Title	Deferring Guidance for Mental Health and Learning Disabilities (MHLD) Service
Date	13/04/20
Version	1.22
Authors	Mental Health Management Team • Adam Daly, Associate Medical Director (Author for correspondence) • Karen McCaffrey, Associate Director of Nursing • Paula MacLeod, General Manager • Gary Tanner, Director of Psychology

Situation

Routine clinics have been deferred to later dates across many secondary care specialties including mental health and learning disabilities (MHLD). Regarding those with Mental Health needs, there are concerns that we will see increased risk for patients, and that those affected will present at Primary Care and Emergency Department Services.

Background

Coronavirus (COVID19) and associated affects has resulted in marked workforce reductions which are likely to continue for several months. This has meant that all services need to prioritise the most unwell patients.

Assessment

A reduction in outpatient activity has allowed safe staffing of the inpatient wards. It has also ensured that the most unwell in the community (a list is kept by each team) have access to the staff and other resources they need.

Those with lower levels of need (routine return patients and non-urgent new referrals) have been added to a defer list of patients who have been deferred. This practice is likely to change once the final staffing situation for the pandemic is known and further clinics, however further guidance is now needed to ensure patients who have been deferred have been appropriately triaged, risk is managed, and that other primary or secondary care services are not used as alternatives.

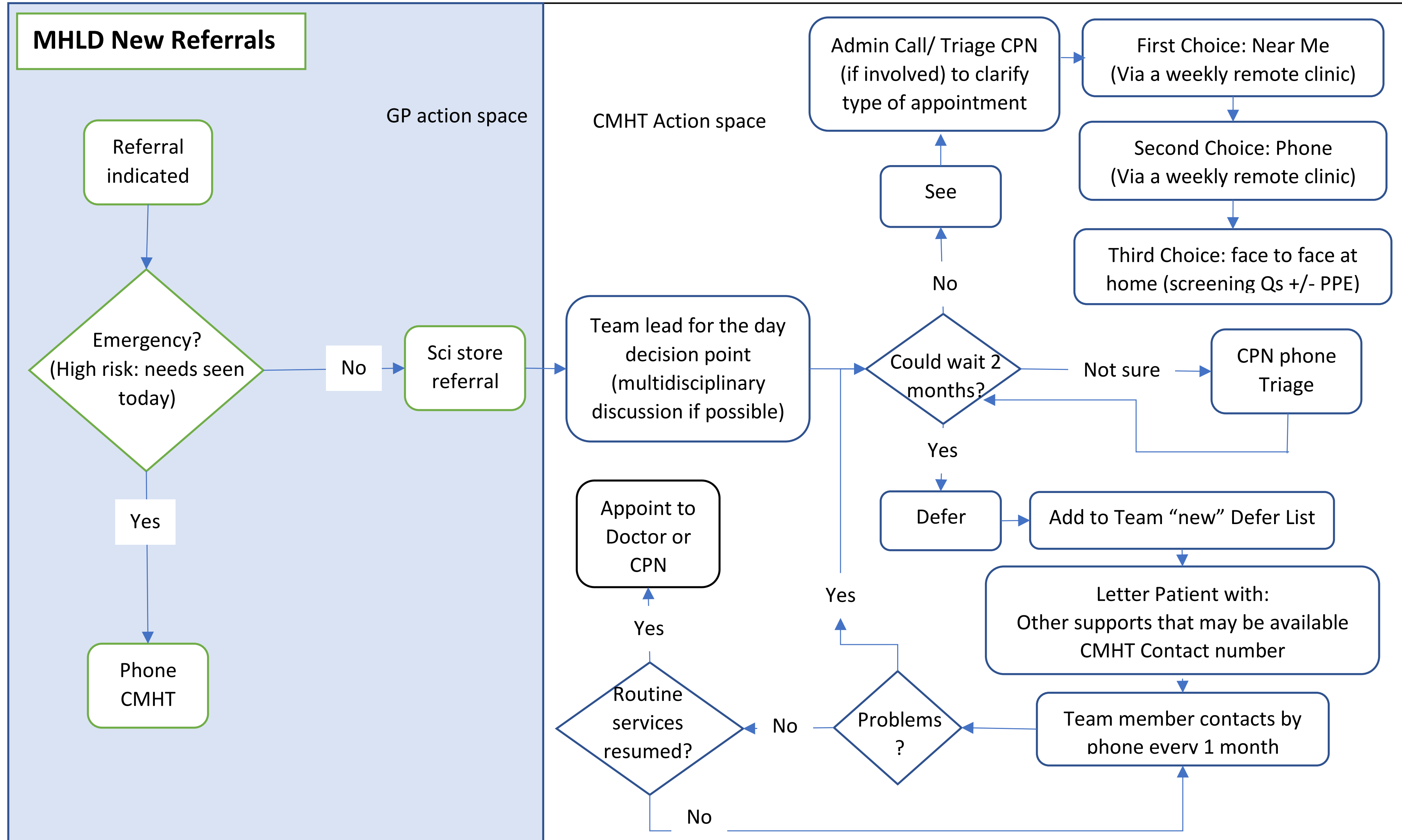
Recommendation

The attached Document is designed so that Mental Health and Learning Disabilities have a consist approach to seeing and deferring cases.

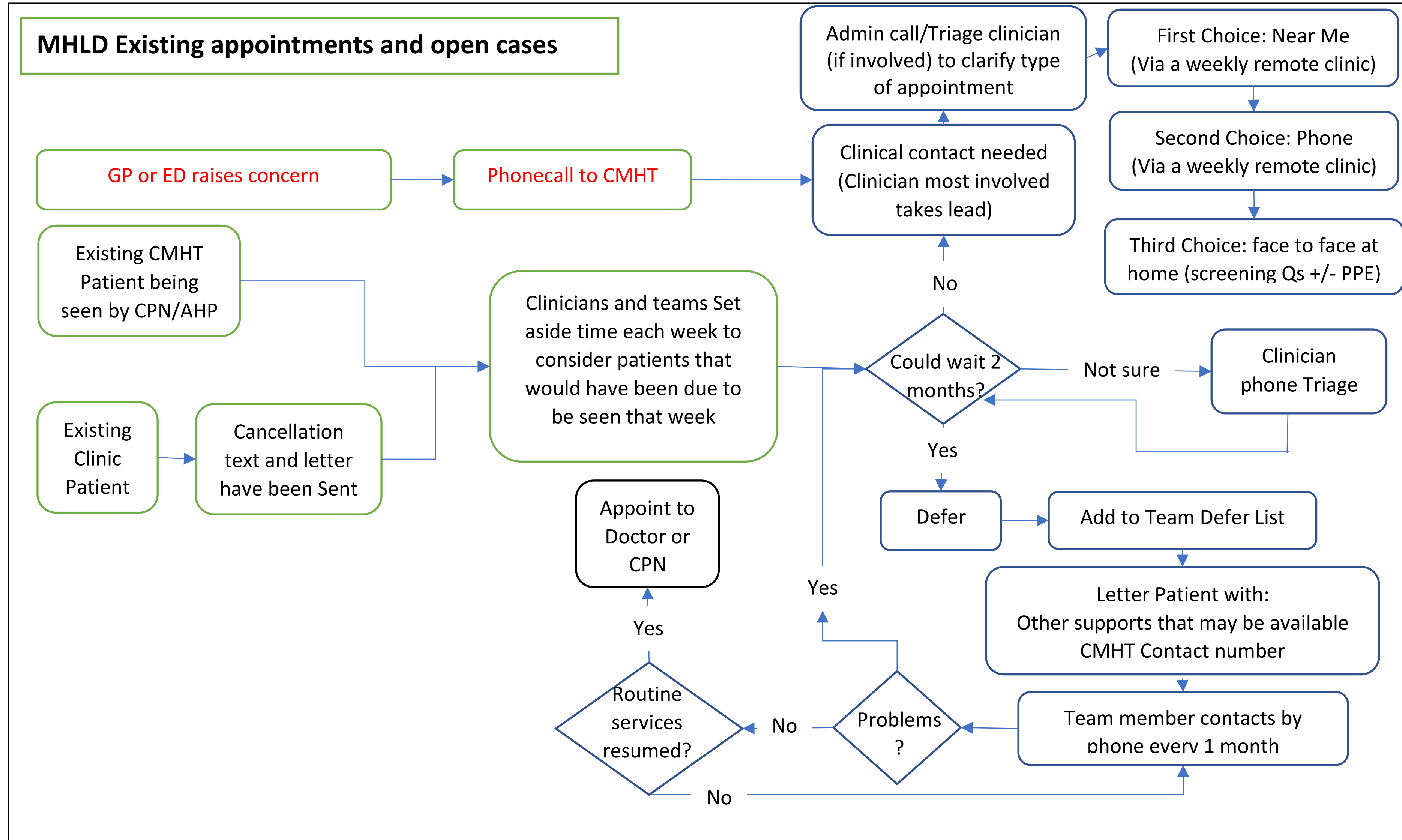
This document should be viewed as a working draft - this guidance will be reviewed as the situation evolves.

Change log			
V1.0	24/03/20	Initial version	MH Management Team
V1.1	31/03/20	Changed “see” criteria for specialist Eating Disorders Service	Adam Daly
V1.2	03/04/20	Added DRAFT flow charts	Adam Daly
V1.21	03/04/20	Flowcharts changed after comments Minor word changes around mood stabilisers	Adam Daly
V1.22	13/04/20	Cover page updated	Adam Daly

Flowchart 1: COVID19 Mental Health and Learning Disabilities referral processing: new referrals



Flowchart 2: COVID19 Mental Health and Learning Disabilities referral processing: existing appointments and open cases



Guidance on deferring new and return appointments for CMHTs during pandemic

Important: Note that no patients are to be discharged if they would normally be kept with the service. The intention of this process is to delay work to create capacity, it is not the intention that people who need mental health input are diverted to either Primary Care or Emergency Department.

Date tbc

Category	General criteria	Specialty Specific criteria
To be seen/ managed now Use the following as clinical need demands 1. Attend Anywhere (preference) 2. Phone interview 3. Face to face (screening questions and PPE if indicated are mandatory)	**Situations when patient is considered high risk of harm to self or others due to a mental disorder** Current suicidal ideations with plans Very distressed patient secondary to mental illness with active thoughts of harming themselves or others Acutely Psychotic/ Acutely depressed /Acutely Manic /Sudden change in presentation of patients due to noncompliance or disengagement. Patients subject to Mental Health Act Patients recently discharged from hospital New / First episode Psychosis (ideally when organic causes and delirium are ruled out) Patients with Diagnosis of Schizophrenia/ Mood disorder presenting in Acute relapse. Patients needing to be given depot antipsychotic.	Addictions Psychiatry • Inpatient detox in high risk situations Learning Disabilities • Patients presenting with Acute Challenging Behaviours requiring immediate attention and treatment (i.e. presenting with high risk) Perinatal • Consider Gestation (higher risk in third trimester, intra-partum of immediately postnatal) • Risk of PPP based on personal history of MH. Eating Disorders • High Physical Risk

	Patients on Clozapine medications requiring ongoing monitoring. Patients on Lithium Therapy requiring ongoing monitoring. Patients on Depakote therapy requiring ongoing monitoring. Patients requiring emergency ECT Treatment or immediately post ECT.	
Consider Phone/attend anywhere advice • Phonecall with patient or referrer (depending on scenario) is likely to be sufficient	Patient known to CMHT presenting with queries about treatment but not acutely unwell. Non-Emergency cases known to CMHT Depression/Anxiety worsening – advise on change of medications/ non-pharmacological additional support required Known Psychosis/ Bipolar - advise on change of medications Any side-effects/ poor tolerance/ poor efficacy from Psychotropic medications	Addictions Psychiatry • Referrals for Disulfiram (if blood taking/ECGs available) Learning Disabilities • Advice on known Challenging behaviour Old Age • Patient presenting with stress and distress symptoms due to Dementia
Defer Patient to a later date • patient sent letter advising of deferral • List kept by team so that these referrals; can be picked up at end of pandemic	**Routine new reviews** for assessment of most mental health disorder including • Low mood • Anxiety • diagnostic challenges assuming risks are low. **Routine return reviews-** review of management plan required but no immediate risk identified from last risk assessment and	Note that the below assume lower overall risk General Psychiatry • Starting Clozapine • Starting Depot • ADHD assessments Learning Disabilities • Autism/ASD

	patient tolerating medication without any obvious side-effects.	• ADHD • History of challenging behaviour Old Age Psychiatry • Cognitive Assessments Addictions Psychiatry • Inpatient detox • Referrals for Disulfiram (if blood taking/ECGs not available)

Additional points

- Forensic Psychiatry: Due to the nature of the forensic psychiatry service and the patients seen (small numbers of highly complex individuals), patients will have individual management plans.
- CAMHS are not included in this list at present and follow separate guidance.

This list is not exhaustive, nor does it replace clinical judgement and clinicians should prioritise their caseload in terms of need, vulnerability and risk assessments and consider those patients who can wait for a routine appointment, those that could benefit from phone contact and those that require to be seen.