Lothian NHS Board

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Date 05/12/2025
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Dear

FREEDOM OF INFORMATION – MENTAL HEALTH

I write in response to your request for information in relation to community mental health teams.

Question:

1. How long approximately is the wait list (e.g. number of weeks) to obtain an assessment by the CMHT and would this be by a consultant psychiatrist or their specialist trainee?
2. Are there criteria used to accept a rereferral onto your Community Mental Health Teams to have a care co-ordinator and provide treatment? If you have criteria, please can you supply them?
3. How long approximately is the wait list to obtain (a) a psychological assessment and then (b) how long is wait for CBT for OCD/BDD in secondary care (e.g. number of weeks)?
4. What is the documented or expected care pathway (e.g. do they have to be seen first by the CMHT and then referred by the CMHT for secondary care psychological therapies or can the referral be done directly by the Talking Therapies or GP for example)?
5. Do your policies or procedures indicate that any alternatives offered to CBT with ERP, for people in the above scenario, e.g. a different type of psychological therapy?
6. Has your team made a referral to tertiary services for OCD/BDD in the last 5 years a) under the Highly Specialised Service stream of funding or b) under local funding?

Answer:

	ELHSCP	EHSCP	MLHSCP	REAS	WLHSCP
1.	CMHT assessment is a nursing assessment, the wait is 3-4 weeks.	This is dependent on need and risk. A medic would make this decision based on the referral made by GP.	consultant psychiatrist, the waiting time is usually 2-4 weeks		In West Lothian, our Community Mental Health Teams (CMHTs) currently have no waiting list for assessment. Individuals are typically seen within a 2-week period. An initial assessment is typically carried out by two members of

					our multidisciplinary team. This usually includes a nurse and either a social worker, psychologist, or occupational therapist, depending on availability and the specific needs of the individual. Psychiatrists are part of our multidisciplinary team (MDT). If a referral is accepted for the CMHT and a psychiatric assessment is clinically indicated, this can be arranged by your allocated worker with a consultant psychiatrist or a specialist trainee, depending on availability and need.
2.	CMHT inclusion is based on risk and function thresholds (overlapped with primary care and IHTT). **RISK** · High apparent risk but no immediate risk to self/others/from others. No immediate intent. · Referral to IHTT likely · Detention considered. · Impulsivity	Each referral is assessed based on the information received. (Unclear what is meant by rereferral)	See enclosed		Those eligible for a service from CMHTs are individuals aged 18-65 years where there is a concern that the individual may be suffering from a mental illness or disorder where that individual has complex needs which require co-ordination of care, treatment and support such that a Multi -Disciplinary

	· Suicidality present – intensity of thoughts but no immediate plan. Some concerns for safety. · Harm to others – intensity of thoughts but no immediate plan. · History of high-risk behaviour e.g. significant self-harm e.g. extensive cutting leading to serious injury. · Limited protective factors identified. · Psychosis present affecting functioning and increasing risk to self and others. · Significant manic episodes – putting self at risk or displaying risky behaviours. · No insight **FUNCTION** · Multiple needs, severe symptoms, AND chaotic lifestyle · High impairment of functioning · Co-existing substance use problem or morbidity · Difficult to engage and has well-known concordance problems · Assertive outreach approach required				Team model of working is indicated. CMHTs will aim to work with people with complex mental health problems and associated risks that may require the use of acts such as the mental health act or adult support and protection act who typically require longer-term care and treatment and multidisciplinary engagement, as we have the capacity to provide assertive care and manage higher levels of risk. CMHTs will work in partnership with patients, families and carers, primary care and other agencies to design, implement and oversee comprehensive packages of health and social care where needed, to support people with complex mental health needs. This will include people needing specialist

	· Referral to OT indicated				care for: • Complex and persistent mental illness associated with significant disability, for example psychoses such as schizophrenia or bipolar disorder. These patients typically will have long term involvement. • Complex problems of management and engagement related to mental disorder. • Any mental disorder where there is a risk of self-harm or harm to others where the level of support required exceeds that which a primary care CPN could offer • Severe disorders of personality where these can be shown to benefit by continued treatment and care. Most patients treated by CMHTs will have disorders which would benefit from time limited interventions and then be referred

					back to their GPs when their condition has improved.
3.	1. Less than 18 weeks. 2. Data not held for a specific diagnostic category - but for PTS treatment 30% wait less that 18 weeks, 50% wait 19-35 weeks, and 20$ wait 36-52 weeks.	CMHT Psychology doesn't have separate assessment and treatment waiting lists. if patients are accepted for treatment following initial assessment, they will be offered the next appropriate and available appointment to start treatment. Wait times are for 'A12 psychological treatment' not CBT specifically. Current waits are: NE CMHT – 55 weeks NW CMHT – 76 weeks SE CMHT – 99 weeks SW CMHT – 56 weeks	2 months / 9 weeks to assessment, and for this presentation, likely 6 months / 27 weeks to treatment		If someone who is accepted onto the caseload of the CMHT required Psychological therapy, then an initial assessment would be completed and evidence of a period of stability would be recommended. There is no waiting lists for CMHT psychology as appointments are offered depending on needs, suitability and readiness to engage with the therapeutic process.
4.	Via Single Point of Contact triage assessment, ie patient initiated telephone contact. Or, via GP referral through Sci Gateway into allocations clinical meeting.	No, based on need the appropriate service will be allocated. To be considered for CMHT psychology, the patient first needs to be referred to and accepted by the wider CMHT. This is the case for all	No individuals can be referred to both at the same time	All referrals that may benefit from Psychological Therapy are considered at the point of referral. If a wider CMHT is required, it will be provided within this team. All HSCP's have	Routine and urgent referrals from the GP (primary care) will be accepted through SCI-Gateway and come to a Single Point of Referral to be discussed at a weekly triage meeting with secondary care services. This meeting has attendance from

		HSCP's.		Psychological Therapy Services that see the majority of referrals for OCD, and would accept referrals direct from GP's.	Psychiatrists, CPN, CMHT, Practitioners from the Psychological Therapies Service (PTS) and Occupational therapists who will review the referral and allocate to the most appropriate team.
5.	Each patient is assessed and individualised treatment options derived from the findings/ analysis of the assessment. Our PTS service includes both CBT therapists, and Psychologists with a broader range of treatment options.	CMHT Psychology offers a range of evidence based therapies which includes but is not limited to CBT. Psychological treatment options would be discussed and agreed with the patient at the start of therapy.	Intervention would be guided by a psychological formulation, and ERP is a likely treatment. However, formulation may guide a different focus, and this would be a shared decision with a patient, in line with the PT Spec that we have in Scotland. Our team are trained in CBT, EMDR, TFCBT, CFT, CAT and some Schema Therapy, any of which could be helpful and/or used integratively, depending on formulation.	All Psychological Therapy provision, within CMHT and the Psycholgical Therapies services are clinically governed through a single structure (hosted be REAS) and would therefore operate in similar ways across the HSCP's as described.	Clinical staff will follow local and national policies and procedures for OCD. Treatments are dependent on training completed by staff. OCD treatment within CMHT Psychological care will be recommended following a comprehensive psychological assessment and agreed with the person attending before commencing. It is more common that people living with OCD will be seen by the PTS team.
6.	No	No	Not relevant to our local service		We have no records of any referrals being made by the CMHT for these reasons

I hope the information provided helps with your request.

If you are unhappy with our response to your request, you do have the right to request us to review it. Your request should be made within 40 working days of receipt of this letter, and we will reply within 20 working days of receipt. If our decision is unchanged following a review and you remain dissatisfied with this, you then have the right to make a formal complaint to the Scottish Information Commissioner within 6 months of receipt of our review response. You can do this by using the Scottish Information Commissioner's Office online appeals service at www.itspublicknowledge.info/Appeal. If you remain dissatisfied with the Commissioner's response you then have the option to appeal to the Court of Session on a point of law.

If you require a review of our decision to be carried out, please write to the FOI Reviewer at the email address at the head of this letter. The review will be undertaken by a Reviewer who was not involved in the original decision-making process.

FOI responses (subject to redaction of personal information) may appear on NHS Lothian's Freedom of Information website at: https://org.nhslothian.scot/FOI/Pages/default.aspx

Yours sincerely

ALISON MACDONALD
Executive Director, Nursing
Cc: Chief Executive
Enc.

Midlothian
Health & Social Care
Partnership

Community Mental Health Team Guidelines

Reviewed June 2024

Role of the CMHT

To provide assessment, formulation (including diagnosis) and treatment of moderate to severe mental illness / mental disorder.

To provide interventions for those with more complex and long-term needs where a variety of services and agencies are involved and those with time-limited conditions who can benefit from specialist interventions, and who meet the guidance on referral.

The CMHT caters for people from 18 years of age to 65yrs.

Where patients transition, such as from Child and Adolescent Mental Health Services or between Community Mental Health Teams, liaison will take place between services to ensure appropriate transition of care.

For patients who are being re-referred to the CMHT but who have reached 65 years of age since their previous discharge, if there has been a gap of more than 2 years since discharge, the referral should be directed to older adult mental health services.
Current patients of the CMHT who reach age 65 will be maintained on caseload until their needs indicate transfer to older adult services would be appropriate. This could include onset of dementia, physical health needs that lead to frailty.

Where discreet CMHTs are in place they will consist of Team Manager, Mental Health Social Worker, Support Worker, Occupational Therapist, Community Psychiatric Nurse, Clinical Psychologist, Psychiatrist, Admin Staff, Occupational Therapists

The CMHT aims to work to the following general principles:

- **Collaboration -** working with patients, carers, family, and partner organisations towards discharge from the service as safely, quickly, and effectively as possible.
- **Recovery** - enabling patients to live a meaningful life in the presence or absence of symptoms and as defined by the individual.
- **Self-management** - enabling individuals to successfully manage their illness / condition.
- **Trauma-informed -** recognising the impact of traumatic experiences on individuals and providing appropriate response.
- **Positive risk taking -** involving shared decision making, personalised care, minimising variation in practice and outcomes, effective risk management within realistic expectations.

Referral's

Referral to the CMHT should be considered for patients with suspected or established moderate to severe mental illness / mental disorder who for reasons of complexity, severity or lack of treatment response require specialist input.

For suspected diagnosis of early onset dementia, the referral will generally be directed to the older adult mental health service.

Referrals to mental health services may include requests in relation to statutory and mandatory requirements provided by psychiatrists and specialist mental health social workers, examples include Mental Health Act work and Adult Support and Protection. There is local variation as to the route for these requests.
Referral should be made using the appropriate referral route for the locality and which can be clarified with your local CMHT. Generally, this will be SCI Gateway.
The referral information suggested is:

- Demographic information, usually provided via Sci Gateway, including a telephone contact number.
- Presenting problem(s) including a description of duration and severity.
- Brief psychiatric / mental health history
- Current working diagnosis where known.
- Impact on bio-psychosocial functioning
- Summary of the relevant risks
- Alcohol or substance use (legal or illegal)
- Care and treatment offered to the patient to date and response.
- Expected outcome of CMHT involvement and expectations of the patient.

Referral Management

Referrals will be screened daily Monday to Friday, excluding public holidays.

Patients referred / triaged as requiring an urgent response will be contacted and discussion offered regarding when an assessment can be offered. The ideal is within 5 working days of receipt though it is recognised this can vary depending on the patient's preference and staff availability which can be dependent on factors such as the size of the team or staff absence (see appendix 4 for description of priority).

Non-urgent referrals will be assessed within 28 working days of receipt.

Crisis referrals requiring a response within 24 hours should be referred via the appropriate pathway for the locality. Details can be provided through your CMHT.

Referrals may on occasion require further information before a definitive decision can be made regarding further management. This could be due to an incomplete referral that does not include all the information required, or the referral may not indicate the presence of moderate to severe mental illness. Best practice will be to discuss the referral directly with the referrer as it is recognised that returning referrals without discussion can lead to delays in appropriate management of the referral.

CMHTs will be expected to keep a record of any referrals not directly assessed with a view to establishing any patterns that can be used to develop the service or for educational purposes.

When a referral is returned, the referrer will be written to with an explanation of the reason for the referral being returned. If this relates to incomplete information this will be detailed in the letter. If the referral does not meet criteria for moderate to severe mental illness, options for other services / signposting will be provided.

The patient will also be informed directly by the CMHT if the referral is not accepted. This will be a brief letter stating the referral has been returned to the referrer and recommending contacting the referrer to discuss the options.

Assessment, Formulation and Diagnosis

Standardised assessment takes place with a member of the multi-disciplinary team. On occasion two members of staff may be present for the assessment.

Aspects such as confidentiality will be discussed at this first appointment.

The assessment will be discussed within the multidisciplinary team who will agree a formulation including working diagnosis and agree a care and treatment plan which will be shared with the patient. This will also be communicated to GP, referrer (if not GP) and all relevant others.

It is understood that not all GPs require a full assessment letter. However, this is the standard approach to completion of an assessment and will contribute to the patient record should the patient move area when the detailed history and mental state will then be available. Without this, it cannot be guaranteed that a full history will follow the patient.

The assessment may identify no role for treatment from the secondary care mental health services, as following the assessment no moderate to severe mental illness is diagnosed. This will be fed back to the patient and the referrer, along with options for treatment and / or support from other services.

Care and Treatment

Treatment offered by the CMHT will be evidence based. It is recognised that there may be differences in availability of some treatment options due to variation across localities.

A care plan will be written with the patient to include the treatment and intervention being provided; the staff involved; the frequency of appointments; where possible an estimated length of treatment; the aim of the treatment.

Care plans will include risk assessment and risk management plans, identifying sources of support if in crisis and if support is needed outside of office hours.

Positive risk management will take place, with recognition that the secondary care mental health service works with patients who may present long-term high risk of completing suicide. The service will work in accordance with relevant clinical guidelines and evidence-based practice.

Where required and in line with procedure, the Care Programme Approach will be used to ensure robust multi-disciplinary and / or multi-agency care planning.

The focus of treatment will relate to the mental illness, hence for patients where there are co-morbid conditions such as acquired brain injury or autism, the input is likely to be time limited to treatment of the mental illness.

Where evidence-based group interventions are available for a particular illness / condition, these may be offered in the first instance. All patients referred for group interventions will meet the criteria for treatment from secondary care mental health services.

The aim is always to work towards discharge. It is recognised that there will be a proportion of patients where long-term support and treatment is appropriate and which will be provided in line with ongoing clinical review and need. In line with a recovery approach there will be no assumption of a life-long intervention from the secondary care mental health service.

Discharge

The CMHT will work collaboratively with patients, their relevant others and partner organisations towards a point of recovery which allows discharge as safely and effectively as possible. Information about the treatment and support that has been provided will be communicated to the general practitioner at the point of discharge. The service is working towards a standard approach to the format of discharge information, which will include:

- Diagnosis
- Care and treatment offered and outcome.
- Anticipatory Care Plan, including supported self-management where appropriate.
- Risk assessment and risk management plans.
- Any ongoing care and treatment recommendations.
- Information regarding re-referral to the service.

Liaison and communication within and with the CMHT

A weekly CMHT meeting will take place and can include discussion of referrals; feedback of assessments; allocation of key worker; review of ongoing cases; discussion and planning of discharges; discussion of any other business relevant to the functioning of the CMHT.

Notes of decisions and outcomes from the meeting will be recorded. This will be both a discreet record of the meeting and entries within individual service user records.

Where it would be useful to discuss a potential referral, the relevant consultant psychiatrist or CMHT leader / advanced practitioner can be contacted.

Please note any referrer or general practitioner, who wishes to attend an MDT meeting or visit the CMHT, can do so by contacting the team.

The CMHT will initiate liaison with the practice/s it covers to offer aspects such as attendance at practice meetings. The level and frequency of contact will relate to agreed need and availability of staff.

When to consider referring to CMHT

Patients should be considered for referral to secondary care mental health services when they:

- meet criteria for a working diagnosis of a moderate to severe mental illness / disorder as recognised by the ICD-10 (this will provide guidance regarding severity)

and in addition, one or more of the following apply:

- they are no longer able to be managed solely in primary care for reasons of
    - severity
    - *and/or* complexity
- they are unable to maintain their usual level of function because of mental illness, examples being:
    - not being able to work
    - leave the house.
    - care for dependents
    - meet daily self-care needs!
- significant risk issues are identified because of mental illness.
- referrer requires a CMHT assessment to confirm or exclude a diagnosis of mental illness (of moderate to severe intensity)
- primary care interventions have been used and not been effective.

There are conditions that do not fall into the remit of the CMHT, but which are identified within diagnostic manuals for mental disorder. These include:

- Autistic Spectrum Disorders - at present there is no CMHT based service for the assessment and diagnosis of ASD.
- Acquired Brain Injury
- Primary diagnosis of drug or alcohol problem (the Drug and Alcohol service operates separate to General Adult Psychiatry though for some teams the referral route is the same).

The CMHT does not offer a service specifically for these conditions.
Where there is a co-morbid mental health issue requiring secondary care mental health service intervention this will be provided for that issue given the general referral criteria are met.

Risk Information

When identifying risks, the referrer should consider the following:

- self-harm
- suicide – ideation / intent / planning
- impulsivity / risk taking behaviour.
- aggression / violence (including any specific risk towards health professionals)
- forensic history
- child concerns
- adult concerns - adult support and protection / vulnerable adult / adults with incapacity
- known risks in relation to a home visit – animals, environment.
- any concerns leading to the need for 2 people to undertake the assessment.

Reviewed June 2024