

Quick guide for Mental Health referrals

Secondary care community mental health teams (CMHTs) are geared towards severe and enduring mental illness. In any mental illness the team can respond quickly where there are significant risks to the safety of the patient or others. The team is happy to discuss referrals.

Emergency within 24hrs: immediate risk to self or others/ active suicide plan/ acute distress due to psychiatric illness, or other need for immediate assessment. Please refer to MHAU via SCIR gateway referral and please phone MHAU to discuss.

Urgent within 5 working days: No immediate risk & would deteriorate without intervention within 5 days. Refer to CMHT via SCI Gateway.

Routine: 4 – 8 weeks but this can vary.

Depression

Mild

; Self-help (Silvercloud via SCI Gateway, Sleepio, RAMH [ACUMEN](#) ★ [Advancing Community Understanding of Mental & Emotional Needs \(ramh.org\)](#) [The Matrix - Home \(nhs.scot\)](#)

1st Line moderate: **Antidepressants or Silvercloud**

NHSGGC preferred drugs: Consider SSRIs as first line– review effect after 4 weeks: increase or switch if partial response, switch if no response. Please allow 4 weeks at maximum dose for a therapeutic benefit.

2nd Line: **Antidepressants** &/OR **Self-help** &/OR **PCMHT**
Alternative SSRI from above or Lofepramine, alternatively if sleep is a problem trazadone or mirtazapine and review after 4 weeks Refer to matrix.

3rd Line: **Alternative antidepressant from above or Venlafaxine**

4th Line: **If above is ineffective consider referral to CMHT for moderate/ severe cases**
Ref NHSGGC Clinical Guidelines, BAP consensus guidelines, Maudsley

Refer sooner if suicidal thoughts or psychotic symptoms or significant neglect of self or others

Anxiety: Generalised anxiety, panic disorder, agoraphobia

Mild

Self-help, Sleepio, RAMH [ACUMEN](#) ★ [Advancing Community Understanding of Mental & Emotional Needs \(ramh.org\)](#), [Breathing and relaxation guide \(download\) - Anxiety UK](#), [The Matrix - Home \(nhs.scot\)](#)

1st line moderate/ severe: **SSRI OR Self-help**

Review after 4 weeks, increase or switch if partial response, switch if none. Please allow 4 weeks at maximum dose for a therapeutic benefit.

2nd line: **alternative SSRI** OR **Self-help** OR **PCMHT/ RAMH**

3rd line: **venlafaxine or mirtazapine**

4th line: **If above is ineffective consider referral to CMHT**

Ref NHSGGC Formulary, SIGN, NICE, RCPsych, Maudsley, BAP consensus guidelines, Matrix

OCD

1st line: **Self-help or PCMHT**

<https://web.nrw.nhs.uk/selfhelp/leaflets/Obsessions%20and%20Compulsions.pdf>

2nd line: **SSRI OR Self-help OR PCMHT**
2 trials of therapeutic dose SSRI for adequate length of time (minimum of 4 weeks)

3rd line: **If ineffective consider referral to CMHT**

Ref NHSGGC Formulary, SIGN, NICE, RCPsych, Maudsley Guidelines, matrix

In any of the above conditions benzodiazepines or night sedation can be prescribed for severe distress for short periods considering as ever the risks associated with dependence etc

PTSD

<4wks since trauma

Mild: watchful wait for another 4wks
and then PCMHT
Severe: refer CMHT

Hypnotics acutely and briefly for severe
insomnia.

>4wks since trauma

Agrees to psychological work:

Mild: PCMHT

Severe: CMHT or if complex trauma; Glasgow
Psychological Trauma Team (refer to matrix)

Refuses psychological work:

1st line: SSRI/SNRI trial

2nd line: CMHT (Ref NICE, matrix)

Please phone CMHT to discuss if unsure.

Complex trauma/ PTSD: Glasgow Psychological Trauma Team accepts GP referrals (psychological
treatment) Refer to matrix

Veterans: consider Combat Stress-self referral?/ CMHT

Bipolar Disorder - depressive or manic episodes

1st Line: refer to CMHT

Psychotic illness

Schizophrenia, delusional disorder, psychotic depression or mania with psychosis

1st Line: First episode psychosis – refer to Esteem (16-35yrs)

All other psychotic episodes – refer to CMHT if urgent/ emergency to MHAU

Emotionally Unstable Personality Disorder

Treat co-morbid mental illness as above.

Comorbid Social stressors- consider CWBN or GP link workers. (*Thriving survivors group*)

Patients have fluctuating difficulties & distress, consider CMHT for assessment if:

- significant disruption to social functioning,
- significant self-harming, or
- significant distress

Or in acute crisis situations if the above symptoms escalate

Ref NICE.

Some of the treatment offered by CMHT is in the form of virtual groups.

Other Personality Disorders

(paranoid, schizoid, dissociative, histrionic, anankastic, anxious-avoidant & dependent)

Treatment options are limited for other diagnosed personality disorders.
Please discuss with CMHT for advice.

Consider referral to CMHT for assessment if: significant disruption to social functioning/ significant distress/ significant risk to self or others.
Patients with diagnosed dissocial personality disorder & significant forensic history may be more appropriately treated by the forensic psychiatry service.

Eating Disorders

Traffic light system for guidance: 'green' patients can be managed by GP; Amber- CMHT; Red- CMHT and AEDS See Appendix for more info.

ADHD CMHT for diagnosis, treatment and initiation of medication. (Private diagnosis, refer to policy)

Autism Autism Resource Centre for diagnosis & support & Social work. CMHT for comorbid mental illness.

Cognitive impairment <65years CMHT for diagnosis

Others

- Perinatal MH service- Refer via SCI gateway. (Pregnancy - 1yr postnatal)
- Tourette's- Movement disorder clinic and not MH service
- Insomnia- Sleep disorders clinic and not MH service unless comorbid MH issue.

Information required by CMHT in the referral:

- Patient consenting to referral.
- Presenting problems: Please describe the symptoms, how it is impacting their day today functioning. Please include the timescale of how long this has been going on and any acute exacerbation.
- Treatments tried by GP and response to the same.
- Risk to self (self-harm, self-neglect, suicidal thoughts) and thoughts of harm to others (in the context of mental health difficulties).
- It is often useful to include their social circumstances in general, but especially if it affects their mental health and support network (not mandatory).
- If the patient is working, please let us know (especially if it is an urgent referral, please advise them that an appointment will be offered within 5 working days of referral).
- Please consider routine bloods prior to referral.

Eating disorders:

- Please specify BMI and bloods done within 5 days. (please see appendix on page 4,5,6)

For urgent referrals:

- As above and please consider if they are significantly unwell enough or pose a significant risk for an urgent referral as we are trying to fit people within 5 working days.
- Please confirm that patient is available to attend an appointment, within 5 working days.
- Please ensure you have documented risks and any active plans.

Employability: Refer to CMHT OT for complex mental health difficulties. Consider,

- RAMH employability <https://ramh.org/services/employability/>
- <https://investinrenfrewshire.com/>

Direct number for CMHT Duty team for any advice:

- Paisley: 0141- 4870116 or PaisleyCmht.InformationMailbox@ggc.scot.nhs.uk
- West Renfrewshire: 0141 849 8127

Appendix 6 - Summary Roles/Responsibilities for Clinicians in NHS GG&C working with Adults with Eating Disorders

| Tier and Risk | Clinicians | Responsibilities | Medical Responsibility |
|---|---|--|--------------------------------|
| Tier One Green = Low | GP | Assessment Diagnosis Medical Monitoring Guided self-help | GP |
| | Primary Care MH Team | | |
| | Primary Care Community Dietitian | Dietary assessment & intervention | |
| Refer to mental health services if tier 2 indicated using AEDS criteria | | | |
| Tier Two Amber = Mild / Moderate | GP | Medical monitoring Referral to CMHT | GP |
| | Primary Community Dietitian | Dietetic assessment & intervention | |
| | CMHT Consultant Psychiatrist CMHT key worker | Psychiatric assessment / Diagnosis Care co-ordination and treatment | CMHT – Consultant Psychiatrist |
| Consultation / liaison with Adult Eating Disorder Service (AEDS) and refer to tier 3 if indicated | | | |
| We recognise there are a significant number of patients with the same level of risk described at Tier 3 & 4 who for a variety of reasons are not open to AEDS. Clinicians working with these patients can access AEDS for advice and consultation, overall medical responsibility remains with the GP or Local Consultant | | | |
| Tier Three Amber Red = Moderate / Severe (in AEDS) | GP | Medical monitoring & liaison with AEDS | GP |
| | CMHT Consultant Psychiatrist CMHT key worker | Psychiatric assessment / Diagnosis Care co-ordination & treatment & liaison with AEDS | CMHT – Consultant Psychiatrist |
| | Adult Eating Disorder Team including AEDS Dietitian | Formulation based psychological assessment & intervention Specialist dietetic intervention | |
| Discuss with AEDS Consultant Psychiatrist for access to specialist inpatient bed if indicated | | | |

Extracted from NHS GG&C AEDS Operational Policy May 2016

Appendix 6 - Summary Roles/Responsibilities for Clinicians in NHS GG&C working with Adults with Eating Disorders

| Tier and Risk | Clinicians | Responsibilities | Medical Responsibility |
|---|---|--|---------------------------------|
| Tier Four Inpatient specialist AEDS bed Red = Severe / Complex (in AEDS) | AEDS Consultant Psychiatrist MH Inpatient Nurses and AEDS Inpatient nurses AEDS inpatient Dietitian AEDS community key worker | Specialist Psychiatric/ Medical Care 24 hour specialist Nursing Care & Psychological Interventions Dietetic intervention Maintain therapeutic contact and liaison with Inpatient Team | AEDS – Consultant Psychiatrist |
| Tier Four Inpatient Psychiatric bed Active to AEDS Red = Severe / Complex (in AEDS) | CMHT Consultant Local Dietitian | Medical / Psychiatric Dietetic care | CMHT Consultant Psychiatrist |
| | AEDS Dietitian - consultation AEDS key worker | Consultation / Supervision AEDS to support staff via ward round, education and liaison | |
| Tier Four Inpatient Medical bed Red = Severe / Complex (in AEDS) | Medical Consultant Nursing Acute Dietitian in consultation with AEDS Dietitian | Medical & Nursing Care/Management Dietetic Assessment and Intervention | Medical Consultant |
| | Liaison Psychiatry | Consultation with CMHT, AEDS and provision of supervision, information & psychiatric support to inpatient services | Liaison Consultant Psychiatrist |
| | AEDS key worker | Ward round / education / liaison with medical / nursing team and liaison psychiatry | |


Extracted from NHS GG&C AEDS Operational Policy May 2016

ADULT EATING DISORDER SERVICE


Individuals receiving in-patient treatment for an eating disorder are viewed as a priority for access to the Adult Eating Disorder Service and will already have CMHT contact.

ANOREXIA

BULIMIA



Indicates referral to AEDS for joint assessment with CMHT to determine level of input and management plan.
Assessment within 10 working days



Indicates management within CMHT and if this input has not resulted in progress towards recovery referral to AEDS for assessment.
Assessment within 30 working days



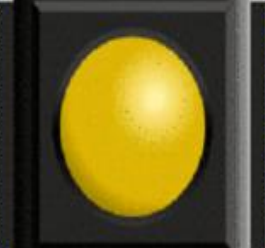
This would indicate management within CMHT or Primary Care Team with advice & support from AEDS.

- SIGNIFICANT** increase in symptoms in **AMBER** risk indicators:
- Dietary intake is restricted resulting in continuing weight loss more than 1kg per week
 - BMI less than 14
 - Plus one or more of the following:
 - Vomiting – once per day or more
 - Purging – once per day or more
 - Exercise – more than once per day
 - Significant depressive symptoms
 - Frequent/recurring suicidal ideation and/or self-harm and/or impulsive behaviours
 - Co-morbidity i.e. Diabetes, pregnancy
 - Significant disruption to daily functioning
 - PCT/CMHT input has not resulted in progress to recovery
 - Physical complications: Abnormal blood results: Hypotension, Low electrolyte, Muscle wasting, Bradycardia, ECG abnormalities



- SIGNIFICANT** increase in symptoms in **AMBER** risk indicators:
- Bingeing – once per day or more
 - Vomiting – once per day or more
 - Purging – once per day or more
 - Plus one or more of the following:
 - Significant fluctuations in weight with/without rapid weight loss
 - Exercise – more than once per day
 - Significant depressive symptoms
 - Frequent/recurring suicidal ideation and/or self-harm and/or impulsive behaviours
 - Co-morbidity i.e. Diabetes, pregnancy
 - Significant disruption to daily functioning
 - PCT/CMHT input has not resulted in progress to recovery
 - Physical abnormalities

- MODERATE** increase in symptoms on **GREEN** risk indicator:
- Dietary intake is restricted resulting in continuing weight loss
 - BMI less than 16
 - Plus one or more of the following:
 - Vomiting – approx 2-3 per week
 - Purging – approx 2-3 per week
 - Exercise – not more than once/day
 - Moderate depressive symptoms
 - Physical complications (abnormal blood results e.g. electrolyte imbalance)
 - Frequent suicidal ideation, self-harm or impulsive behaviour
 - Co-morbidity i.e. Diabetes, pregnancy
 - Moderate disruption to daily functioning
 - CMHT/PCT input has not resulted in progress to recovery



- MODERATE** increase in symptoms on **GREEN** risk indicator:
- Bingeing – approx 2-3 times per week
 - Vomiting – approx 2-3 times per week
 - Purging – approx 2-3 times per week
 - Plus one or more than the following:
 - Weight Loss – moderate fluctuations in weight/moderate weight loss
 - Exercise – no more than once per day
 - Moderate depressive symptoms
 - Physical complications (Abnormal blood results e.g. electrolyte imbalance)
 - Frequent suicidal ideation and/or self-harm and/or impulsive behaviours
 - Co-morbidity i.e. Diabetes, pregnancy
 - Moderate disruption to daily functioning
 - PCT/CMHT input has not resulted in progress to recovery

- Dietary intake is restricted resulting in gradual weight loss
- BMI more than 16 < 17.5
- Plus one or more of the following:
 - Occasional vomiting &/or laxative/diuretic use approximately once per week
 - Exercise – no more than 3 times per week
 - Mild to moderate depressive symptoms



- Occasional (approx once/week) bingeing & vomiting and/or laxative/diuretic use (purging)
- Weight Loss – minimal fluctuations in weight/minimal weight loss
- Exercise – no more than 3 times per week
- Depressive Symptoms – mild to moderate

Adult Eating Disorder Service
Indicator Form

| | | | | | |
|---------|--|---------|--|----------------------|--|
| Name: | | | | CHI N ^o : | |
| Height: | | Weight: | | BMI: | |
| BP: | | Pulse: | | Temp: | |

- Are you referring this person because they are an in-patient? Yes No
 If an in-patient, is the person maintaining their weight? Yes No
- How much weight has the person lost over the past three months?
- On average how much weight does the person lose in a week?
- If female, is she amenorrhoeic? Yes No
- Are the blood results available? Yes No

Please give details below of any abnormalities found in the blood results FBC, U&E, LFT, Glucose, Ca, Mg, and Phosphate.

- Briefly describe what the person eats on an average day?

Exercise: (Please Circle the Appropriate Choice)

- How often does the person exercise? Once per week 2-3 Times per week Once per day > Once per day
- How long does the person exercise? < 30 minutes 30 minutes 1 hour 1½ hours > 2 hours
- Is the activity at an appropriate level for this person's weight? Yes No

Binge Pattern:

- Does the person eat an excessive amount over a short period of time? If yes please complete below Yes No
 Approximately how often does the person binge? Once per week 2-3 per week Once per day > Once per day
Please circle as appropriate

Purge Pattern:

- Does the person vomit or regurgitate food? If yes please complete below, Yes No
 Approximately how often does the person purge? Once per week 2-3 per week Once per day > Once per day
Please circle as appropriate
 Does the person use laxatives, diuretics or diet pills to help them lose weight? Once per week 2-3 per week Once per day > Once per day
Please circle as appropriate

Muscle Weakness/Mobility:

- From your clinical observations can the person rise from a sitting position with ease or is assistance required? Yes No
 Is person's mobility restricted or limited due to muscle weakness? Yes No

- Using the traffic light indicator tool, is the risk GREEN AMBER RED