relation to the five condition specific ICPs (see condition specific ICPs).

5.3 Inpatient Services
There are a variety of tertiary care inpatient services, some provided in Lanarkshire and others outside:
- Eating Disorder Unit
- Mother and Baby Mental Health Unit
- Intensive Psychiatric Care Unit
- Inpatient Forensic Services
- Inpatient Complex Needs Service (rehabilitation and recovery)
Inclusion criteria are defined for each of these services. The reasons for admission, expected length of stay and plan for discharge are all documented for these admissions.
6. ICP Monitoring

Monitoring of the service provided to each person will take place using:

- **Variance Analysis** - questions to be agreed in conjunction with ICP development groups and national QIS ICP programme team.
- **Staff, Patient and Carer Surveys** - to be developed in conjunction with ICP development groups, national QIS public involvement group, etc.
## Appendices

### Appendix 1: Generic ICP Development Group Members

<table>
<thead>
<tr>
<th>Helen Ballantyne, Head III Occupational Therapist, NHS Lanarkshire</th>
<th>Annie McGeeney, Fieldwork Manager, Mental Health, South Lanarkshire Council</th>
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</thead>
<tbody>
<tr>
<td>Pamela Currie, Co-ordinator, Reach Out Team, NHS Lanarkshire</td>
<td>Dennis McLafferty, Senior Development Officer, North Lanarkshire Council</td>
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<tr>
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<td>Graham Paul, Senior Charge Nurse, NHS Lanarkshire</td>
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<tr>
<td>Eddie Dunnachie, Charge Nurse, NHS Lanarkshire</td>
<td>Karen Robertson, Associate Director of Nursing Mental Health and Learning Disabilities, NHS Lanarkshire</td>
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<tr>
<td>Janet Graham, Senior Charge Nurse (acting), NHS Lanarkshire</td>
<td>Helen Sloan, Charge Nurse, NHS Lanarkshire</td>
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<tr>
<td>Anne Hickey, Counselling Psychologist, NHS Lanarkshire</td>
<td>Lorraine Smith, Service Development Manager, NHS Lanarkshire</td>
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<td>Louise Holland, Lanarkshire Links</td>
<td>Karen Speirs, Mental Health Collaborative Programme Manager</td>
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<tr>
<td>Sonia Keith, Consultant Psychiatrist, NHS Lanarkshire</td>
<td>Ina Tainsh, Health Records Manager, NHS Lanarkshire</td>
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<tr>
<td>Janet King, Chartered Clinical Psychologist, NHS Lanarkshire</td>
<td>Alison Thom, Consultant Psychiatrist/Lead Clinician, NHS Lanarkshire</td>
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<tr>
<td>Peter Ledwith, Staff Nurse, NHS Lanarkshire</td>
<td>Theresa Watson, Senior Nurse for Clinical and Professional Practice (MH), NHS Lanarkshire</td>
</tr>
<tr>
<td>Rhonda Martin, Senior Charge Nurse, NHS Lanarkshire</td>
<td>Carol Yates, Staff Nurse, NHS Lanarkshire</td>
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**ICP Team:**     Patricia Kent, ICP Manager

Janis Dickson, Mental Health ICP Project Assistant
Appendix 2: Guidance and Policy to support Values

Guidance and Policy Base to Support Values (2010)

The Mental Health (Care and Treatment) (Scotland) Act 2003 is underpinned by the Milan principles of reciprocity, respect for equality and diversity in a non-discriminatory manner.

The 10 Essential Shared Capabilities for Mental Health promotes working in partnership, challenging inequalities (social inequality and exclusion), promoting recovery, providing service user centred care and making a difference.

The Scottish Recovery Indicator states the service should provide interventions designed specifically to promote participation in life’s roles, to self manage illness, and to enhance relationships with others.

NHS Lanarkshire’s Organisational Values which commit to quality, patient focused services; quality healthcare environment; continuous improvement; involvement; communication; respect, fairness and consistency; competence and continuous learning.


1. Person centred: providing care that is responsive to individual personal preferences, needs and values and assuring that patient values guide all clinical decisions
2. Safe: avoiding injuries to patients from care that is intended to help them
3. Effective: providing services based on scientific knowledge
4. Efficient: avoiding waste, including waste of equipment, supplies, ideas and energy
5. Equitable: providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location or socio-economic status
6. Timely: reducing wait and sometimes harmful delays for both those who receive care and those who give care.

Caring and Compassionate Practice is the work of a group from the Nursing, Midwifery and Allied Health Profession (NMAHP) Practice Development Centre in NHS Lanarkshire. It sets out a list of people’s expectations accompanied by statements that set the minimum practice standards for how nurses, midwives, allied health professionals and support workers must work on a day to day basis:

- To be valued as a person
- To feel and be safe
- To be cared for with dignity
- To see NMAHPs make the best possible effort
- To experience courtesy
- To be respected
- To receive kindness.
Appendix 3: Crisis Service Model

NHS Lanarkshire Mental Health Services

Crisis Function within CMHT Pathway
(Monday to Friday 8.30am-6.30pm)

- Referral from:
  - General Practitioner
  - Self-referral for active patient on caseload
  - Other services within multi-disciplinary team
  - Crisis Assessment Service

Referral discussed with patient (and carer if appropriate) by referrer before referral made

Duty Person takes call

Pass onto CAS (dependant on time call comes in)

Triage
Using Crisis Service Referral Form (including Risk Assessment)

Referral not appropriate

Communicate outcome to referrer

Referral appropriate

Telephone Assessment

Assessment

Ursgent (Within 7 Working Days)

Emergency (Same Day)

Multidisciplinary Allocation Meeting

Further input needed

NO

MHO rota available

Discharge from PMS

CRISIS INTERVENTION

Activity involved with services

YES

Review care plan/develop joint care with CMHT

YES

Admission to hospital

NO

CMHT follow-up

Discharge
Appendix 4: Suicide Assessment and Treatment Pathway

Suicide Assessment and Treatment Pathway

This pathway should be used in conjunction with the Supporting Guidance document.

A1. Lead Questions
- Have you ever felt that life isn't worth living?
- Are you thinking of suicide?
- Have you ever thought that you would do something to harm yourself?

A2. So that I understand you clearly, do you wish to kill yourself?

A3. Specific Questions
- Why are you thinking about suicide?
- How recently/did you have you thought about suicide?
- What exactly would you do if you had a plan?
- What has stopped you from carrying this out so far?
- Have you known somebody who has completed suicide?
- Have you tried to kill yourself before?
- Have you been drinking alcohol today?
- Have you been misusing drugs today?

F1. Features
- fleeting thoughts which are easily dismissed
- no plan
- mild or no symptoms of mental illness
- no alcohol or drug problems/ intoxication
- stable psychological situation
- no self harming behaviour

F2. Features
- fleeting suicidal thoughts
- no plan
- evidence of mental illness
- evidence of alcohol or drug problems/intoxication
- unstable psychological situation but no impending crisis
- intermittent dangerous or self harming behaviour

F3. Features
- frequent/ fixed suicidal thoughts
- no specific plans or immediate intent but may have considered methods
- significant mental illness
- significant alcohol or drug problems/intoxication
- unstable psychological situation with impending crisis
- frequent dangerous or self harming behaviour

F4. Features
- define suicidal intent with specific plan and access to means of lethality
- significant mental illness
- significant alcohol or drug problems/ intoxication
- unstable psychological situation with impending crisis
- escalating and more frequent dangerous/ Russian Roulette or self harming behaviour

Actions
- Consider engaging family and friends, community support
- Deliberate emotional distress as far as possible
- Indicate or evidence of mental illness, arrange for assessment by an appropriate professional
- No immediate follow up for suicide risk
- Encourage/allow verbal/ emotional expression of distress

Actions
- Deliberate emotional distress as far as possible
- Secure safety
- Arrange full mental health and psychological assessment. Timescale appropriate to level of risk
- Engage family and friends, community and professional support
- Identify suicide prevention strategies appropriate to person
- Encourage/allow verbal/ emotional expression of distress
- Utilise problem solving techniques
- Distraction
- Promote hopefulness and build upon self-confidence by engaging in future oriented conversations
- Explore previous coping strategies

F4. Features
- Define suicidal intent with specific plan and access to means of lethality
- Significant mental illness
- Significant alcohol or drug problems/ intoxication
- Unstable psychological situation with impending crisis
- Escalating and more frequent dangerous/ Russian Roulette or self harming behaviour

Actions
- Deliberate emotional distress as far as possible
- Immediate action to secure safety
- Remove restrict lethal means
- Arrange immediate full mental health and psychological assessment.
- Ensure family and friends, community and professional support
- After crisis, identify suicide prevention strategies
- Ensure personal safety
- Do not leave person until measures to ensure immediate safety in place
- Encourage/allow verbal/ emotional expression of distress
- Utilise problem solving techniques
- Promote hopefulness and build upon self-confidence by engaging in future oriented conversations
- Reflect upon impact of suicide on family, friends, etc.
- If person fails to engage with arranged support, initiate pro-active follow-up as per local policy

Actions
- Deliberate emotional distress as far as possible
- Secure safety
- Arrange full mental health and psychological assessment. Timescale appropriate to level of risk
- Engage family and friends, community and professional support
- Identify suicide prevention strategies appropriate to person
- Encourage/allow verbal/ emotional expression of distress
- Utilise problem solving techniques
- Distraction
- Promote hopefulness and build upon self-confidence by engaging in future oriented conversations
- Explore previous coping strategies
- Self-monitoring/relapse prevention strategies
- If person fails to engage with arranged support, initiate pro-active follow-up as per local policy

This pathway is intended as guidance only and staff should use their professional judgement when making decisions.

In consultation with the person, inform GP and key support agencies regarding outcome of assessment irrespective of level of risk identified.
Appendix 5: Antenatal and Postnatal Mental Health and Wellbeing Pathway

Antenatal and Postnatal Mental Health and Wellbeing Pathway

(antenatal) Presentation at Midwifery or Primary Care Services (Tier 1)

Complete the following as applicable to determine if mental health need:
- Midwifery Trigger Questions (SWHRM)
- Known to Mental Health Services (Open Case)

Mental Health Assessment:
- Consult service identified
- Review of current medication
- Care Plan reviewed, agreed and shared with relevant parties
- Ongoing review
- Actions as per condition specific ICPS

Mental Health Risk Assessment:
- Ensure the following are assessed:
  - Suicide/self harm
  - Changes in treatment/medication
  - Medication impact on foetus
  - MAPPA issues
  - Child protection
  - Parenting skills
  - Substance misuse
  - Domestic violence

Referral to Community Mental Health Services (Tier 2)

Follow Depression ICP and this Flowchart

Midwife:
- Ongoing monitoring/advice
- Signposting to Tier 2 information and self-help

Exit Pathway with onward referral as appropriate

Referral back to GPs/PHNs For Tier 0 intervention

Week 34 (Pregnancy Birth Plan):
- Consider need for inpatient admission for/birth as per Mental Health Pregnancy Birth Plan
- Liaise with obstetrician re Mental Health Pregnancy Birth Plan
- Consider suitability of current medication regime for breastfeeding if desired/appropriate
- Consider requirement for alternative childcare arrangements for other children if appropriate (liaise with Social Services)
- Agree arrangements for postnatal follow-up
- Follow condition specific ICPS (i.e Bipolar Disorder Schizophrenia Depression/Borderline Personality Disorder)

Birth/Postnatal

Midwife:
- Immediate concerns re mental health state
- Referral to Crisis Service or CMHT

Midwife:
- Assessment in Maternity Unit using Risk Factor Checklist and judgement

Midwife:
- Monitored by Community Midwifery for 10 days if concerns referred to CMHT/CP

Public Health Nurse (PHN):
- Care transferred to PHN GP after 10 days
- EPDS completed by PHN after 6-8 weeks and 3-4 months

Inpatient Admission:
- Severe PND or Postpartum Psychosis
- Risk of harm or neglect to mother or baby pre/post birth
- Deleroration in mental health
- Baby under 1 year old
- Admission to Mother and Baby Unit, Glasgow
- Admission to Lanarkshire Inpatient MH Services if no mother/baby unit bed available or doesn’t meet criteria
- Arrangements made for care of baby by family or Social Services

New Referrals/Open Cases referred to CMHT:
- Managed jointly by CMHT and Public Health Nurse (first visit joint)
- Repeat Mental Health Assessment and follow Depression ICP as appropriate
- Seen within 1 week of discharge
- Monitored for 3 months
- Encourage family planning advice

Treatment Options (including Groups, Social Work, Admission)
- Parenting ability
- Infant mental health (Cohn's approach)
- Condition specific ICPS

Planned Treatment

Review of Treatment

Further Treatment Required

Improvement

References:
- National Institute for Clinical Excellence (NICE) No. 45 Antenatal and Postnatal Mental Health, Feb 2007
- Scottish Intercollegiate Guidelines Network No. 49 Postnatal Depression and Postpartum Psychosis, June 2002
- Health and Social Care (Scotland) Act 2014
- Quality Improvement Scotland Standards for Mental Health Integrated Care Pathways, Dec 2007 (August 2015)

Abbreviations:
- CPN = Community Psychiatric Nurse
- GPs = General Practitioner
- PHN = Public Health Nurse
- PND = Postpartum Depression
- PAT = Psychiatric Assessment Team
- CMHT = Community Mental Health Team
- SWHRM = Scottish Women’s Health Research Manual
- EPDS = Edinburgh Postnatal Depression Scale
- MAPPA = Multi-Agency Public Protection Arrangements
References

2. Overview of Mental Health Services, Audit Scotland, May 2009.
7. Developing social prescribing and community referrals for mental health in Scotland, Scottish Development Centre for Mental Health, November 2007
13. Crisis Function within CMHT Pathway, NHS Lanarkshire Mental Health Services, July 2010.
<table>
<thead>
<tr>
<th><strong>Glossary/Abbreviations</strong></th>
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<tr>
<td><strong>AVON Mental Health Measure</strong></td>
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<td><strong>Crisis Resolution and Home Treatment (CRHT) Model</strong></td>
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<td><strong>Diagnostic and Statistical Manual of Mental Disorders (DSM IV)</strong></td>
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<td><strong>Health of the Nation Outcomes Scale or HONOS 65+</strong></td>
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<td><strong>International Classification of Diseases (ICD 10)</strong></td>
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<td><strong>NHS Quality Improvement Scotland (QIS)</strong></td>
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<td><strong>National Institute for Clinical Excellence (NICE)</strong></td>
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<td><strong>Scottish Intercollegiate Guidelines Network (SIGN)</strong></td>
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<td><strong>Variance</strong></td>
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<td><strong>World Health Organisation (WHO)</strong></td>
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