OLDER ADULT Community Mental Health Team Referral Guidance

Older People Community Mental Health Service are concerned with the care and treatment of people with complex mixtures of psychological, cognitive, functional, behavioural, physical, and social risk usually related to mental disorder and frailty experienced in later life.

The service provision will focus adults over the age of 70 years as a chronological indicator for people experiencing serious mental disorder manifest in later life. This is positive protective action, acceptable within the Equalities Act 2010, for the defined clinical cohort. Not an age cut-off that necessitates a transition of service for mental ill-health manifest prior to such an age. The age threshold is an indicative protective element of an essentially needs led service for the defined clinical cohort When the needs of an individual aged under 70 years are best be met by the Older People's service they will be accepted, following assessment and agreement from the Older Adult Mental Health Service clinicians. This indicative age threshold does not apply to people living with dementia.

All people in later life using Older People Community Mental Health Service will be experiencing significant mental disorder. Significance would be indicated by the nature and severity of the condition with inadequate front-line treatment responses evident at the point of referral.

The Older People Community Mental Health Teams supports people who are defined as being:

1. First Presentation over the age of 70
2. Age related Frailty
3. Any Age Adult presenting with Dementia

The service **meets** the needs of services users who have:

1. Depression moderate to severe
2. Generalised Anxiety disorder moderate – severe
3. Bipolar Affective disorder moderate – severe

4. Psychosis - First episode/late onset
5. Psychosis - on-going/recurrent symptoms/high relapse risk, moderate - severe needs
6. Obsessive Compulsive Disorder (OCD)
7. Post-Traumatic Stress Disorder (PTSD)
8. Specific/Social phobia
9. Eating disorders (in conjunction with specialist eating disorders service where necessary)
10. Personality disorder co-existing with the above diagnosis and / or personality disorder that causes significant distress or risk to the Service User or others and where there may be a benefit from specialist expertise
11. Organic mental health disorders i.e., Dementia (any age) with moderate to severe behavioural and psychological symptoms (BPSD) and associated moderate to severe risks to self or others &/or severe self-neglect

Older Adult CMHT will **not** accept the following**:**

1. Minor/mild/low severity – depression/anxiety
2. Primary substance misuse unless comorbidity alongside age related mental health disorder
3. Learning disabilities unless it occurs within/alongside age related mental health disorder
4. Presentation changes as a result of likely/ confirmed Delirium and/or other reversible medical conditions not excluded prior to referral (i.e., via physical health screening and review)
5. Normal grief reaction
6. Social need/assessment only (no age-related mental health disorder (as above))
7. Cognitive changes associated with severe and enduring psychosis and or other long term psychiatric or medical conditions
8. Advanced dementia with low level risks and/or end of life care

Priority for assessment (taken within the above criteria) are where one or more of the following criteria exists:

1. The individual is at risk to themselves
2. The individual is at risk of abuse from another party
3. The individual poses a risk to others
4. Impaired ability to function effectively and safely within the community without assistance
5. Changes in behaviour manifest as stress or distress, which may lead to a breakdown in the integrity of their current social situation, community tenure and/or risk of unnecessary escalations in care
6. Carers breakdown

Information required by referrer to screen referral effectively and agree outcomes:

- Description of onset, length of history and progression
- Description of cognitive, behavioural and psychological symptoms

- Brief cognitive screen (e.g. with 6CIT, AMTS, GPCOG)
- Description of impact of symptoms on daily life
- Patient/ carers/ professional perspective of problem
- Collateral history (e.g. from family member) where possible
- Assess for other psychiatric illness e.g. depression
- If applicable, results from screening tool useful but not essential. For example, GAD7 (anxiety), PHQ9 (depression) or the geriatric depression scale/
- Social situation
- Past Medical History
- Past Psychiatric history
- Current Medication list
- Alcohol or substance misuse (opiate or non-opiate)

Appropriate Examination & Investigation Results/Requests

- Physical examination
- Indicators of frailty (results from screening tool useful but not essential)
- Exclude treatable causes
- Review to identify any *medication that may impair cognitive functioning
- Assess for and treat delirium (short history, <2 weeks, of confusion, hallucinations, and /or delusions with fluctuating cognition)
- Appropriate blood and urine tests to exclude reversible causes of cognitive decline (completed within previous 3 months) may include FBC, B12 & folate, U&Es, glucose, HbA1c, LFTs, TFTs, calcium, MSU (advisable if acute onset of confusion).
- Consider ECG
- Consider requesting CT/ MRI scan

RISK upon examination:

- Previous or current self-harm and/or suicidal expression/intentions (including any recent attempts) disclosed. ***(If yes, please refer to Triage code A and/or B above)***
- Detail and/or evidence of current plans or preparations disclosed, regarding suicide**.** ***(If yes, please refer to Triage code A and/or B above)***
- Patients view of risk of harm to self or others ***(including Triggers)***
- Other potential risks to self/others/staff
- Current available support
- Carer/Relevant others Views
- Evidence of self-neglect ***(If Yes have you referred to social services.)***
- Protective Factors:
- Previous and/or current Safeguarding concerns.
- Dol's/ MARF/MARAC made or outstanding?
- Known forensic history:
- Is the patient consenting to be seen?
- If not is there a responsible person with POA (health and welfare)?
    - (*Please provide contact details*)
- Where is the patient now, with whom, able to get to us if needed?
- How is the appointment time be communicated to them?

- What action needs to be taken if the patient cannot be contacted and we are unable to get back to the referrer e.g. surgery closed e.g. police welfare check