Mental Health Clustering Booklet

(V5.0)

(2016/17)

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Contents

Introduction

The Mental Health currencies have been mandated for use since April 2012. For most provider and commissioning organisations completeness and accuracy of cluster allocations is now a key concern and a great deal of audit/assurance work is being undertaken. This manual is not intended to replace face-to-face training sessions, but to provide clinicians with all the information needed to accurately use the model.

What is a Cluster?

In this context a cluster is a global description of a group of people with similar characteristics as identified from a holistic assessment and then rated using the Mental Health Clustering Tool (MHCT). The clusters allow for a degree of variation in the combination and severity of rated needs. However, as the clusters are statistically underpinned, definite patterns in the MHCT ratings exist for each of them. These ranges are indicated by the colour coded grids (Appendix 3) and are supplemented by the contextual information on the left hand side of each page, which is particularly useful when reviewing the appropriateness of previous cluster allocations.

When should I cluster someone?

People's needs change over time, and over the course of their treatment. A payment system for mental healthcare must reflect the differing levels of input that are provided throughout changing and unpredictable episodes of care. In order to achieve this, it is essential that people are not only assessed and clustered at the point of referral, but also re-assessed and re-clustered periodically. In practice this will equate to assessing and clustering people at:

- The end of the initial assessment (typically within 2 contacts).
- All planned CPA or other formal care reviews.
- Any other point where a significant change in planned care is deemed necessary (e.g. unplanned reviews, urgent admissions etc.)

Organisations should ensure there is clarity about who is responsible for clustering, particularly when more than one professional is involved.

How do I Cluster someone who is newly referred?

As organisations use different IT systems, the exact procedures will vary from provider to provider. However all providers will follow these basic steps:

Step 1: Based on the information you have gathered during your routine screening/assessment process, rate the individual's identified needs using the Mental Health Clustering Tool - Version 5.0 (Appendix 1).

Step 2: Use the Decision Tree (Appendix 2) to decide if the presenting needs are non-psychotic, psychotic or organic in origin. Then decide which of the next level of headings is most accurate. This will have narrowed down the list of clusters that are likely to describe the person's needs.

Step 3: Look at the rating grids (Appendix 3) to decide which one is the most appropriate by using the colour-coded key.

- Start with the Red ratings. These indicate the type and level of need which must be apparent in order to be a member of this cluster. If the ratings do not match, try another cluster.
- Next, consider the Orange ratings. These represent expected ratings. You may allocate a person to a cluster if the orange ratings do not exactly match the coloured grids. However, this reflects a "weaker fit" to that cluster.

Finally review the Yellow ratings. These represent ratings that may occur. These scales have significantly less bearing on cluster allocation but may indicate the need for additional care plan interventions.

Remember, the final clustering decision is yours, based on your assessment results and your clinical judgement in applying this guidance.

Care Review and the clustering process

Every day practitioners make decisions about starting, stopping, increasing and decreasing interventions. These decisions are made according to a range of complex and inter-related factors, but primarily in response to individual service user need. The Care Pathways and Packages model describes these individually assessed needs in a consistent way, using a combination of the Mental Health Clustering Tool (MHCT) and the resulting set of needs-based clusters.

The clusters, therefore, describe groups of service users with similar types of characteristics. These groups/clusters can be compared to each other in a variety of ways including: severity of need; complexity of need; acuity; intensity of likely treatment response; anticipated course of illness etc.

Whilst some comparisons will be more useful than others in different situations, in this booklet a global judgement is made which combines all these factors and either leads to the term **'step-up'** or **'step-down'** being used to describe movement between any given clusters.

Care Transition Protocols

The points at which the appropriateness of the current cluster allocation is reconsidered should not be arbitrary. It should occur at natural and appropriate points in the individual's care pathway. Typically these are termed as reviews but it is important to note that reviews can be relatively informal as well as formal, and can be in response to unforeseen changes in need i.e. unplanned as well as pre-planned.

Consider the following clinical scenarios:

- The planned review of a service user halfway through a course of 16 sessions of CBT for depression will often reveal significant improvements and a corresponding reduction in MHCT ratings for anxiety and low mood. This is rarely seen as a sustainable change in the user's presentation and thus the original treatment plan continues until the intervention is completed, rather than be reduced to a lower intensity intervention (e.g. computerised CBT).

- Some months after treatment from an Assertive Outreach Team begins, improvements in presentation (particularly patterns of engagement) are not uncommon. These are unlikely to trigger a significant reduction in the overall level of intervention provided until the improvements have been maintained for some time. Thus the cluster allocation that originally triggered an assertive and intensive service response remains valid, as it is still seen as a truer reflection of the individual's overall needs.

- Service Users diagnosed with borderline personality disorder are well known to exhibit erratic patterns of behaviour, with fluctuations in distress and risk commonplace. Despite increases in risk, decisions are often made to take therapeutic risks rather than immediately increasing the overall level of intervention in response to what may turn out to be transient and self-limiting increases in perceived need.

From these examples it is clear that individuals only fit the needs profiles for the appropriate cluster at certain key points in their journey (i.e. the start of a period of care) and that, at clinical reviews additional factors must also be taken into account before an alternative cluster allocation is made and care is changed significantly.

These factors are described in this booklet as care transition protocols and include the step-up and step-down criteria for each cluster. **Only when a set of criteria have been met should the allocated cluster be changed to that suggested by the clustering tool ratings.** The protocols also include examples of local discharge criteria which outline the circumstances when service users could be discharged from in-scope Mental Health Services completely.
N.B. Providers and commissioners will need to agree their own local discharge criteria; hence this section of the booklet is editable.

The care transition pages in this booklet describe, for each cluster: the length of time service users are likely to remain in MH Services; a frequency for re-assessing the appropriateness of the cluster; and the likelihood of each possible cluster transition. It also attempts to visually represent the relationship between each cluster in terms of intensity, acuity and complexity etc.
N.B. In general cluster reviews should be aligned to care reviews. The review frequencies quoted are outer limits, not absolute frequencies.

As most practitioners work with specific groups of service users and will only routinely encounter a small number of clusters, they will become familiar with their own 'portion' of the booklet. In addition, the 6 steps described below will guide practitioners through the process.

Step-by-step guide to the use of MHCT ratings, cluster profiles and care transition protocols at care reviews

1. Select the page containing care transition protocols that correspond to the individual's current cluster.

2. After completing an appropriate re-assessment of risks and needs complete a new MHCT.

3. Consider the **step-up criteria**. If any one of these is met, this suggests the current cluster allocation needs to change and, with reference to the clustering booklet; the latest MHCT ratings should be used to decide on the new cluster. If the step-up criteria are not met…

4. Consider the **discharge criteria**. If all of these are met, this indicates the need to explore discharge from in-scope Mental Health Services back to GP-led (Primary) Care. If the discharge criteria are not met…

5. Consider the **step-down criteria**. If all of these are met, this suggests the current cluster allocation needs to change and, with reference to the clustering booklet, the MHCT ratings should be used to decide on the new cluster. If the step-down criteria are not met …

6. This indicates that the existing cluster allocation remains valid, as any differences in the user's needs that have occurred do not warrant the changes in service response that allocation to a different cluster would trigger.

Patient Safety

Any issues relating to service User safety that arise through the use of the Mental Health Clustering Tool and the Mental Health Care Clusters should be raised through your organisation's own patient safety reporting routes. Any urgent Service User safety issues that directly relate to the clustering tool or the clusters should also be reported via pricing@monitor.gov.uk.

Brief note on changes made for 2016/17:

Each year the clustering booklet is reviewed. There are no major changes to the booklet for 2016/17 but we are repeating the changes included for 2015/16. We may, however issue a further version of the booklet later in the year as the Royal College of Psychiatrists will be publishing an updated version of HoNOS. This does not change the number of scales or the rating of the scales, but some of the language will be updated.

Changes were made last year in response to some difficulties reported when allocating some patients diagnosed with Bipolar Affective Disorder to a cluster. A specific guidance note on this issue is appended to the booklet. The main aim has been to legitimise the allocation of patients with Bipolar disorder to the complex non-psychotic clusters where psychosis has never been apparent, or where its occurrence was so long ago that the patient's well-established pattern of needs does not fit well with the psychosis superclass.

Bipolar advice

All patients, including those with a diagnosis of bipolar disorder should be allocated to the cluster **which best describes the combination and severity of their primary presenting needs**. Patients with the same diagnosis can therefore be accurately allocated to different clusters within a superclass (non-psychotic, psychotic / organic). As a diagnosis of bipolar disorder covers a particularly wide variety of presentations these patients may be allocated to either a psychotic or a non-psychotic cluster depending on your clinical judgement, though consideration of the likely and unlikely diagnoses sections of the clustering booklet should be carefully considered.

Please see annex four of this document for further practice guidance regarding allocating patients with bipolar diagnosis to a cluster.

Advice concerning the transition of patients into and out of clusters 14 and 15 (psychotic crisis and psychotic depression)

Patients' needs change over time. The clusters are relatively broad in nature and hence there will be a range of presentations (more – less well) within each. It is not unusual for patients in clusters 10, 13, 16 and 17 to relapse and be better described by cluster 14 i.e. be experiencing a psychotic crisis.
In this case, assuming the change in presentation warrants a significant change in the intensity of their treatment package, they should be re-clustered accordingly (i.e. to cluster 14).
Whilst not universally followed, this process is reasonably well recognised. Upon recovery however it is important to **take account of the patient's previous presentation** when stepping the patient down from cluster 14 post crisis.
So, if for example the patient has been in cluster 17 prior to their psychotic crisis, even if their symptoms are well controlled, at the point of stepping down from 14 it is unlikely that anything other than cluster 17 will meet their needs.

Similarly, if a patient in cluster 10 (first episode psychosis) becomes acutely unwell and warrants allocation to cluster 14, upon stepping-down, if they are within three years of initial presentation they should be re-allocated to cluster 10 for the remainder of their three year treatment package.

For the purposes of payment, where providers are being paid for an episode of care, it should be noted that a separate payment for cluster 14 will only be made when this is the first presentation of a patient into secondary mental health services. For other patients in receipt of on-going treatment, although the crisis should be recorded and captured using the clustering tool and reported via the Mental Health Dataset, the episodic payment should continue.

Appendix 1

Mental Health Clustering Tool Version 5.0

Mental Health Clustering Tool (MHCT) version 5.0 (2016)

The MHCT incorporates items from the Health of the Nations Outcome Scales (HoNOS), (Wing et al. 1999[1]) and the Summary of Assessments of Risk and Need (SARN), (Self et al 2008[2]) in order to provide all the information necessary to allocate individuals to clusters.

HoNOS is an internationally recognised outcome measure developed by the Royal College of Psychiatrists Research Unit (CRU) to measure health and social functioning outcomes in Mental Health Services. The aim of the HoNOS was to produce a brief measure capable of being completed routinely by clinicians and recorded as part of a minimum mental health dataset. The first twelve items of the MHCT are HoNOS items. The HoNOS items are used here with the permission of the Royal College of Psychiatrists, who hold the copyright. Readers will want to note that the Royal College will be publishing an updated version of HoNOS in early 2016 following an international review. Although some of the words will change the items and the scales will remain the same. The tool will be updated to reflect the new wording when it is available

SARN

The Summary of Assessments of Risk and Need (SARN) was developed by the Care Pathways and Packages Project[1] to aid in the process of establishing a classification of Service Users based on their needs so that appropriate service responses could be developed both at the individual and service level. It provides a brief description of the needs of people entering into Mental Health Services for the first time or presenting with a possible need for change in their care or treatment. It allows professionals from a range of backgrounds to summarise their assessments in a shared format. Thus it provides a common language for describing health states and related social conditions and improves communication between different users of the tool including health and social care professionals, Service Users themselves, commissioners and researchers.

Mental Health Clustering Tool (MHCT)

Part 1 contains scales relating to the severity of problems experienced by the individual during the 2 weeks prior to the date of the rating.

Part 2 contains scales that consider problems from a 'historical' perspective. These will be problems that occur in episodic or unpredictable ways. Whilst they may not have been experienced by the individual during the two weeks prior to the rating date, clinical judgement would suggest that there is still a cause for concern that cannot be disregarded (i.e. no evidence to suggest that the person has changed since the last occurrence either as a result of time, therapy, medication or environment etc.). In these circumstances, any event that remains relevant to the cluster allocation (and hence the interventions offered) should be included.

Summary of rating information

- **Rate each scale in order from 1 to 13 (Part 1), followed by A to E (Part 2).**
- **For the first 12 scales, do not include information rated in an earlier scale except for scale 10 which is an overall rating.**
- **Rate the MOST SEVERE problem that occurred in the rating period**
- **All scales follow the format:**
  0 = no problem
  1 = minor problem requiring no action
  2 = mild problem but definitely present
  3 = moderately severe problem
  4 = severe to very severe problem

Rate 9 if Not Known but be aware that this is likely to make accurate clustering impractical and indicate that further assessment is required.

[1] CPPP was a consortium of providers and commissioners in Yorkshire and the North East that undertook the initial development work on mental health currencies.

References

[1]Wing, J. K., Curtis, R. H. & Beevor, A. S. (1999) Health of the Nation Outcome Scales (HoNOS). *British Journal of Psychiatry, 174 (5), 432-434.*

[2]Self R; Rigby A; Leggett C and Paxton R (2008) Clinical Decision Support Tool: A rational needs-based approach to making clinical decisions. *Journal of Mental Health*, 17(1): 33-48.

PART 1: Current Ratings

For scales 1-13, rate the most severe occurrence in the previous two weeks

1. Overactive, aggressive, disruptive or agitated behaviour (current)					
	0	**1**	**2**	**3**	**4**
• *Include such behaviour due to any cause (e.g. drugs, alcohol, dementia, psychosis, depression, etc.)* • *Do not include bizarre behaviour rated at Scale 6.*	No problem of this kind during the period rated.	Irritability, quarrels, restlessness etc. not requiring action.	Includes aggressive gestures, pushing or pestering others; threats or verbal aggression; lesser damage to property (e.g. broken cup, window); marked over-activity or agitation.	Physically aggressive to others or animals (short of rating 4); threatening manner; more serious over-activity or destruction of property.	At least one serious physical attack on others or on animals; destructive of property (e.g. fire-setting); serious intimidation or obscene behaviour. ***Rate 9 if not known***
2. Non-accidental self-injury (current)					
	0	**1**	**2**	**3**	**4**
• *Do not include accidental self-injury (due e.g. to dementia or severe learning disability); the cognitive problem is rated at Scale 4 and the injury at Scale 5.* • *Do not include illness or injury as a direct consequence of drug/alcohol use rated at Scale 3 (e.g. cirrhosis of the liver) or injury resulting from drink driving which are rated at Scale 5).*	No problem of this kind during the period rated.	Fleeting thoughts about ending it all but little risk during the period rated; no self-harm.	Mild risk during the period rated; includes non-hazardous self-harm (e.g. wrist-scratching).	Moderate to serious risk of deliberate self-harm during the period rated; includes preparatory acts (e.g. collecting tablets).	Serious suicidal attempt and/or serious deliberate self-injury during the period rated. ***Rate 9 if Not Known***
3. Problem-drinking or drug-taking (current)					
	0	**1**	**2**	**3**	**4**
• *Do not include aggressive/destructive behaviour due to alcohol or drug use, rated at Scale 1.* • *Do not include Physical Illness or disability problems or disability due to alcohol or drug use, rated at Scale 5.*	No problem of this kind during the period rated.	Some over-indulgence but within social norm.	Loss of control of drinking or drug-taking, but not seriously addicted.	Marked craving or dependence on alcohol or drugs with frequent loss of control; risk taking under the influence.	Incapacitated by alcohol/drug problem. ***Rate 9 if Not Known***
4. Cognitive problems (current)					
	0	**1**	**2**	**3**	**4**
• *Include problems of memory, orientation and understanding associated with any disorder: learning disability, dementia, schizophrenia, etc.* • *Do not include temporary problems (e.g. hangovers) resulting from drug/alcohol use, rated at Scale 3.*	No problem of this kind during the period rated.	Minor problems with memory or understanding (e.g. forgets names occasionally).	Mild but definite problems (e.g. has lost the way in a familiar place or failed to recognise a familiar person); sometimes mixed up about simple decisions.	Marked disorientation in time, place or person; bewildered by everyday events; speech is sometimes incoherent; mental slowing.	Severe disorientation (e.g. unable to recognise relatives); at risk of accidents; speech incomprehensible; clouding or stupor. ***Rate 9 if Not Known***

5. Physical Illness or disability problems (current)					
	0	**1**	**2**	**3**	**4**
• *Include illness or disability from any cause that limits or prevents movement, or impairs sight or hearing, or otherwise interferes with personal functioning.* • *Include side-effects from medication; effects of drug/alcohol use; physical disabilities resulting from accidents or self-harm associated with cognitive problems, drink-driving, etc.* • *Do not include mental/behavioural problems rated at Scale 4.*	No physical health problem during the period rated.	Minor health problems during the period (e.g. cold, non-serious fall, etc.)	Physical health problem imposes mild restriction on mobility and activity.	Moderate degree of restriction on activity due to physical health problem.	Severe or complete incapacity due to physical health problem. ***Rate 9 if Not Known***
6. Problems associated with hallucinations and delusions (current)					
	0	**1**	**2**	**3**	**4**
• *Include hallucinations and delusions irrespective of diagnosis.* • *Include odd and bizarre behaviour associated with hallucinations or delusions.* • *Do not include aggressive, destructive or overactive behaviours attributed to hallucinations or delusions, rated at Scale 1.*	No evidence of hallucinations or delusions during the period rated.	Somewhat odd or eccentric beliefs not in keeping with cultural norms.	Delusions or hallucinations (e.g. voices, visions) are present, but there is little distress to patient or manifestation in bizarre behaviour, i.e. clinically present but mild.	Marked preoccupation with delusions or hallucinations, causing much distress and/or manifested in obviously bizarre behaviour, i.e. moderately severe clinical problem.	Mental state and behaviour is seriously and adversely affected by delusions or hallucinations, with severe impact on patient. ***Rate 9 if Not Known***
7. Problems with depressed mood (current)					
	0	**1**	**2**	**3**	**4**
• *Do not include over-activity or agitation, rated at Scale 1.* • *Do not include suicidal ideation or attempts, rated at Scale 2.* • *Do not include delusions or hallucinations, rated at Scale 6.*	No problem associated with depressed mood during the period rated.	Gloomy; or minor changes in mood.	Mild but definite depression and distress (e.g. feelings of guilt; loss of self-esteem).	Depression with inappropriate self-blame; preoccupied with feelings of guilt.	Severe or very severe depression, with guilt or self-accusation. ***Rate 9 if Not Known***
8. Other mental and behavioural problems (current)					
	0	**1**	**2**	**3**	**4**
• *Rate only the most severe clinical problem not considered at scales 6 and 7 as follows.* • *Specify the type of problem by entering the appropriate letter: A phobic; B anxiety; C obsessive-compulsive; D mental strain/tension; E dissociative; F somatoform; G eating; H sleep; I sexual; J other, specify.*	No evidence of any of these problems during period rated.	Minor problems only.	A problem is clinically present at a mild level (e.g. patient has a degree of control).	Occasional severe attack or distress, with loss of control (e.g. has to avoid anxiety provoking situations altogether, call in a neighbour to help, etc.) i.e. moderately severe level of problem.	Severe problem dominates most activities. ***Rate 9 if Not Known***

9. Problems with relationships (current)					
	0	**1**	**2**	**3**	**4**
• *Rate the patient's most severe problem associated with active or passive withdrawal from social relationships, and/or non-supportive, destructive or self-damaging relationships.*	No significant problem during the period.	Minor non-clinical problems.	Definite problem in making or sustaining supportive relationships; patient complains and/or problems are evident to others.	Persisting major problem due to active or passive withdrawal from social relationships and/or to relationships that provide little or no comfort or support.	Severe and distressing social isolation due to inability to communicate socially and/or withdrawal from social relationships. ***Rate 9 if Not Known***
10. Problems with activities of daily living (current)					
	0	**1**	**2**	**3**	**4**
• *Rate the overall level of functioning in activities of daily living (ADL) (e.g. problems with basic activities of self-care such as eating, washing, dressing, toilet; also complex skills such as budgeting, organising where to live, occupation and recreation, mobility and use of transport, shopping, self-development, etc.).* • *Include any lack of motivation for using self-help opportunities, since this contributes to a lower overall level of functioning.* • *Do not include lack of opportunities for exercising intact abilities and skills, rated at Scales 11-12.*	No problem during period rated; good ability to function in all areas.	Minor problems only (e.g. untidy, disorganised).	Self-care adequate, but major lack of performance of one or more complex skills (see above).	Major problem in one or more areas of self-care (eating, washing, dressing, toilet) as well as major inability to perform several complex skills.	Severe disability or incapacity in all or nearly all areas of self-care and complex skills. ***Rate 9 if Not Known***
11. Problems with living conditions (current)					
	0	**1**	**2**	**3**	**4**
• *Rate the overall severity of problems with the quality of living conditions and daily domestic routine. Are the basic necessities met (heat, light, hygiene)? If so, is there help to cope with disabilities and a choice of opportunities to use skills and develop new ones?* • *Do not rate the level of functional disability itself, rated at Scale 10.* **NB: Rate patient's usual situation. If in acute ward, rate activities during period before admission. If information not available, rate 9.**	Accommodation and living conditions are acceptable; helpful in keeping any disability rated at Scale 10 to the lowest level possible, and supportive of self-help.	Accommodation is reasonably acceptable although there are minor or transient problems (e.g. not ideal location, not preferred option, doesn't like the food, etc.)	Significant problem with one or more aspects of the accommodation and/or regime (e.g. restricted choice; staff or household have little understanding of how to limit disability or how to help use or develop new or intact skills).	Distressing multiple problems with accommodation (e.g. some basic necessities absent); housing environment has minimal or no facilities to improve patient's independence.	Accommodation is unacceptable (e.g. lack of basic necessities, patient is at risk of eviction, or 'roofless', or living conditions are otherwise intolerable) making patient's problems worse. ***Rate 9 if Not Known***

12. Problems with occupation and activities (current)					
	0	**1**	**2**	**3**	**4**
• *Rate the overall level of problems with quality of day-time environment. Is there help to cope with disabilities, and opportunities for maintaining or improving occupational and recreational skills and activities? Consider factors such as stigma, lack of qualified staff, access to supportive facilities e.g. staffing and equipment of day centres, workshops, social clubs, etc.* • *Do not rate the level of functional disability itself, rated at Scale 10.* **NB: Rate patient's usual situation. If in acute ward, rate activities during period before admission. If information not available, rate 9.**	Patient's day-time environment is acceptable: helpful in keeping any disability rated at Scale 10 to the lowest level possible, and supportive of self-help.	Minor or temporary problems (e.g. late giro cheques): reasonable facilities available but not always at desired times, etc.	Limited choice of activities; lack of reasonable tolerance (e.g. unfairly refused entry to public library or baths, etc.); handicapped by lack of a permanent address; insufficient carer or professional support; helpful day setting available but for very limited hours.	Marked deficiency in skilled services available to help minimise level of existing disability; no opportunities to use intact skills or add new ones; unskilled care difficult to access.	Lack of any opportunity for daytime activities makes patient's problems worse. ***Rate 9 if Not Known***
13. Strong unreasonable beliefs that are <u>not</u> psychotic in origin (current)					
	0	**1**	**2**	**3**	**4**
• *Rate any apparent strong unreasonable beliefs (found in **some** people with disorders such as Obsessive Compulsive Disorder, Anorexia Nervosa, personality disorder, morbid jealousy etc.)* • *Do not include Delusions rated at scale 6.* • *Do not include Severity of disorders listed above where strong unreasonable beliefs are not present – rated at Scale 8.* • *Do not include Beliefs/behaviours consistent with a person's culture.*	No Strong unreasonable beliefs evident.	Holds illogical or unreasonable belief(s) but has insight into their lack of logic or reasonableness and can challenge them most of the time and they have only a minor impact on the individual's life.	Holds illogical or unreasonable belief(s) but individual has insight into their lack of logic or reasonableness. Belief(s) can be successfully challenged by individual on occasions. Beliefs have a mild impact on the person's life.	Holds strong illogical and unreasonable belief(s) but has some insight into the relationship between the beliefs and the disorder. Belief(s) can be 'shaken' by rational argument. Tries to resist belief but with little effect. Has a significant negative impact on person's life. The disorder makes treatment more difficult than usual.	Holds strong illogical or unreasonable belief(s) with little or no insight in the relationship between the belief and the disorder. Belief(s) cannot be 'shaken' by rational argument. Does not attempt to resist belief(s). Has a significant negative impact on the person's life or other people's lives and the disorder is very resistant to treatment. ***Rate 9 if not known***

PART 2: Historical Ratings

Scales A-E, rate problems that occur in an episodic or unpredictable way. Include any event that remains relevant to the current plan of care.
Whilst there may or may not be any direct observation or report of a manifestation during the last two weeks, the evidence and clinical judgement would suggest that there is still a cause for concern that cannot be disregarded (i.e. no evidence to suggest that the person has changed since the last occurrence either as a result of time, therapy, medication or environment etc.)

A. Agitated behaviour/expansive mood (historical)					
	0	**1**	**2**	**3**	**4**
• *Rate agitation and overactive behaviour causing disruption to social role functioning. Behaviour causing concern or harm to others.* • *Elevated mood that is out of proportion to circumstances.* • *Include such behaviour due to any cause (e.g. drugs, alcohol, dementia, psychosis, depression etc.)* • *Excessive irritability, restlessness, intimidation, obscene behaviour and aggression to people animals or property.* • *Do not include odd or bizarre behaviour to be rated at Scale 6.*	No needs in this area.	Presents as irritable, argumentative with some agitation. Some signs of elevated mood or agitation not causing disruption to functioning.	Makes verbal/gestural threats. Pushes/pesters but no evidence of intent to cause serious harm. Causes minor damage to property (e.g. glass or crockery). Is obviously over-active or agitated.	Agitation or threatening manner causing fear in others. Physical aggression to people or animals. Property destruction. Serious levels of elevated mood, agitation, restlessness causing significant disruption to functioning.	Serious physical harm caused to persons/animals. Major destruction of property. Seriously intimidating others or exhibiting highly obscene behaviour. Elevated mood, agitation, restlessness causing complete disruption. ***Rate 9 if not known***
B. Repeat self-harm (historical)					
	0	**1**	**2**	**3**	**4**
• *Rate repeat acts of self-harm with the intention of managing people, stressful situations, emotions or to produce mutilation for any reason.* • *Include self-cutting, biting, striking, burning, breaking bones or taking poisonous substances etc.* • *Do not include accidental self-injury (due e.g. to learning disability or cognitive impairment); the cognitive problem is rated at Scale 4 and the injury at Scale 5.* • *Do not include harm as a direct consequence of drug/alcohol use (e.g. liver damage) to be rated at Scale 3. Injury sustained whilst intoxicated to be rated at Scale 5.* • *Do not include harm with intention of killing self (rated at Scale 2).*	No problem of this kind.	Superficial scratching or non-hazardous doses of drugs.	Superficial cutting, biting, bruising etc. or small ingestions of hazardous substances unlikely to lead to significant harm even if hospital treatment not sought.	Repeat self-injury requiring hospital treatment. Possible dangers if hospital treatment not sought. However, unlikely to leave lasting severe damage even if behaviour continues providing hospital treatment sought.	Repeat serious self-injury requiring hospital treatment and likely to leave lasting severe damage if behaviour continues (i.e. severe scarring, crippling or damage to internal organ) and possibly to death. ***Rate 9 if not known***

C. Safeguarding other children & vulnerable adults (historical)					
	0	**1**	**2**	**3**	**4**
• *Rate the potential or actual impact of the patient's mental illness, or behaviour, on the safety and well-being of vulnerable people of any age.* • *Include any patient who has substantial access and contact with children or other vulnerable persons.* • *Do not include risk to wider population covered at scale A.* • *Do not include challenge to relationships covered in scale 9.*	No obvious impact of the individual's illness or behaviour on the safety or well-being of vulnerable persons.	Mild concerns about the impact of the individual's illness or behaviour on the safety or well-being of vulnerable persons.	Illness or behaviour has an impact on the safety or well-being of vulnerable persons. The individual is aware of the potential impact but is supported and is able to make adequate arrangements.	Illness or behaviour has an impact on the safety or well-being of vulnerable persons but does not meet the criteria to rate 4. There may be delusions, non-accidental self-injury risk or self-harm. However, the individual has insight, can take action to significantly reduce the impact of their behaviour on the children and is adequately supported.	Without action the illness or behaviour is likely to have direct or indirect significant impact on the safety or well-being of vulnerable persons. Problems such as delusions, severe non-accidental self-injury risk or problems of impulse control may be present. There may be lack of insight, an inability or unwillingness to take precautions to protect vulnerable persons and/or lack of adequate support and protection for vulnerable persons. ***Rate 9 if not known***
D. Engagement (historical)					
	0	**1**	**2**	**3**	**4**
• *Rate the individual's motivation and understanding of their problems, acceptance of their care/treatment and ability to relate to care staff.* • *Include the ability, willingness or motivation to engage in their care/ treatment appropriately, agreeing personal goals, attending appointments. Dependency issues.* • *Do not include Cognitive issues as in scale 4, severity of illness or failure to comply due to practical reasons.*	Has ability to engage/disengage appropriately with services. Has good understanding of problems and care plan.	Some reluctance to engage or slight risk of dependency. Has understanding of own problems.	Occasional difficulties in engagement, i.e. missed appointments or contacting services between appointments inappropriately. Some understanding of own problems.	Contacts services inappropriately. Has little understanding of own problems. Unreliable attendance at appointments. Or attendance depends on prompting or support.	Contacts multiple agencies, i.e. GP, A & E etc. constantly. Little or no understanding of own problems. Fails to comply with planned care. Rarely attends appointments. Refuses service input. Or Attendance and compliance dependent on intensive prompting and support. ***Rate 9 if not known***

E. Vulnerability (historical)					
	0	**1**	**2**	**3**	**4**
• *Rate failure of an individual to protect themselves from risk of harm to their health and safety or well-being.* • *Include physical, sexual, emotional and financial exploitation or harm/harassment* • *Do not include problems of engagement rated at scale D.*	No vulnerability evident.	No significant impact on person's health, safety or well-being.	Concern about the individual's ability to protect their health, safety or well-being requiring support or removal of existing support would increase concern.	Clear evidence of significant vulnerability affecting the individual's ability to protect their health and safety or well-being that requires support (but not as severe as a rating of 4). Or removal of existing support would increase risk.	Severe vulnerability – total breakdown in individual's ability to protect themselves resulting in major risk to the individual's health, safety or well-being. ***Rate 9 if not known***

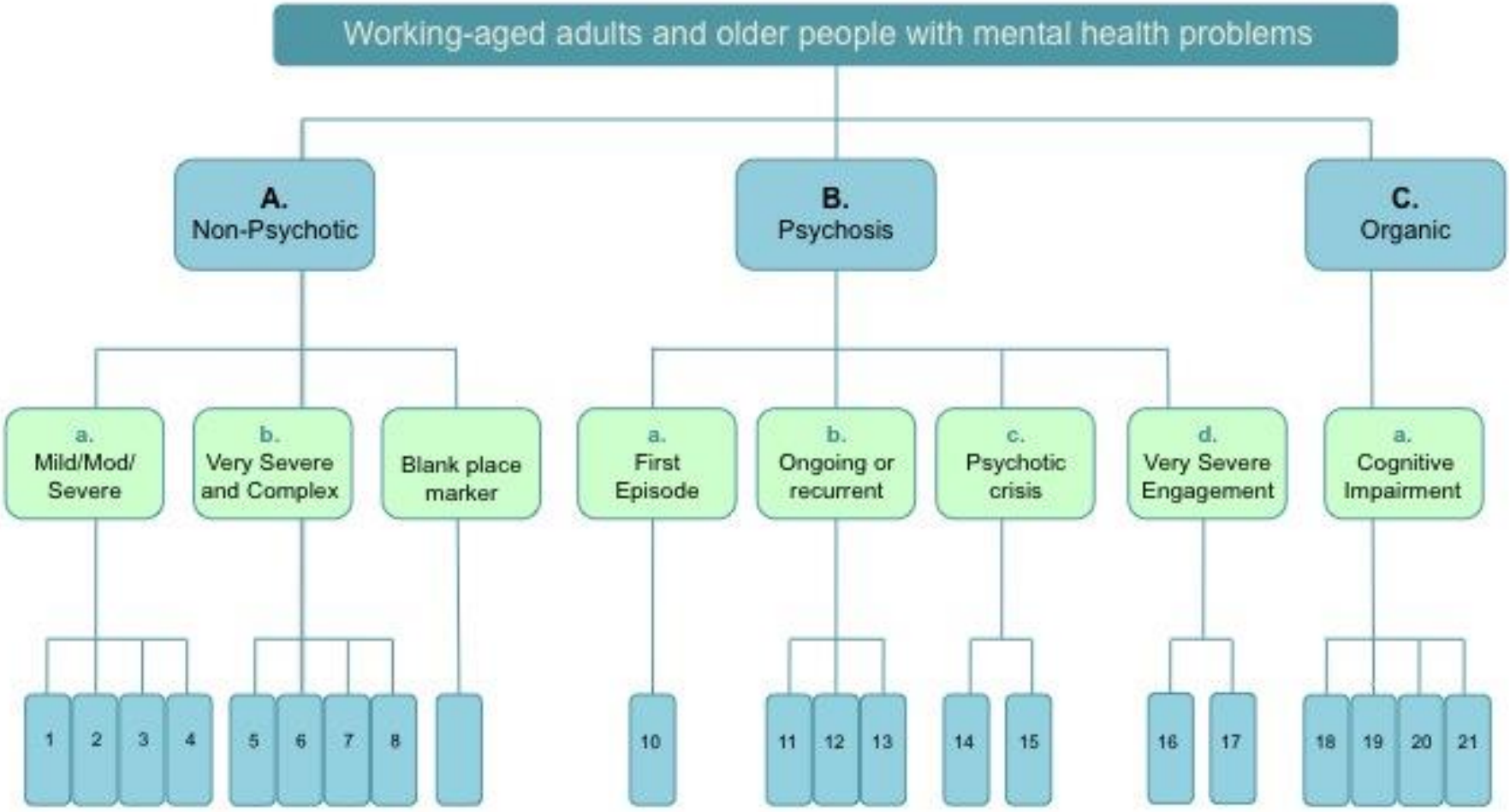
Item	Rating	Item	Rating
Part 1 (Current)		Part 2 (Historical)	
1		**A**	
2		**B**	
3		**C**	
4		**D**	
5		**E**	
6			
7			
8			
Please Circle	A B C D E F G H I J		
N.B. If J – (other) please specify			
9			
10			
11			
12			
13			

Appendix 2

Decision Tree

DECISION TREE

(RELATIONSHIP OF CARE CLUSTERS TO EACH OTHER)



Appendix 3

Cluster Descriptions
& Care Transition Protocols

Guide to appendix 3

Brief pen picture description of cluster members

Diagnoses most frequently encountered NB. Not an exhaustive/definitive list

Counter-intuitive diagnosis for the cluster

Brief description of likely impairments to functioning

Brief description of likely nature and course of condition.

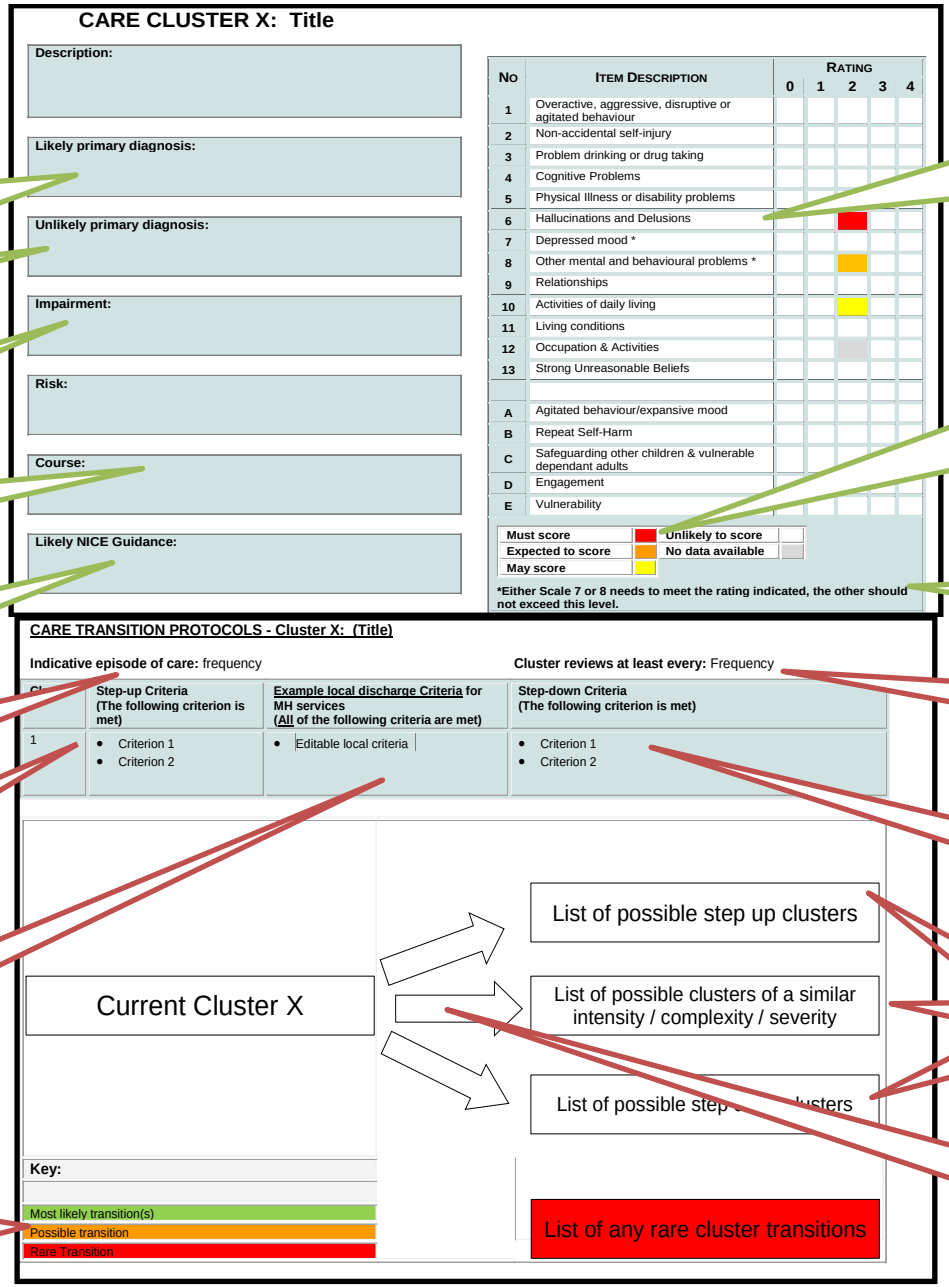
Range of NICE Guidance that may be useful when planning treatment

Indication of likely duration of treatment

1st set of criteria to be considered at review NB. Only 1 needs to be met

2nd set of criteria to be considered at review NB. All need to be met

Explanation of colours used to indicate how likely movement to each cluster is at review.



CARE CLUSTER X: Title

Description:

Likely primary diagnosis:

Unlikely primary diagnosis:

Impairment:

Risk:

Course:

Likely NICE Guidance:

No	Item Description	Rating 0	1	2	3	4
1	Overactive, aggressive, disruptive or agitated behaviour					
2	Non-accidental self-injury					
3	Problem drinking or drug taking					
4	Cognitive Problems					
5	Physical Illness or disability problems					
6	Hallucinations and Delusions					
7	Depressed mood *					
8	Other mental and behavioural problems *					
9	Relationships					
10	Activities of daily living					
11	Living conditions					
12	Occupation & Activities					
13	Strong Unreasonable Beliefs					
A	Agitated behaviour/expansive mood					
B	Repeat Self-Harm					
C	Safeguarding other children & vulnerable dependant adults					
D	Engagement					
E	Vulnerability					

Must score | Unlikely to score
Expected to score | No data available
May score

*Either Scale 7 or 8 needs to meet the rating indicated, the other should not exceed this level.

CARE TRANSITION PROTOCOLS - Cluster X: (Title)

Indicative episode of care: frequency

Cluster reviews at least every: Frequency

Cl	Step-up Criteria (The following criterion is met)	Example local discharge Criteria for MH services (All of the following criteria are met)	Step-down Criteria (The following criterion is met)
1	• Criterion 1 • Criterion 2	• Editable local criteria	• Criterion 1 • Criterion 2

Current Cluster X

List of possible step up clusters

List of possible clusters of a similar intensity / complexity / severity

List of possible step [illegible]usters

List of any rare cluster transitions

Key:

Most likely transition(s)

Possible transition

Rare Transition

Table showing scoring ranges for each MHCT scale to be used when allocating to the cluster (based on original analysis)

Explanation of colour coding used to indicate importance of each scale to membership of the cluster. (See page 4 for full explanation)

Explanatory note specifically relating to the scoring of scales 7 & 8.

Outer limit for reviews NB Reviews will often occur more frequently

3rd set of criteria to be considered at review NB. All need to be met

Lists of possible cluster transitions. NB includes the option of discharge from all 'in-scope' services.

Arrows indicating whether each list of clusters are notionally: steps up, down or represent little change

CARE CLUSTER 0: Variance

Cluster reviews at least every: 6 months

Description:
Despite careful consideration of all the other clusters, this group of Service Users are not adequately described by any of their rating profiles or descriptions. They do however require mental health care and will be offered a service.

Likely primary diagnosis:

Unlikely primary diagnosis:

Impairment:

Risk:

Course:

Likely NICE Guidance:

No	Item Description	Rating				
		0	1	2	3	4
1	Overactive, aggressive, disruptive or agitated behaviour					
2	Non-accidental self-injury					
3	Problem drinking or drug taking					
4	Cognitive Problems					
5	Physical Illness or disability problems					
6	Hallucinations and Delusions					
7	Depressed mood *					
8	Other mental and behavioural problems *					
9	Relationships					
10	Activities of daily living					
11	Living conditions					
12	Occupation & Activities					
13	Strong Unreasonable Beliefs					
A	Agitated behaviour/expansive mood					
B	Repeat Self-Harm					
C	Safeguarding other children & vulnerable dependant adults					
D	Engagement					
E	Vulnerability					

Must score		**Unlikely to score**	
Expected to score		**No data available**	
May score			

***Use the highest rating from Scales 7 & 8 when deciding if the rating fits the range indicated.**

CARE CLUSTER 1: Common Mental Health Problems (Low Severity)

Description:
This group has definite but minor problems of depressed mood, anxiety or other disorder but they do not present with any distressing psychotic symptoms.

Likely primary diagnosis:
May not attract a formal diagnosis but may include mild symptoms of: F32 Depressive Episode, F40 Phobic Anxiety Disorders, F41 Other Anxiety Disorders, F42 Obsessive-Compulsive Disorder, F43 Stress Reaction / Adjustment Disorder, F50 Eating Disorder.

Unlikely primary diagnosis:
F00-03 Dementias, F20-29 Schizophrenia, schizotypal and delusional disorders , F30 Manic Episode, F31 Bipolar Disorder, F33Major depressive disorder, recurrent.

Impairment:
Disorder unlikely to cause disruption to wider functioning.

Risk:
Unlikely to be an issue.

Course:
The problem is likely to be short term and related to life events.

Likely NICE Guidance:
Service user experience in adult mental health CG136, Anxiety CG113, Depression in adults CG90, Depression with Chronic Health Problems CG91, Common mental health disorders CG123, OCD CG31, Eating Disorders CG9.

No	Item Description	Rating				
		0	1	2	3	4
1	Overactive, aggressive, disruptive or agitated behaviour	May score				
2	Non-accidental self-injury	Expected to score				
3	Problem drinking or drug taking	May score	May score	May score		
4	Cognitive Problems	May score	May score			
5	Physical Illness or disability problems	May score	May score			
6	Hallucinations and Delusions	Must score	Must score			
7	Depressed mood *		Must score			
8	Other mental and behavioural problems *		Must score			
9	Relationships	Expected to score	Expected to score			
10	Activities of daily living	May score				
11	Living conditions	May score				
12	Occupation & Activities	May score				
13	Strong Unreasonable Beliefs	Expected to score	Expected to score			
A	Agitated behaviour/expansive mood	May score				
B	Repeat Self-Harm	Expected to score	Expected to score			
C	Safeguarding other children & vulnerable dependant adults	May score				
D	Engagement	Expected to score				
E	Vulnerability	May score				

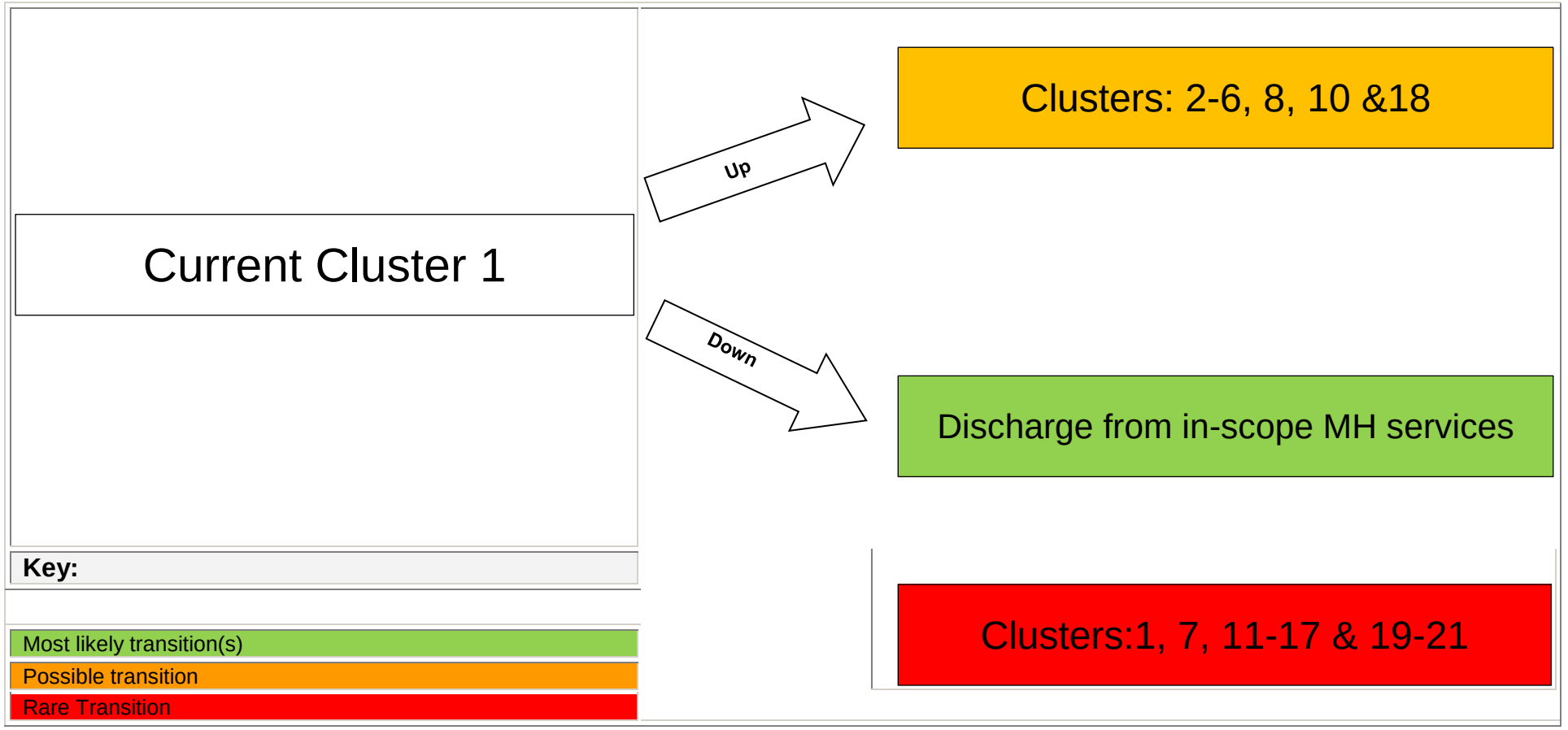
Must score		**Unlikely to score**	
Expected to score		**No data available**	
May score			

***Use the highest rating from Scales 7 & 8 when deciding if the rating fits the range indicated.**

CARE TRANSITION PROTOCOLS - Cluster 1: Common Mental Health Problems (low severity)

Indicative episode of care: 8 – 12 weeks **Cluster reviews at least every:** 12 weeks

Cluster	Step-up Criteria (The following criterion is met)	Example local discharge Criteria for MH services (All of the following criteria are met)	Step-down Criteria (The following criterion is met)
1	• Service User fits description and scoring profile of any likely/ possible 'step-up' cluster.	• MHCT V1 item 2 (Non-accidental self-injury) = 0 • MHCT V1 item 7 (Depression) = 1 or less • MHCT V1 item 8 (Other) = 1 or less	N/A



CARE CLUSTER 2: Common Mental Health Problems (Low Severity with greater need)

Description:
This group has definite but minor problems of depressed mood, anxiety or other disorder but they do not present with any distressing psychotic symptoms. They may have already received care associated with cluster 1 and require more specific intervention, or previously been successfully treated at a higher level but are re-presenting with low level symptoms.

Likely primary diagnosis:
Likely to include: F32 Depressive Episode, F40 Phobic Anxiety Disorders, F41 Other Anxiety Disorders, F42 Obsessive-Compulsive Disorder, F43 Stress Reaction / Adjustment Disorder, F50 Eating Disorder.

Unlikely primary diagnosis:
F00-03 Dementias, F20-29 Schizophrenia, schizotypal and delusional disorders , F30 Manic Episode, F31 Bipolar Disorder, F33Major depressive disorder, recurrent.

Impairment:
Disorder unlikely to cause disruption to wider functioning but some people will experience minor problems.

Risk:
Unlikely to be an issue.

Course:
The problem is likely to be short term and related to life events.

Likely NICE Guidance:
Service user experience in adult mental health CG136, Anxiety CG113, Depression in adults CG90, Depression with Chronic Health Problems CG91, Common mental health disorders CG123, OCD CG31, Eating Disorders CG9.

No	Item Description	Rating				
		0	1	2	3	4
1	Overactive, aggressive, disruptive or agitated behaviour					
2	Non-accidental self-injury					
3	Problem drinking or drug taking					
4	Cognitive Problems					
5	Physical Illness or disability problems					
6	Hallucinations and Delusions					
7	Depressed mood *					
8	Other mental and behavioural problems *					
9	Relationships					
10	Activities of daily living					
11	Living conditions					
12	Occupation & Activities					
13	Strong Unreasonable Beliefs					
A	Agitated behaviour/expansive mood					
B	Repeat Self-Harm					
C	Safeguarding other children & vulnerable dependant adults					
D	Engagement					
E	Vulnerability					

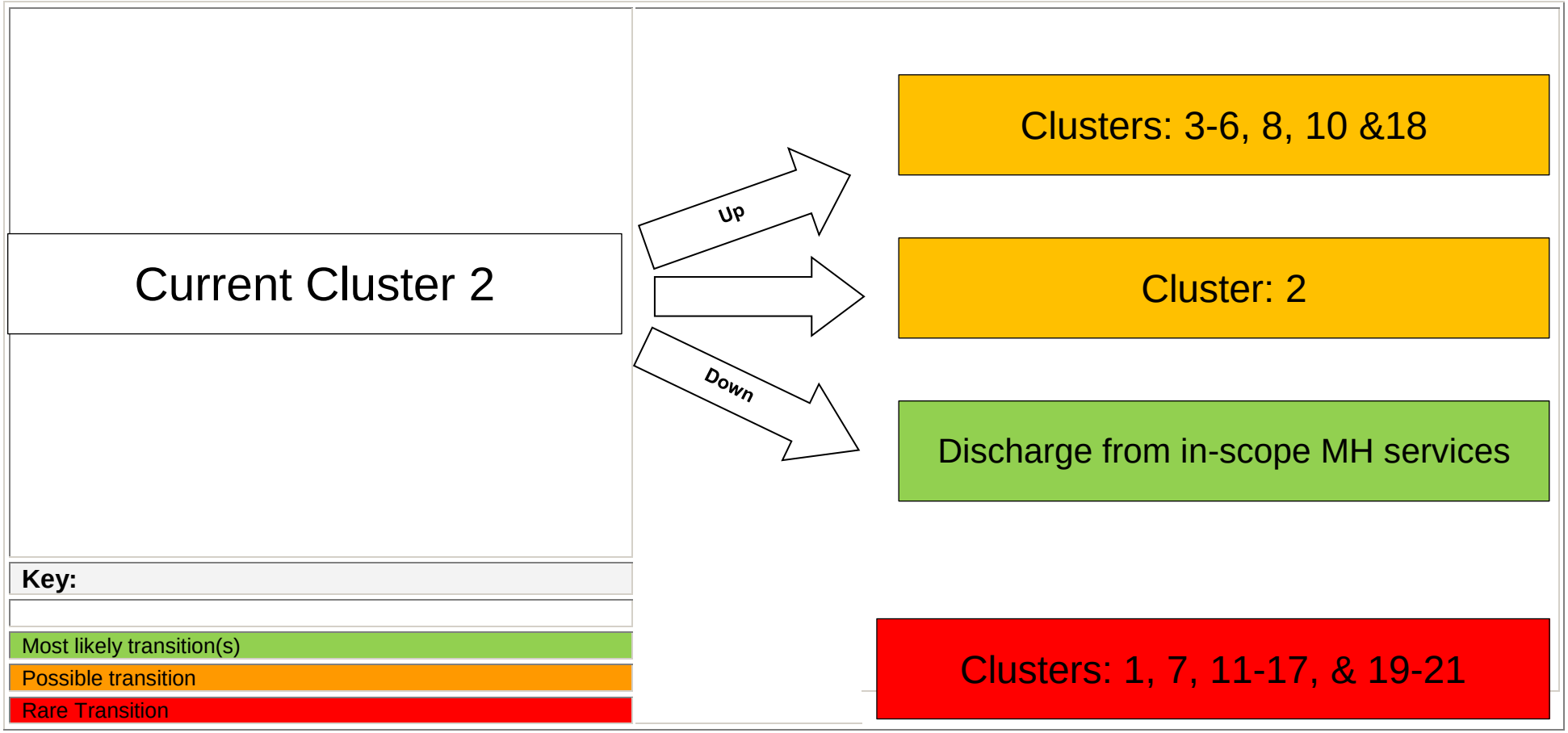
Must score		**Unlikely to score**	
Expected to score		**No data available**	
May score			

***Use the highest rating from Scales 7 & 8 when deciding if the rating fits the range indicated.**

CARE TRANSITION PROTOCOLS - Cluster 2: Common Mental Health Problems

Indicative episode of care: 12 – 15 weeks **Cluster reviews at least every:** 15 weeks

Cluster	Step-up Criteria (The following criterion is met)	Example local discharge Criteria for MH services (All of the following criteria are met)	Step-down Criteria (The following criterion is met)
2	• Service User fits description and scoring profile of any likely/ possible 'step-up' cluster.	• MHCT V1 item 2 (Non-accidental self-injury) = 0 • MHCT V1 item 7 (Depression) = 1 or less • MHCT V1 item 8 (Other) = 1 or less	N/A



CARE CLUSTER 3: Non-Psychotic (Moderate Severity)

Description:
Moderate problems involving depressed mood, anxiety or other disorder (not including psychosis).

Likely primary diagnosis:
Likely to include: F32 Depressive Episode, F40 Phobic Anxiety Disorders, F41 Other Anxiety Disorders, F42 Obsessive-Compulsive Disorder, F43 Stress Reaction / Adjustment Disorder, F50 Eating Disorder.

Unlikely primary diagnosis:
F00-03 Dementias, F20-29 Schizophrenia, schizotypal and delusional disorders , F30 Manic Episode, F31 Bipolar Disorder

Impairment:
Disorder unlikely to cause disruption to wider function but some people will experience moderate problems.

Risk:
Unlikely to be a serious issue.

Course:
Short-term.

Likely NICE Guidance:
Service user experience in adult mental health CG136, Anxiety CG113, Depression in adults CG90, Depression with Chronic Health Problems CG91, Common mental health disorders CG123, OCD CG31, Eating Disorders CG9, Post-traumatic stress disorder (PTSD) CG 26.

No	Item Description	Rating				
		0	1	2	3	4
1	Overactive, aggressive, disruptive or agitated behaviour	May score				
2	Non-accidental self-injury	Expected to score	Expected to score			
3	Problem drinking or drug taking	May score	May score	May score		
4	Cognitive Problems	May score	May score			
5	Physical Illness or disability problems	May score	May score	May score		
6	Hallucinations and Delusions	Must score	Must score			
7	Depressed mood *			Must score		
8	Other mental and behavioural problems *			Must score		
9	Relationships	Expected to score	Expected to score	Expected to score		
10	Activities of daily living	May score	May score	May score		
11	Living conditions	May score	May score	May score		
12	Occupation & Activities	May score	May score	May score		
13	Strong Unreasonable Beliefs	Expected to score	Expected to score			
A	Agitated behaviour/expansive mood	May score				
B	Repeat Self-Harm	Expected to score	Expected to score			
C	Safeguarding other children & vulnerable dependant adults	May score				
D	Engagement	Expected to score				
E	Vulnerability	May score				

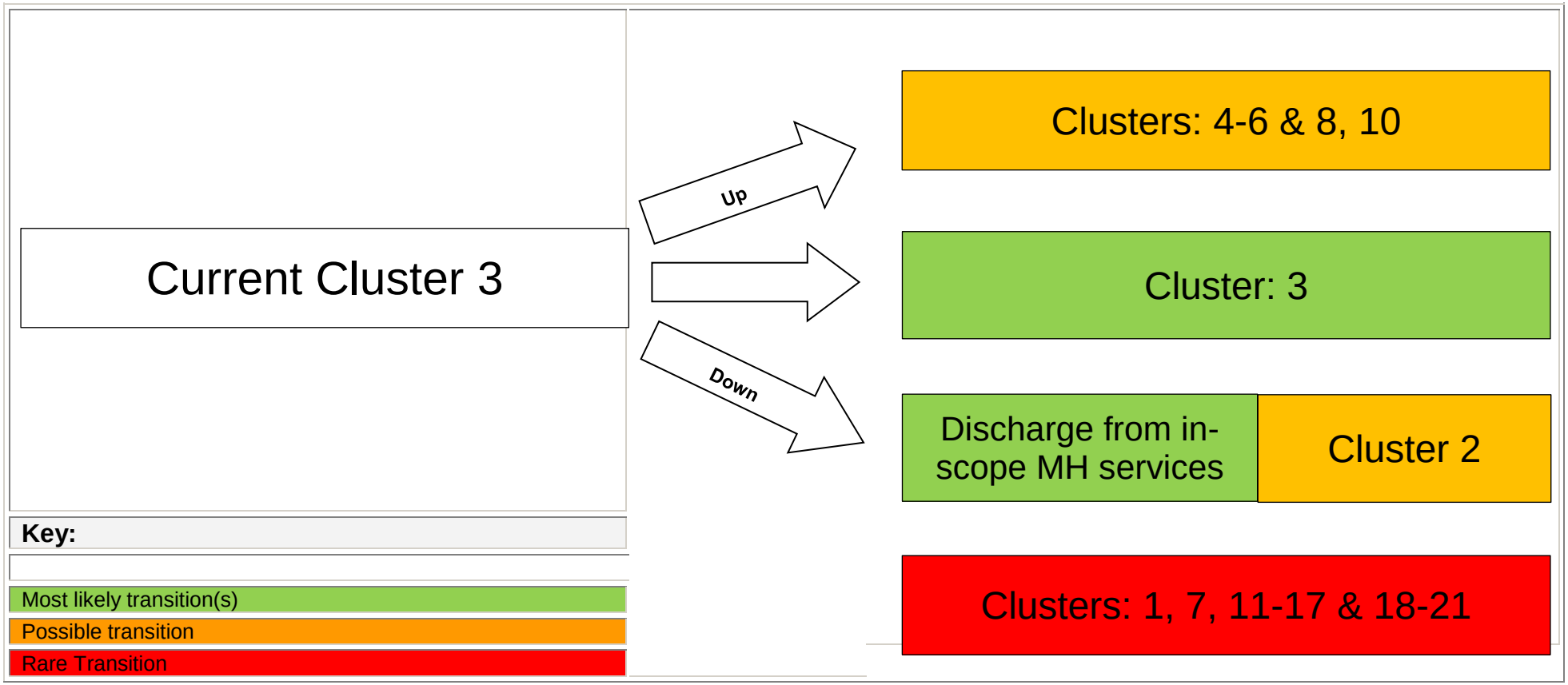
Must score		Unlikely to score	
Expected to score		No data available	
May score			

***Use the highest rating from Scales 7 & 8 when deciding if the rating fits the range indicated.**

CARE TRANSITION PROTOCOLS - Cluster 3: Non-Psychotic (Moderate Severity)

Indicative episode of care: 4 - 6 months **Cluster reviews at least every**: 6 months

Cluster	Step-up Criteria (The following criterion is met)	Example local discharge Criteria for MH services (All of the following criteria are met)	Step-down Criteria (All of the following criteria are met)
3	• Service User fits description and scoring profile of any likely/ possible 'step-up' cluster.	• MHCT V1 item 2 (Non-accidental self-injury) = 0 • MHCT V1 item 7 (Depression) = 1 or less • MHCT V1 item 8 (Other) = 1 or less	• Patient has completed a successful period of treatment but is left with residual co-morbidities requiring an alternative treatment package at a lower intensity. • Service User fits description and scoring profile of any likely/ possible 'step-down' cluster



CARE CLUSTER 4: Non-Psychotic (Severe)

Description:
The group is characterised by severe mood disturbance and/or anxiety and/or other increasing complexity of needs. They may experience disruption to function in everyday life and there is an increasing likelihood of significant risks.

Likely primary diagnosis:
Likely to include: F32 Depressive Episode, F40 Phobic Anxiety Disorders, F41 Other Anxiety Disorders, F42 Obsessive-Compulsive Disorder, F43 Stress Reaction / Adjustment Disorder, F44 Dissociative Disorder, F45 Somatoform Disorder, F48 Other Neurotic Disorders, F50 Eating Disorder.

Unlikely primary diagnosis:
F00-03 Dementias, F20-29 Schizophrenia, schizotypal and delusional disorders , F30 Manic Episode, F31.2&31.5 Bipolar Disorder with psychosis

Impairment:
Some may experience significant disruption in everyday functioning.

Risk:
Some may experience moderate risk in self through self-harm or suicidal thoughts or behaviours.

Course:
Unlikely to improve without treatment and may deteriorate with long term impact on functioning.

Likely NICE Guidance:
Service user experience in adult mental health CG136, Anxiety CG113, Depression in adults CG90, Depression with Chronic health Problems CG91, Common mental health disorders CG123, Medicines adherence CG76, OCD CG31, Eating Disorders CG9, Post-traumatic stress-disorder (PTSD) CG 26, Self-harm CG16.

No	Item Description	Rating				
		0	1	2	3	4
1	Overactive, aggressive, disruptive or agitated behaviour					
2	Non-accidental self-injury					
3	Problem drinking or drug taking					
4	Cognitive Problems					
5	Physical Illness or disability problems					
6	Hallucinations and Delusions					
7	Depressed mood *					
8	Other mental and behavioural problems *					
9	Relationships					
10	Activities of daily living					
11	Living conditions					
12	Occupation & Activities					
13	Strong Unreasonable Beliefs					
A	Agitated behaviour/expansive mood					
B	Repeat Self-Harm					
C	Safeguarding other children & vulnerable dependant adults					
D	Engagement					
E	Vulnerability					

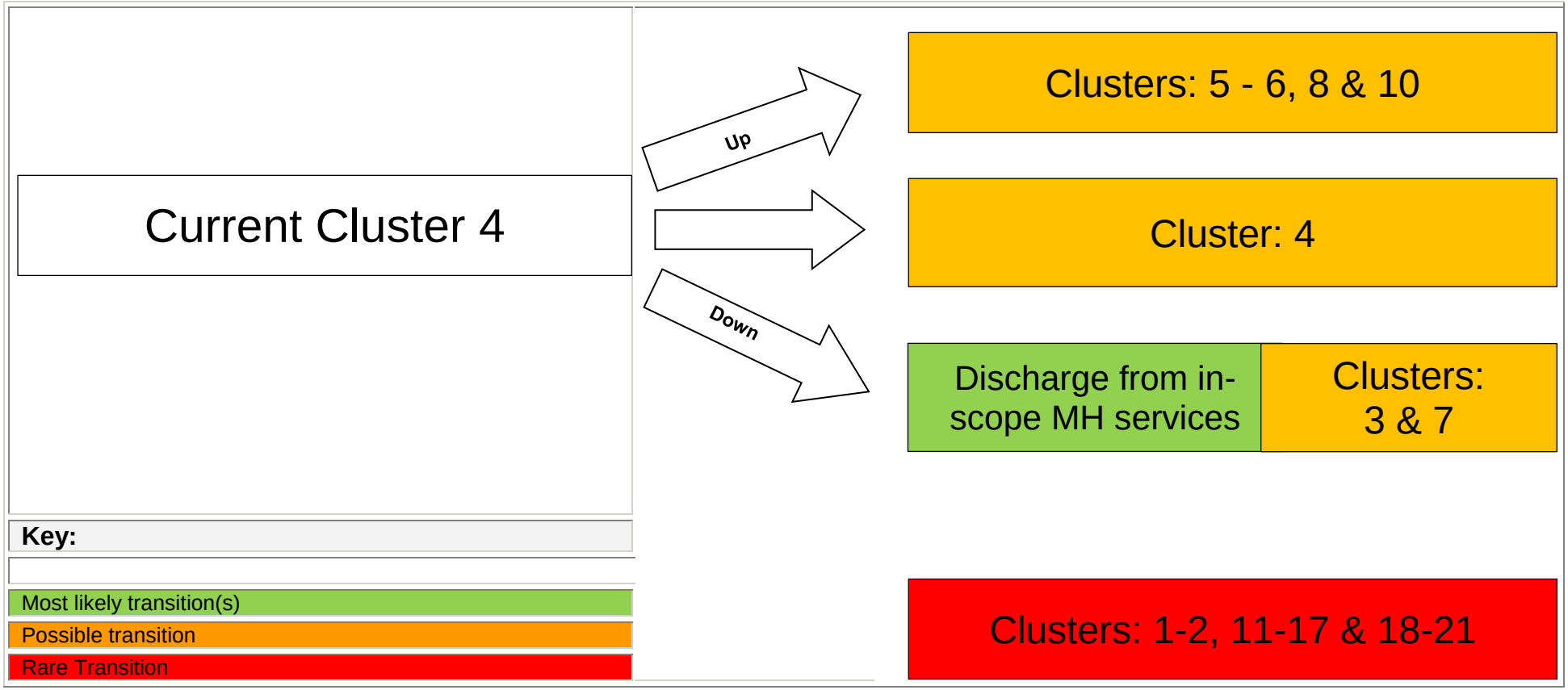
Must score		**Unlikely to score**	
Expected to score		**No data available**	
May score			

***Use the highest rating from Scales 7 & 8 when deciding if the rating fits the range indicated.**

CARE TRANSITION PROTOCOLS - Cluster 4: Non-Psychotic (Severe)

Indicative episode of care: 6 - 12 months **Cluster reviews at least every:** 6 months

Cluster	Step-up Criteria (The following criterion is met)	Example local discharge Criteria for MH services (All of the following criteria are met)	Step-down Criteria (All of the following criteria are met)
4	• Service User fits description and scoring profile of any likely/ possible 'step-up' cluster.	• MHCT V1 item 2 (Non-accidental self-injury) = 0 • MHCT V1 item 7 (Depression) = 1 or less • MHCT V1 item 8 (Other) = 1 or less	• Patient has completed a successful period of treatment but is left with residual co-morbidities requiring an alternative treatment package at a lower intensity. • Service User fits description and scoring profile of any likely/ possible 'step-down' cluster



CARE CLUSTER 5: Non-psychotic Disorders (Very Severe)

Description:
This group will be experiencing severe mood disturbance and/or anxiety and/or other symptoms. They will not present with distressing hallucinations or delusions but may have some unreasonable beliefs. They may often be at high risk for non-accidental self-injury and they may present safeguarding issues and have severe disruption to everyday living.

Likely primary diagnosis:
Likely to include: F32 Depressive Episode (non-psychotic), F33 Recurrent Depressive Episode (non-psychotic), F40 Phobic Anxiety Disorders, F41 Other Anxiety Disorders, F42 Obsessive-Compulsive Disorder, F43 Stress Reaction / Adjustment Disorder, F44 Dissociative Disorder, F45 Somatoform Disorder, F48 Other Neurotic Disorders, F50 Eating Disorder.

Unlikely primary diagnosis:
F00-03 Dementias, F20-29 Schizophrenia, schizotypal and delusional disorders , F30 Manic Episode, F31.2&31.5 Bipolar Disorder with psychosis

Impairment:
Moderate or severe problems with relationships. Level of problems in other areas of role functioning likely to vary.

Risk:
Likely moderate or severe risk of non-accidental self-injury with other possible risk, including safeguarding issues if any responsibility for young children or vulnerable dependent adults.

Course:
Probably known to service for more than a year or expected to be known for an extended period.

Likely NICE Guidance:
Service user experience in adult mental health CG136, Anxiety CG113 Depression in adults CG90, Depression with Chronic health Problems CG91, Common mental health disorders CG123, Medicines adherence CG76, OCD CG31, Eating Disorders CG9, Post-traumatic stress-disorder (PTSD) CG 26, Self-harm CG16.

No	Item Description	Rating				
		0	1	2	3	4
1	Overactive, aggressive, disruptive or agitated behaviour	May score	May score			
2	Non-accidental self-injury				Expected to score	Expected to score
3	Problem drinking or drug taking	May score	May score	May score	May score	
4	Cognitive Problems	May score	May score	May score		
5	Physical Illness or disability problems	May score	May score	May score		
6	Hallucinations and Delusions	Must score	Must score			
7	Depressed mood *					Must score
8	Other mental and behavioural problems *					Must score
9	Relationships		Expected to score	Expected to score	Expected to score	Expected to score
10	Activities of daily living			May score	May score	May score
11	Living conditions		May score	May score	May score	May score
12	Occupation & Activities			May score	May score	May score
13	Strong Unreasonable Beliefs	Expected to score	Expected to score	Expected to score		
A	Agitated behaviour/expansive mood	May score	May score	May score		
B	Repeat Self-Harm			Expected to score	Expected to score	
C	Safeguarding other children & vulnerable dependant adults		May score	May score	May score	May score
D	Engagement	Expected to score	Expected to score			
E	Vulnerability		May score	May score	May score	

Must score		**Unlikely to score**	
Expected to score		**No data available**	
May score			

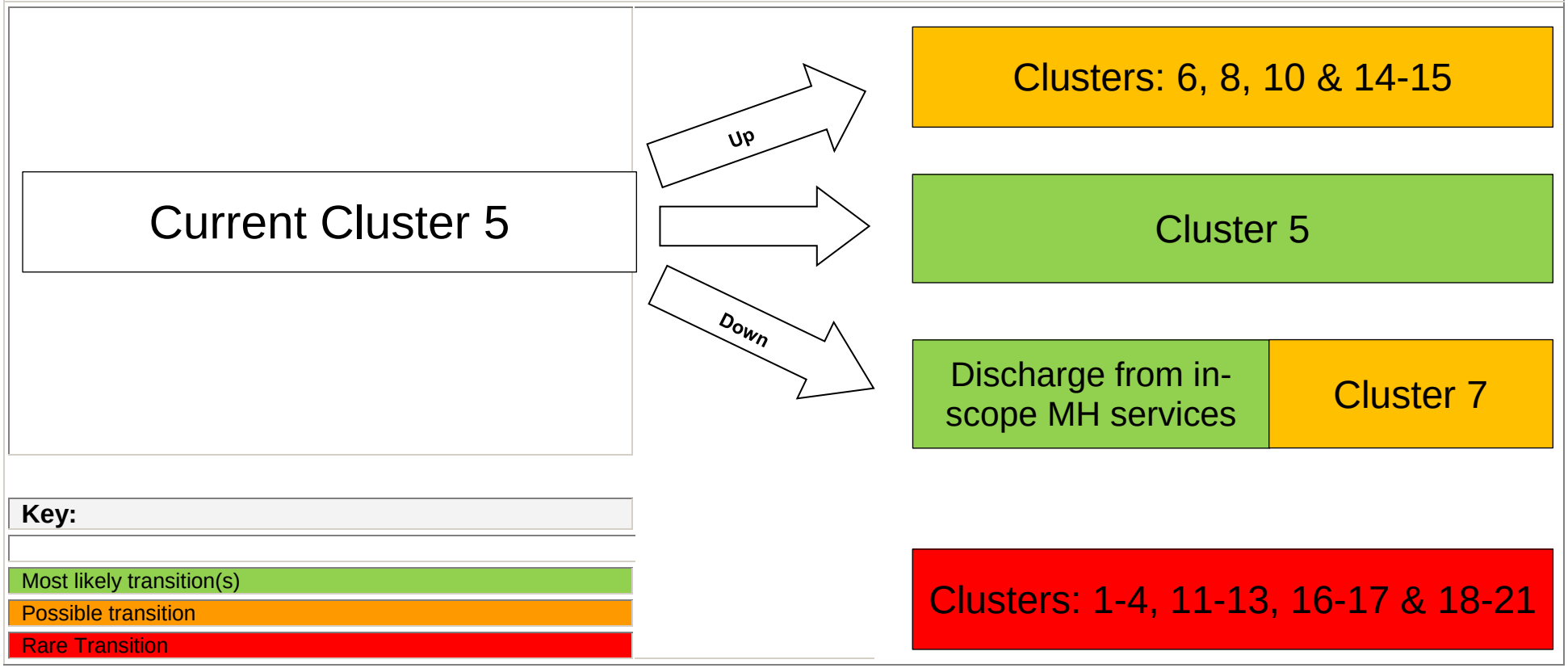
***Use the highest rating from Scales 7 & 8 when deciding if the rating fits the range indicated.**

CARE TRANSITION PROTOCOLS - Cluster 5: Non-Psychotic (very severe)

Indicative episode of care: 1- 3 years.

Cluster reviews at least every: 6 Months

Cluster	Step-up Criteria (The following criterion is met)	Example local discharge Criteria for MH services (All of the following criteria are met)	Step-down Criteria (The following criterion is met)
5	• Service User fits description and scoring profile of any likely/ possible 'step-up' cluster.	• MHCT V1 item 2 (Non-accidental self-injury) = 0 • MHCT V1 item 7 (Depression) = 1 or less • MHCT V1 item 8 (Other) = 1 or less	• Service User fits description and scoring profile of any likely/ possible 'step-down' cluster.



CARE CLUSTER 6: Non-Psychotic Disorder of Over-Valued Ideas

Description:
Moderate to very severe disorders that are difficult to treat. This may include mood disturbance treatment resistant eating disorder, OCD etc. where extreme beliefs are strongly held, some personality disorders and enduring depression.

Likely primary diagnosis:
Likely to include: F32 Depressive Episode (non-psychotic), F33 Recurrent Depressive Episode (non-psychotic), F40 Phobic Anxiety Disorders, F41 Other Anxiety Disorders, F42 Obsessive-Compulsive Disorder, F43 Stress Reaction/Adjustment Disorder, F44 Dissociative Disorder, F45 Somatoform Disorder, F48 Other Neurotic Disorders, F50 Eating Disorder and some F60.

Unlikely primary diagnosis:
F00-03 Dementias, F20-29 Schizophrenia, schizotypal and delusional disorders , F30 Manic Episode, F31.2&31.5 Bipolar Disorder with psychosis

Impairment:
Likely to seriously affect activity and role functioning in many ways.

Risk:
Unlikely to be a major feature but safeguarding may be an issue if any responsibility for young children or vulnerable dependant adults.

Course:
The problems will be enduring.

Likely NICE Guidance:
Service user experience in adult mental health CG136, Eating Disorders CG9, OCD CG31, Post-traumatic stress-disorder (PTSD) CG 26 Anxiety CG113, Depression in adults CG90, Medicines adherence CG76 Antisocial personality Disorder CG77, Borderline Personality Disorder CG78, Self-harm CG16, Self-harm (longer-term management) CG 133, Depression with Chronic health Problems CG91.

No	Item Description	Rating				
		0	1	2	3	4
1	Overactive, aggressive, disruptive or agitated behaviour					
2	Non-accidental self-injury					
3	Problem drinking or drug taking					
4	Cognitive Problems					
5	Physical Illness or disability problems					
6	Hallucinations and Delusions					
7	Depressed mood *					
8	Other mental and behavioural problems *					
9	Relationships					
10	Activities of daily living					
11	Living conditions					
12	Occupation & Activities					
13	Strong Unreasonable Beliefs					
A	Agitated behaviour/expansive mood					
B	Repeat Self-Harm					
C	Safeguarding other children & vulnerable dependant adults					
D	Engagement					
E	Vulnerability					

Must score		**Unlikely to score**	
Expected to score		**No data available**	
May score			

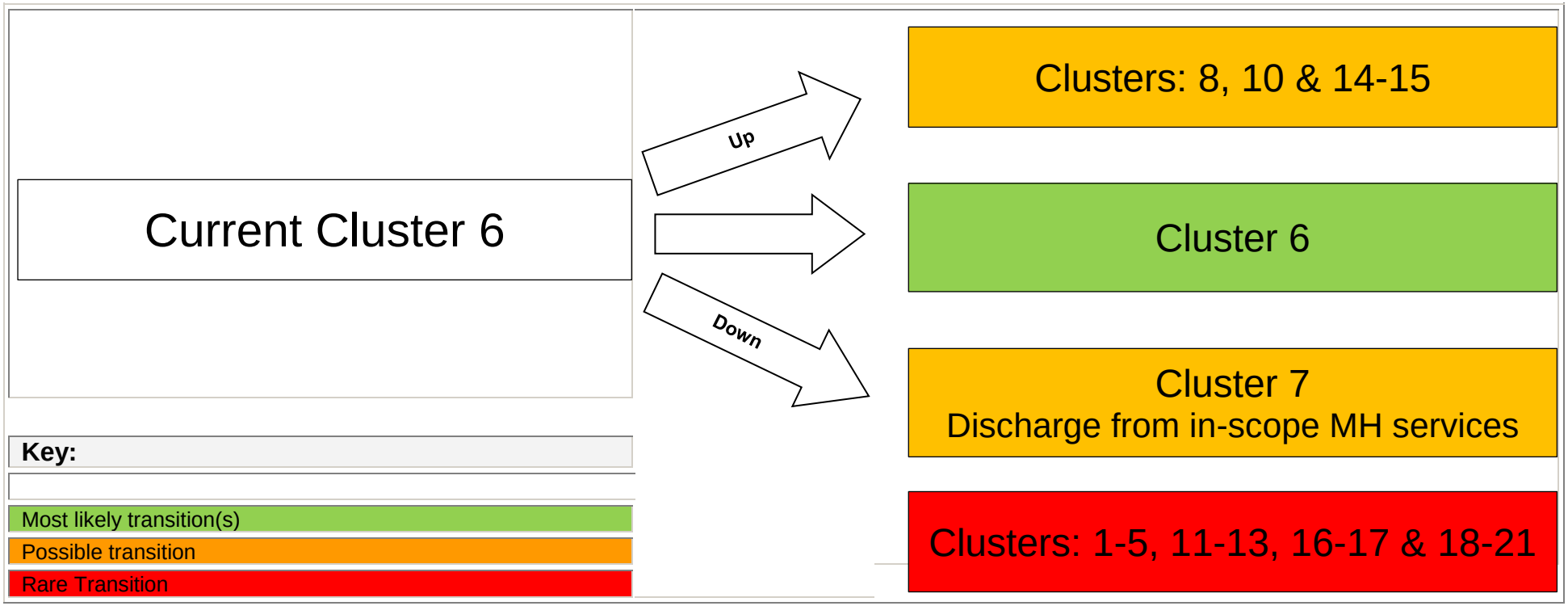
***Use the highest rating from Scales 7 & 8 when deciding if the rating fits the range indicated.**

CARE TRANSITION PROTOCOLS - Cluster 6: Non-Psychotic Disorders of overvalued Ideas

Indicative episode of care: 3 years +

Cluster reviews at least every: 6 months

Cluster	Step-up Criteria (The following criterion is met)	Example local discharge Criteria for MH services (All of the following criteria are met)	Step-down Criteria (The following criterion is met)
6	• Service User fits description and scoring profile of any likely/ possible 'step-up' cluster.	• MHCT V1 item 2 (Non-accidental self-injury) = 1 or less • MHCT V1 item 7 (Depression) = 1 or less • MHCT V1 item 8 (Other) = 1 or less • MHCT V1 item 13 (Strong unreasonable beliefs) = 2 or less	• Service User fits description and scoring profile of any likely/ possible 'step-down' cluster.



CARE CLUSTER 7: Enduring Non-Psychotic Disorders (High Disability)

Description:
This group suffers from moderate to severe disorders that are very disabling. They will have received treatment for a number of years and although they may have improvement in positive symptoms considerable disability remains that is likely to affect role functioning in many ways.

Likely primary diagnosis:
Likely to include: F32 Depressive Episode (Non-Psychotic), F33 Recurrent Depressive Episode (Non-Psychotic), F40 Phobic Anxiety Disorders, F41 Other Anxiety Disorders, F42 Obsessive-Compulsive Disorder, F43 Stress Reaction/Adjustment Disorder, F44 Dissociative Disorder, F45 Somatoform Disorder, F48 Other Neurotic Disorders, F50 Eating Disorder and some F60.

Unlikely primary diagnosis:
F00-03 Dementias, F20-29 Schizophrenia, schizotypal and delusional disorders , F30 Manic Episode, F31.2&31.5 Bipolar Disorder with psychosis

Impairment:
Likely to seriously affect activity and role functioning in many ways.

Risk:
Unlikely to be a major feature but safeguarding may be an issue if any responsibility for young children or vulnerable dependant adults.

Course:
The problems will be enduring.

Likely NICE Guidance:
Service user experience in adult mental health CG136, Eating Disorders CG9, OCD CG31, Anxiety CG113, Depression in adults CG90, Medicines adherence CG76, Post-traumatic stress-disorder (PTSD) CG26, Antisocial personality Disorder CG77, Borderline Personality Disorder CG78, Self-harm (longer-term management) CG 133, Depression with Chronic health Problems CG91

No	Item Description	Rating				
		0	1	2	3	4
1	Overactive, aggressive, disruptive or agitated behaviour					
2	Non-accidental self-injury					
3	Problem drinking or drug taking					
4	Cognitive Problems					
5	Physical Illness or disability problems					
6	Hallucinations and Delusions					
7	Depressed mood *					
8	Other mental and behavioural problems *					
9	Relationships					
10	Activities of daily living					
11	Living conditions					
12	Occupation & Activities					
13	Strong Unreasonable Beliefs					
A	Agitated behaviour/expansive mood					
B	Repeat Self-Harm					
C	Safeguarding other children & vulnerable dependant adults					
D	Engagement					
E	Vulnerability					

Must score		**Unlikely to score**	
Expected to score		**No data available**	
May score			

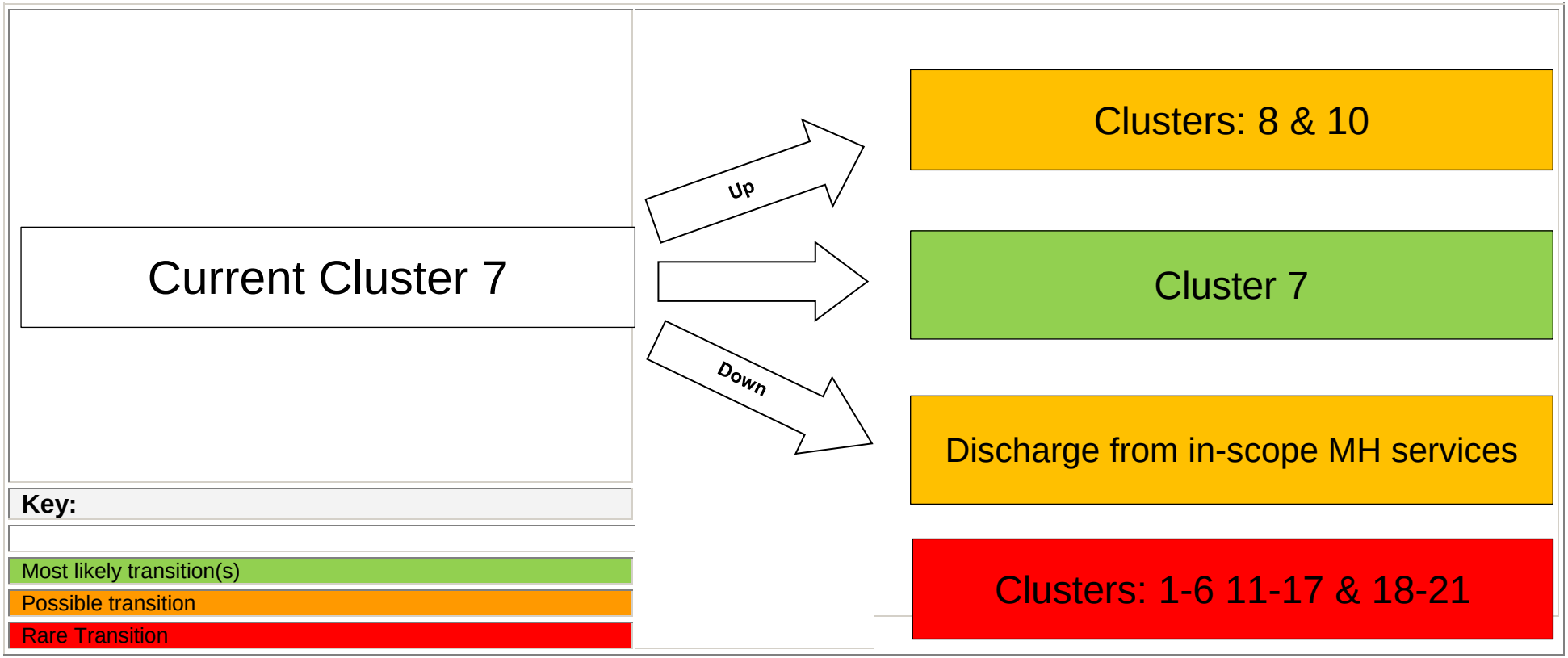
***Use the highest rating from Scales 7 & 8 when deciding if the rating fits the range indicated.**

CARE TRANSITION PROTOCOLS - Cluster 7: Enduring Non-Psychotic Disorders (high disability)

Indicative episode of care: 3 years +

Cluster reviews at least: Annually

Cluster	Step-up Criteria (The following criterion is met)	Example local discharge Criteria for MH services (All of the following criteria are met)	Step-down Criteria (The following criterion is met)
7	• Service User fits description and scoring profile of any likely/ possible 'step-up' cluster.	• MHCT V1 item 2 (Non-accidental self-injury) = 1 or less • MHCT V1 item 7 (Depression) = 1 or less • MHCT V1 item 8 (Other) = 1 or less N/A	• Service User fits description and scoring profile of any likely/ possible 'step-down' cluster.



CARE CLUSTER 8: Non-Psychotic Chaotic and Challenging Disorders

Description:
This group will have a wide range of symptoms and chaotic and challenging lifestyles. They are characterised by moderate to very severe repeat deliberate self-harm and/or other impulsive behaviour and chaotic, over dependent engagement and often hostile with services.

Likely primary diagnosis:
Likely to include F60 Personality disorder.

Unlikely primary diagnosis:
F00-03 Dementias, F20-29 Schizophrenia, schizotypal and delusional disorders , F30 Manic Episode, F31 Bipolar Disorder.

Impairment:
Poor role functioning with severe problems in relationships.

Risk:
Moderate to very severe repeat deliberate self-harm, with chaotic, over dependent and often hostile engagement with service. Non-accidental self-injury risks likely to be present. Safeguarding may be an issue.

Course:
The problems will be enduring.

Likely NICE Guidance:
Service user experience in adult mental health CG136, Borderline Personality Disorder CG78, Self-harm CG16, Self-harm (longer-term management) CG 133, Post-traumatic stress-disorder (PTSD) CG 26 Depression in adults CG90, Anxiety CG113, Alcohol dependence and harmful alcohol misuse CG115, Antisocial personality disorder CG77.

No	Item Description	Rating				
		0	1	2	3	4
1	Overactive, aggressive, disruptive or agitated behaviour		May score	May score	May score	
2	Non-accidental self-injury			Expected to score	Expected to score	
3	Problem drinking or drug taking			May score	May score	May score
4	Cognitive Problems	May score	May score	May score		
5	Physical Illness or disability problems			May score	May score	May score
6	Hallucinations and Delusions	May score	May score	May score		
7	Depressed mood *				Must score	Must score
8	Other mental and behavioural problems *				Must score	Must score
9	Relationships			Expected to score	Expected to score	Expected to score
10	Activities of daily living			May score	May score	May score
11	Living conditions			May score	May score	May score
12	Occupation & Activities			May score	May score	May score
13	Strong Unreasonable Beliefs			Expected to score	Expected to score	Expected to score
A	Agitated behaviour/expansive mood			May score	May score	May score
B	Repeat Self-Harm				Must score	Must score
C	Safeguarding other children & vulnerable dependant adults			May score	May score	May score
D	Engagement				Expected to score	Expected to score
E	Vulnerability			May score	May score	May score

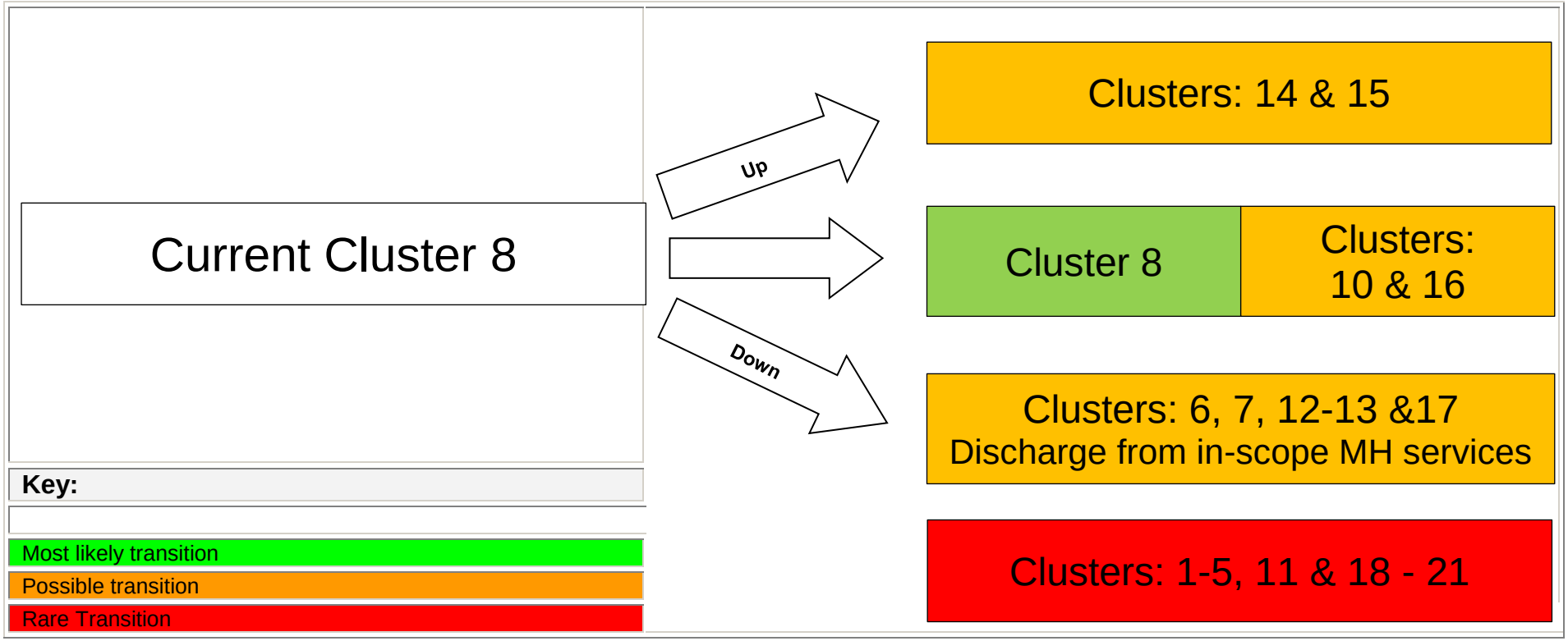
Must score		Unlikely to score	
Expected to score		No data available	
May score			

***Use the highest rating from Scales 7 & 8 when deciding if the rating fits the range indicated.**

CARE TRANSITION PROTOCOLS - Cluster 8: Non-Psychotic Chaotic and Challenging Disorders

Indicative episode of care: 3 years + **Cluster reviews at least:** Annually

Cluster	Step-up Criteria (The following criterion is met)	Example local discharge Criteria for MH services (All of the following criteria are met)	Step-down Criteria (The following criterion is met)
8	• Service User fits description and scoring profile of any likely/ possible 'step-up' cluster.	• MHCT V1 item 2 (Non-accidental self-injury) = 1 or less • MHCT V1 item B (self-harm) = 1 or less • MHCT V1 item 7 (Depression) = 1 or less • MHCT V1 Item 8 (Other) = 1 or less	• Service User fits description and scoring profile of any likely/ possible 'step-down' cluster consistently for the past 12 months.



CARE CLUSTER 9: Blank Cluster

Description:

Likely primary diagnosis:

Unlikely primary diagnosis:

Impairment:

Risk:

Course:

Likely NICE Guidance:

No	Item Description	Rating				
		0	1	2	3	4
1	Overactive, aggressive, disruptive or agitated behaviour					
2	Non-accidental self-injury					
3	Problem drinking or drug taking					
4	Cognitive Problems					
5	Physical Illness or disability problems					
6	Hallucinations and Delusions					
7	Depressed mood *					
8	Other mental and behavioural problems *					
9	Relationships					
10	Activities of daily living					
11	Living conditions					
12	Occupation & Activities					
13	Strong Unreasonable Beliefs					
A	Agitated behaviour/expansive mood					
B	Repeat Self-Harm					
C	Safeguarding other children & vulnerable dependant adults					
D	Engagement					
E	Vulnerability					

Must score		**Unlikely to score**	
Expected to score		**No data available**	
May score			

***Use the highest rating from Scales 7 & 8 when deciding if the rating fits the range indicated.**

CARE TRANSITION PROTOCOLS - Cluster 9: Blank Cluster

Indicative episode of care: **Cluster reviews at least:**

Cluster	Step-up Criteria (The following criterion is met)	Example local discharge Criteria for MH services (All of the following criteria are met)	Step-down Criteria (The following criterion is met)
	• .	•	•

Current Cluster 9

Key:
Most likely transition(s)
Possible transition
Rare Transition

CARE CLUSTER 10: First Episode Psychosis (with/without manic features)

Description:
This group will be presenting to the service for the first time with mild to severe psychotic phenomena. They may also have mood disturbance and/or anxiety or other behaviours. Drinking or drug-taking may be present but *will* not be the only problem.

Likely primary diagnosis:
Likely to include (F20-F29) Schizophrenia, schizotypal and delusional disorders, F31 Bi-polar disorder.

Unlikely primary diagnosis:
F00-03 Dementias.

Impairment:
Mild to moderate problems with activities of daily living. Poor role functioning with mild to moderate problems with relationships.

Risk:
Vulnerable to harm from self or others. Some may be at risk of Non-accidental self-injury or a threat to others.

Course:
First Episode.

Likely NICE Guidance:
Service user experience in adult mental health CG136, Schizophrenia (update) CG82, Bipolar disorder CG38, Medicines adherence CG76 Depression in adults CG90, Anxiety CG113, Alcohol dependence and harmful alcohol misuse CG115, Self-Harm CG16.

No	Item Description	Rating				
		0	1	2	3	4
1	Overactive, aggressive, disruptive or agitated behaviour					
2	Non-accidental self-injury					
3	Problem drinking or drug taking					
4	Cognitive Problems					
5	Physical Illness or disability problems					
6	Hallucinations and Delusions					
7	Depressed mood *					
8	Other mental and behavioural problems *					
9	Relationships					
10	Activities of daily living					
11	Living conditions					
12	Occupation & Activities					
13	Strong Unreasonable Beliefs					
A	Agitated behaviour/expansive mood					
B	Repeat Self-Harm					
C	Safeguarding other children & vulnerable dependant adults					
D	Engagement					
E	Vulnerability					

Must score		**Unlikely to score**	
Expected to score		**No data available**	
May score			

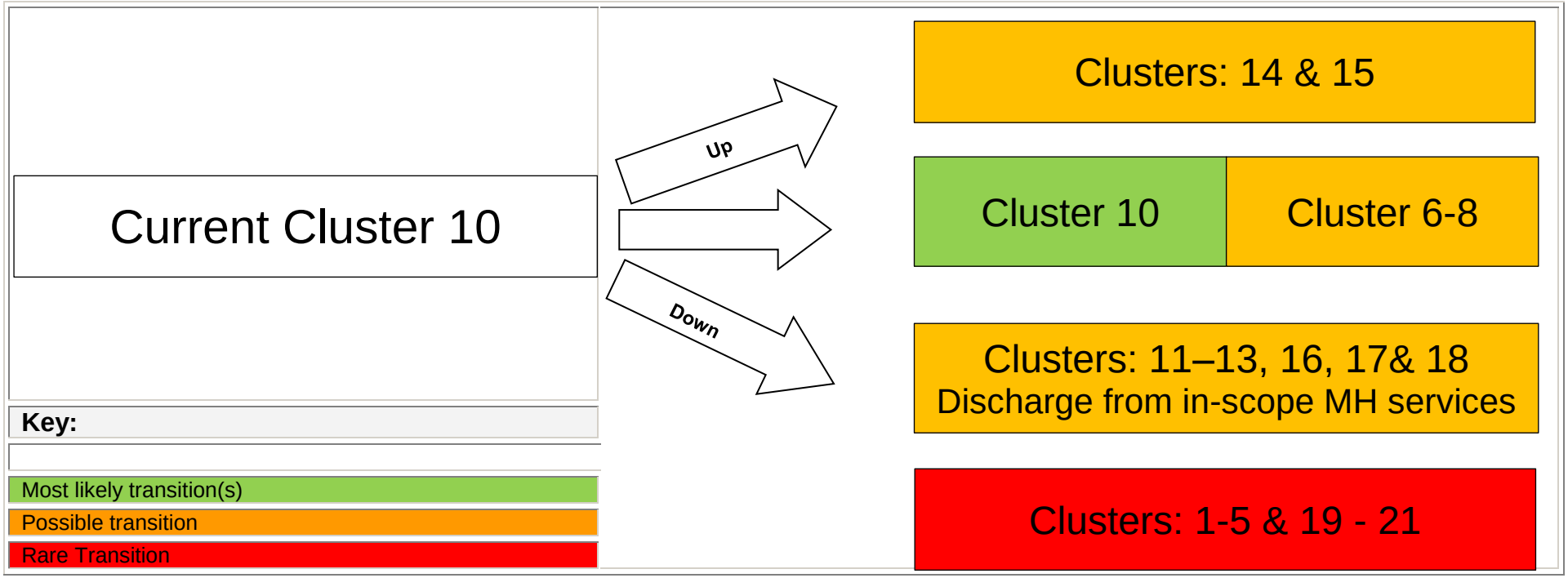
***Use the highest rating from Scales 7 & 8 when deciding if the rating fits the range indicated.**

CARE TRANSITION PROTOCOLS - Cluster 10: First Episode in Psychosis

Indicative episode of care: 3 years.
Cluster reviews at least: Annually

NO	ITEM DESCRIPTION	RATING

Cluster	Step-up Criteria (The following criterion is met)	Example local discharge Criteria for MH services (All of the following criteria are met)	Step-down Criteria (All of the following criteria are met)
10	• Service User fits description and scoring profile of any likely/ possible 'step-up' cluster.	• Requires no psychotropic medication or has been on a stable dose for the past year. • Rates 0-1 on MHCT V1 item 6 (Hallucinations and Delusions) • Not currently detained under the Mental Health Act. • Has required no inpatient / IHT packages for the past year. • Any residual risks can be managed by primary care. • Rates 0-1 on MHCT V1 item 12 (Occupation and Activities). • Level of social inclusion meets service user's expectations. • Has received three years of intervention from an Early Intervention in Psychosis Team, or no longer feels they require a service.	• Has a prescribed period of treatment from an Early Intervention in Psychosis Team or equivalent (depending on age). • Service user fits description and scoring profile of any likely/ possible 'step down' cluster and the level of need is likely to be maintained until the next planned review.



CARE CLUSTER 11: Ongoing Recurrent Psychosis (Low Symptoms)

Description:
This group has a history of psychotic symptoms that are currently controlled and causing minor problems if any at all. They are currently experiencing a sustained period of recovery where they are capable of full or near functioning. However, there may be impairment in self-esteem and efficacy and vulnerability to life.

Likely primary diagnosis:
Likely to include (F20-F29) Schizophrenia, schizotypal and delusional disorders F30 Manic Episode, F31 Bipolar Affective Disorder.

Unlikely primary diagnosis:
F00-03 Dementias, F32 Depressive episode, F33 Recurrent depressive disorder , F40-48 Neurotic, stress-related and somatoform disorders, F50 Eating disorders, F60 Specific personality disorders.

Impairment:
Full or near full functioning.

Risk:
Relapse.

Course:
Long term.

Likely NICE Guidance:
Service user experience in adult mental health CG136, Schizophrenia (update) CG82, Bipolar disorder CG38.

		0	1	2	3	4
1	Overactive, aggressive, disruptive or agitated behaviour					
2	Non-accidental self-injury					
3	Problem drinking or drug taking					
4	Cognitive Problems					
5	Physical Illness or disability problems					
6	Hallucinations and Delusions					
7	Depressed mood *					
8	Other mental and behavioural problems *					
9	Relationships					
10	Activities of daily living					
11	Living conditions					
12	Occupation & Activities					
13	Strong Unreasonable Beliefs					
A	Agitated behaviour/expansive mood					
B	Repeat Self-Harm					
C	Safeguarding other children & vulnerable dependant adults					
D	Engagement					
E	Vulnerability					

Must score		**Unlikely to score**	
Expected to score		**No data available**	
May score			

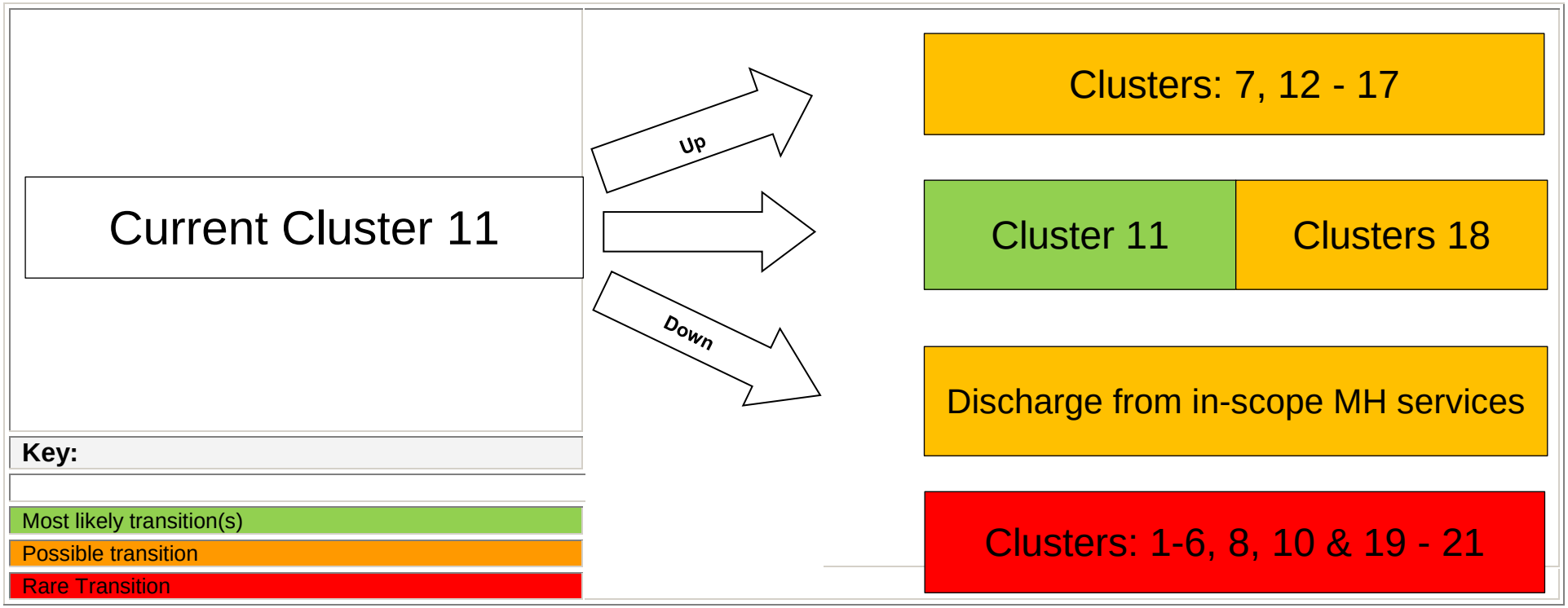
***Use the highest rating from Scales 7 & 8 when deciding if the rating fits the range indicated.**

CARE TRANSITION PROTOCOLS - Cluster 11: Ongoing Recurrent Psychosis (low symptoms

Indicative episode of care: 2 years +

Cluster reviews at least: Annually

Cluster	Step-up Criteria (The following criterion is met)	Example local discharge Criteria for MH services (All of the following criteria are met)	Step-down Criteria (The following criterion is met)
11	• Service User fits description and scoring profile of any likely/ possible 'step-up' cluster.	• Fits profile of cluster 11 at the point of the planned CPA review, and has done so consistently for the past 12 months. • Requires no psychotropic medication or has been on a stable dose for the past year. • Not currently detained under the Mental Health Act. • Has required no inpatient / IHT packages for the past year. • Any residual risks can be managed by primary care. • Scores 0-1 on MHCT V1 item 12 (Occupation and Activities). • Level of social inclusion meets service user's expectations.	N/A



CARE CLUSTER 12: Ongoing or Recurrent Psychosis (High Disability)

Description:
This group has a history of psychotic symptoms with a significant disability with major impact on role functioning. They are likely to be vulnerable to abuse or exploitation.

Likely primary diagnosis:
Likely to include (F20-F29) Schizophrenia, schizotypal and delusional disorders F30 Manic Episode, F31 Bipolar Affective Disorder.

Unlikely primary diagnosis:
F00-03 Dementias, F32 Depressive episode, F33 Recurrent depressive disorder, F40-48 Neurotic, stress-related and somatoform disorders, F50 Eating disorders, F60 Specific personality disorders.

Impairment:
Possible cognitive and physical problems linked with long-term illness and medication. May have limited survival skills and be lacking basic life skills and poor role functioning in all areas.

Risk:
Vulnerable to abuse or exploitation.

Course:
Long term.

Likely NICE Guidance:
Service user experience in adult mental health CG136, Schizophrenia (update) CG82, Bipolar disorder CG38, Self-Harm CG16 , Self-harm (longer-term management) CG 133, Medicines adherence CG76.

No	Item Description	Rating				
		0	1	2	3	4
1	Overactive, aggressive, disruptive or agitated behaviour					
2	Non-accidental self-injury					
3	Problem drinking or drug taking					
4	Cognitive Problems					
5	Physical Illness or disability problems					
6	Hallucinations and Delusions					
7	Depressed mood *					
8	Other mental and behavioural problems *					
9	Relationships					
10	Activities of daily living					
11	Living conditions					
12	Occupation & Activities					
13	Strong Unreasonable Beliefs					
A	Agitated behaviour/expansive mood					
B	Repeat Self-Harm					
C	Safeguarding other children & vulnerable dependant adults					
D	Engagement					
E	Vulnerability					

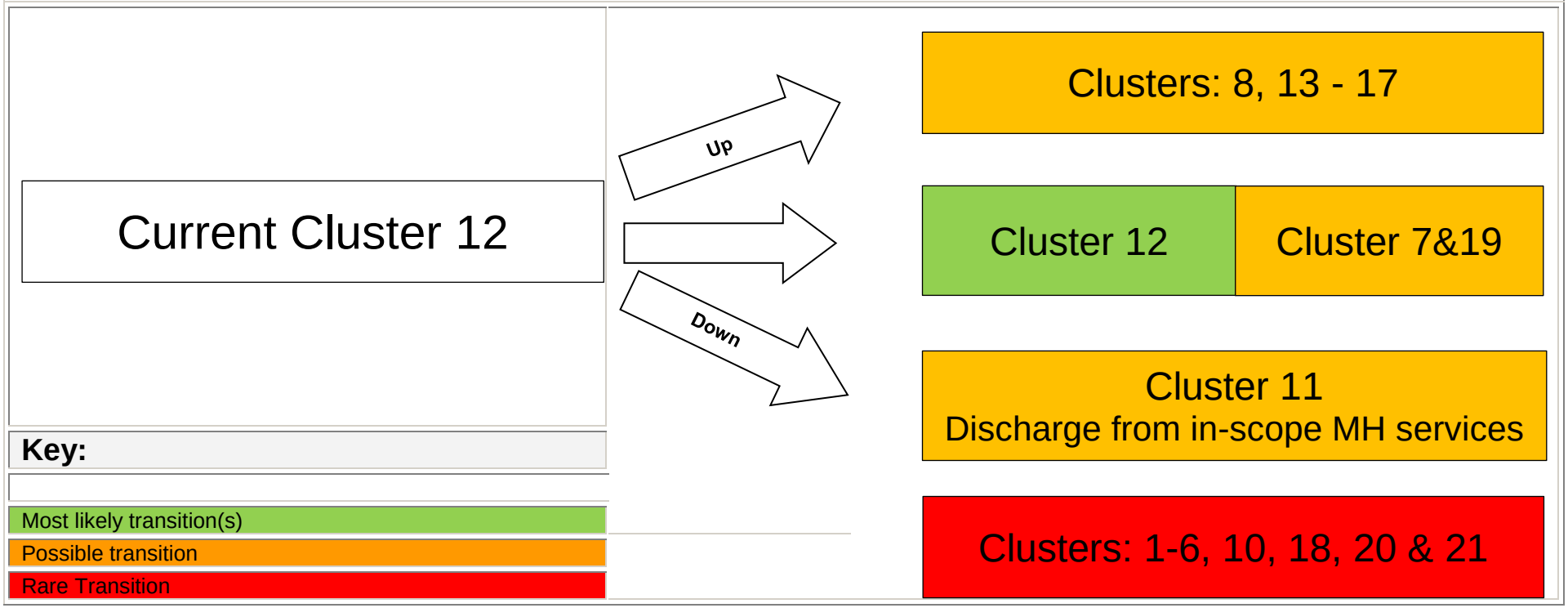
Must score		**Unlikely to score**	
Expected to score		**No data available**	
May score			

***Use the highest rating from Scales 7 & 8 when deciding if the rating fits the range indicated.**

CARE TRANSITION PROTOCOLS - Cluster 12: Ongoing or Recurrent Psychosis (high disability)

Indicative episode of care: 3 years + **Cluster reviews at least:** Annually

Cluster	Step-up Criteria (The following criterion is met)	Example local discharge Criteria for MH services (All of the following criteria are met)	Step-down Criteria (The following criterion is met)
12	• Service User fits description and scoring profile of any likely/ possible 'step-up' cluster.	• Fits profile of cluster 12 at the point of the planned CPA review, and has done so consistently for the past 12 months. • Requires no psychotropic medication or has been on a stable dose for the past year. • Not currently detained under the Mental Health Act. • Has required no inpatient / IHT packages for the past year. • Any residual risks can be managed by primary care. • Scores 0-1 on MHCT V1 item 12 (Occupation and Activities). • Level of social inclusion meets service user's expectations.	• Service User fits description and scoring profile of any likely/ possible 'step-down' cluster consistently for the past 12 months.



CARE CLUSTER 13: Ongoing or Recurrent Psychosis (High Symptom & Disability)

Description:
This group will have a history of psychotic symptoms which are not controlled. They will present with severe to very severe psychotic symptoms and some anxiety or depression. They have a significant disability with major impact on role functioning.

Likely primary diagnosis:
Likely to include (F20-F29) Schizophrenia, schizotypal and delusional disorders F30 Manic Episode, F31 Bipolar Affective Disorder.

Unlikely primary diagnosis:
F00-03 Dementias, F32 Depressive episode, F33 Recurrent depressive disorder, F40-48 Neurotic, stress-related and somatoform disorders, F50 Eating disorders, F60 Specific personality disorders

Impairment:
Possible cognitive and physical problems linked with long-term illness and medication. May be lacking basic life skills and poor role functioning in all areas.

Risk:
Vulnerability to abuse or exploitation.

Course:
Long term.

Likely NICE Guidance:
Service user experience in adult mental health CG136, Schizophrenia (update) CG82, Bipolar disorder CG38, Medicines adherence CG76 Self-Harm CG16, Self-harm (longer-term management) CG 133.

No	Item Description	Rating				
		0	1	2	3	4
1	Overactive, aggressive, disruptive or agitated behaviour	May score	May score	May score		
2	Non-accidental self-injury	Expected to score	Expected to score	Expected to score		
3	Problem drinking or drug taking	Expected to score	Expected to score	Expected to score		
4	Cognitive Problems		May score	May score	May score	
5	Physical Illness or disability problems		May score	May score	May score	
6	Hallucinations and Delusions				Must score	Must score
7	Depressed mood *		Expected to score	Expected to score	Expected to score	
8	Other mental and behavioural problems *		May score	May score	May score	
9	Relationships		May score	May score	May score	
10	Activities of daily living		May score	May score	May score	
11	Living conditions		May score	May score	May score	
12	Occupation & Activities		Expected to score	Expected to score	Expected to score	
13	Strong Unreasonable Beliefs	May score	May score	May score	May score	
A	Agitated behaviour/expansive mood		Expected to score	Expected to score	Expected to score	
B	Repeat Self-Harm	Expected to score	Expected to score	Expected to score		
C	Safeguarding other children & vulnerable dependant adults		May score	May score	May score	
D	Engagement	Expected to score	Expected to score	Expected to score		
E	Vulnerability		Expected to score	Expected to score	Expected to score	

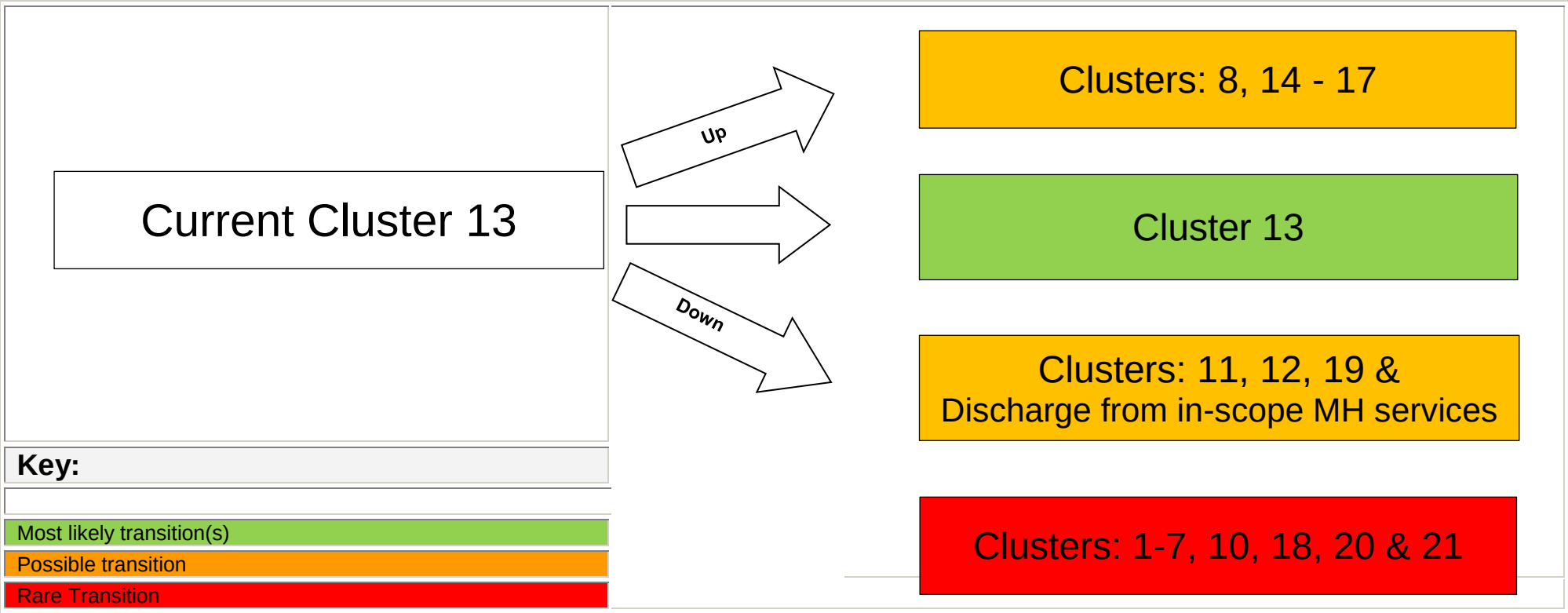
Must score		**Unlikely to score**	
Expected to score		**No data available**	
May score			

***Use the highest rating from Scales 7 & 8 when deciding if the rating fits the range indicated.**

CARE TRANSITION PROTOCOLS - Cluster 13: Ongoing or Recurrent Psychosis (high symptom and disability)

Indicative episode of care: 3 years + **Cluster reviews at least:** Annually

Cluster	Step-up Criteria (The following criterion is met)	Example local discharge Criteria for MH services (All of the following criteria are met)	Step-down Criteria (The following criterion is met)
13	• Service User fits description and scoring profile of any likely/ possible 'step-up' cluster.	• Has received 2 years of specialist MH intervention. • Requires no psychotropic medication or has been on a stable dose for the past year. • Scores 0-1 on MHCT V1 item 6 (Hallucinations and Delusions) • Not currently detained under the Mental Health Act. • Has required no inpatient / IHT packages for the past year. • Any residual risks can be managed by primary care. • Scores 0-1 on MHCT V1 item 12 (Occupation and Activities). • Level of social inclusion meets service user's expectations.	• Service User fits description and scoring profile of any likely/ possible 'step-down' cluster consistently for the past 12 months.



CARE CLUSTER 14: Psychotic Crisis

Description:
They will be experiencing an acute psychotic episode with severe symptoms that cause severe disruption to role functioning. They may present as vulnerable and a risk to others or themselves.

Likely primary diagnosis:
Likely to include (F20-F29) Schizophrenia, schizotypal and delusional disorders F30 Manic Episode, F31 Bipolar Affective Disorder.

Unlikely primary diagnosis:
F00-03 Dementias, F32 Depressive episode, F33 Recurrent depressive disorder, F40-48 Neurotic, stress-related and somatoform disorders, F50 Eating disorders,

Impairment:
Cognitive problems may present. Activities will be severely disrupted in most areas. Role functioning is severely disrupted in most areas.

Risk:
There may be risks to self or others because of challenging behaviour and some vulnerability to abuse or exploitation. Also, possibly poor engagement with service. Safeguarding risk if parent/carer.

Course:
Acute

Likely NICE Guidance:
Service user experience in adult mental health CG136, Schizophrenia (update) CG82, Bipolar disorder CG38, Medicines adherence CG76 Self-Harm CG16, Violence CG25.

No	Item Description	Rating				
		0	1	2	3	4
1	Overactive, aggressive, disruptive or agitated behaviour					
2	Non-accidental self-injury					
3	Problem drinking or drug taking					
4	Cognitive Problems					
5	Physical Illness or disability problems					
6	Hallucinations and Delusions					
7	Depressed mood *					
8	Other mental and behavioural problems *					
9	Relationships					
10	Activities of daily living					
11	Living conditions					
12	Occupation & Activities					
13	Strong Unreasonable Beliefs					
A	Agitated behaviour/expansive mood					
B	Repeat Self-Harm					
C	Safeguarding other children & vulnerable dependant adults					
D	Engagement					
E	Vulnerability					

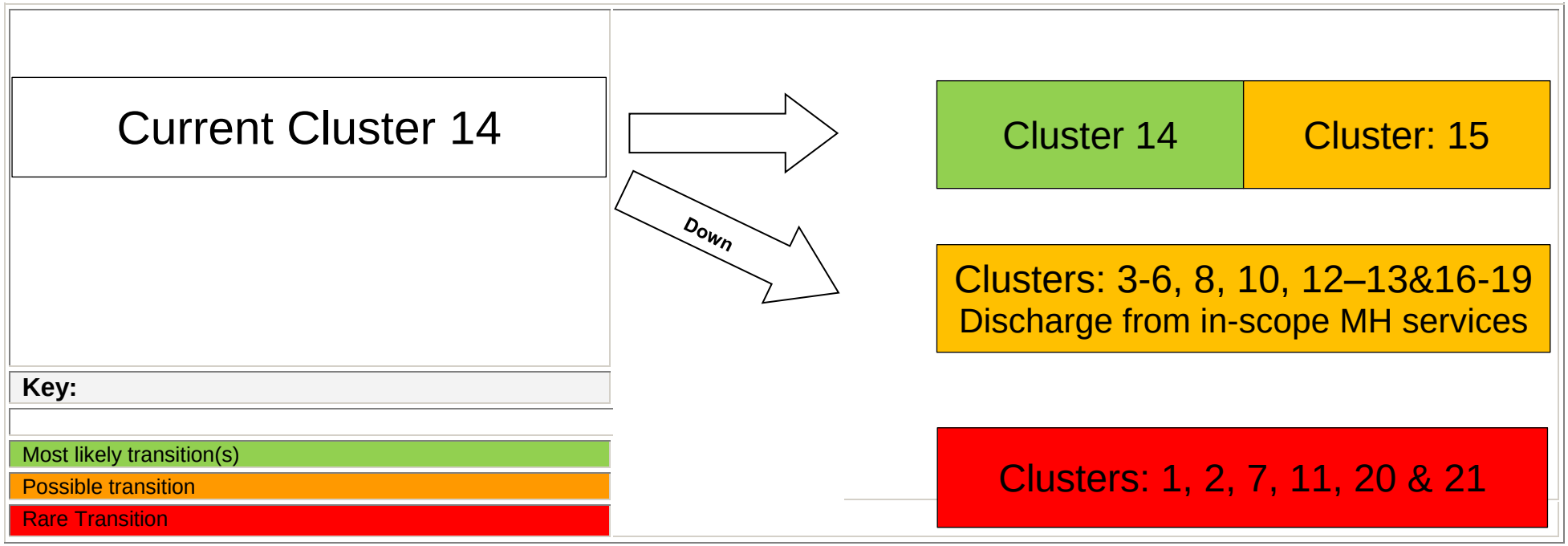
Must score		**Unlikely to score**	
Expected to score		**No data available**	
May score			

***Use the highest rating from Scales 7 & 8 when deciding if the rating fits the range indicated.**

CARE TRANSITION PROTOCOLS - Cluster 14: Psychotic Crisis

Indicative episode of care: 8 – 12 weeks **Cluster reviews at least every:** 4 weeks

Cluster	Step-up Criteria (The following criterion is met)	Example local discharge Criteria for MH services (All of the following criteria are met)	Step-down Criteria (The following criterion is met)
14	N/A	• Requires no psychotropic medication or has been on a stable dose and is adherent. • Scores 0-1 on MHCT V1 item 6 (Hallucinations and Delusions). • Any residual risks can be managed by Primary Care. • Scores 0-2 on MHCT V1 item 12 (Occupation and Activities). • Level of social inclusion meets service user's expectations.	• Service User fits description and scoring profile of any likely/ possible 'step-down' cluster.



CARE CLUSTER 15: Severe Psychotic Depression

Description:
This group will be suffering from an acute episode of moderate to severe depressive symptoms. Hallucinations and delusions will be present. It is likely that this group will present a risk of Non-accidental self-injury and have disruption in many areas of their lives.

Likely primary diagnosis:
Likely to include, F32.3 Severe depressive episode with psychotic symptoms

Unlikely primary diagnosis:
F00-03 Dementias, F40-48 Neurotic, stress-related and somatoform disorders, F50 Eating disorders,

Impairment:
Cognitive problems may present. Activities will be severely disrupted in most areas. Role functioning is severely disrupted in most areas

Risk:
Risk of Non-accidental self-injury and vulnerability likely to be present with other risks variable. Consider safeguarding risks if parent or carer.

Course:
Acute

Likely NICE Guidance:
Service user experience in adult mental health CG136, Medicines adherence CG76, Depression in adults CG90, OCD CG31, Schizophrenia (update) CG82, Bipolar disorder CG38, Self-Harm CG16.

No	Item Description	Rating				
		0	1	2	3	4
1	Overactive, aggressive, disruptive or agitated behaviour	May score	May score	May score	Unlikely to score	Unlikely to score
2	Non-accidental self-injury	Unlikely to score	Unlikely to score	Expected to score	Expected to score	Expected to score
3	Problem drinking or drug taking	Expected to score	Expected to score	Expected to score	Unlikely to score	Unlikely to score
4	Cognitive Problems	Unlikely to score	Unlikely to score	May score	May score	May score
5	Physical Illness or disability problems	Unlikely to score	May score	May score	May score	May score
6	Hallucinations and Delusions	Unlikely to score	Unlikely to score	Must score	Must score	Must score
7	Depressed mood *	Unlikely to score	Unlikely to score	Unlikely to score	Must score	Must score
8	Other mental and behavioural problems *	Unlikely to score	Unlikely to score	Must score	Must score	Must score
9	Relationships	Unlikely to score	Unlikely to score	May score	May score	May score
10	Activities of daily living	Unlikely to score	Unlikely to score	May score	May score	May score
11	Living conditions	Unlikely to score	May score	May score	May score	Unlikely to score
12	Occupation & Activities	Unlikely to score	Unlikely to score	Expected to score	Expected to score	Expected to score
13	Strong Unreasonable Beliefs	May score	May score	May score	May score	May score
		Unlikely to score	Unlikely to score	Unlikely to score	Unlikely to score	Unlikely to score
A	Agitated behaviour/expansive mood	Expected to score	Expected to score	Expected to score	Unlikely to score	Unlikely to score
B	Repeat Self-Harm	Expected to score	Expected to score	Expected to score	Expected to score	Unlikely to score
C	Safeguarding other children & vulnerable dependant adults	Unlikely to score	Unlikely to score	May score	May score	May score
D	Engagement	Expected to score	Expected to score	Expected to score	Unlikely to score	Unlikely to score
E	Vulnerability	Unlikely to score	Unlikely to score	Expected to score	Expected to score	Expected to score

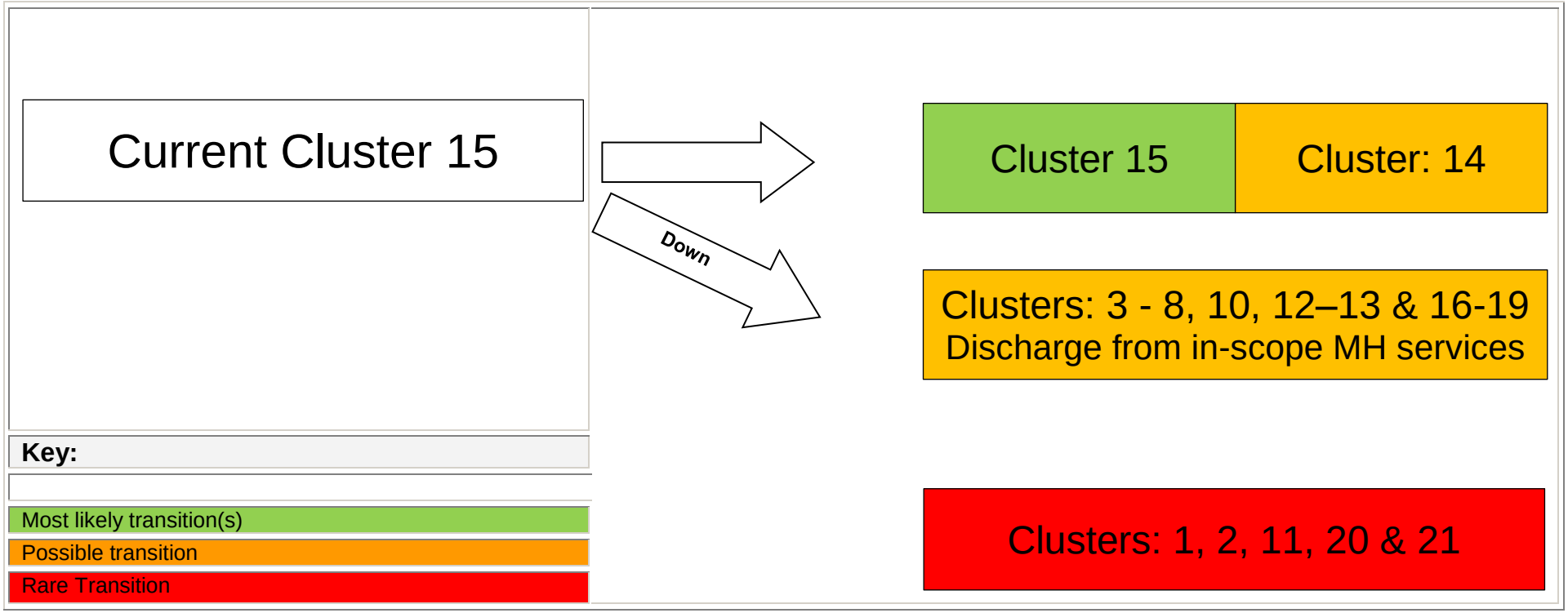
Must score		Unlikely to score	
Expected to score		No data available	
May score			

***Use the highest rating from Scales 7 & 8 when deciding if the rating fits the range indicated.**

CARE TRANSITION PROTOCOLS - Cluster 15: Severe Psychotic Depression

Indicative episode of care: 8 – 12 weeks **Cluster reviews at least every:** 4 weeks

Cluster	Step-up Criteria (The following criterion is met)	Example local discharge Criteria for MH services (All of the following criteria are met)	Step-down Criteria (The following criterion is met)
15	N/A	• Requires no psychotropic medication or has been on a stable dose and is adherent. • Scores 0-1 on MHCT V1 item 6 (Hallucinations and Delusions). • Any residual risks can be managed by Primary Care. • Scores 0-2 on MHCT V1 item 12 (Occupation and Activities). • Level of social inclusion meets service user's expectations	• Service User fits description and scoring profile of any likely/ possible 'step-down' cluster.



CARE CLUSTER 16: Psychosis & Affective Disorder (High Substance Misuse & Engagement)

Description:
This group has enduring, moderate to severe psychotic or bipolar affective symptoms with unstable, chaotic lifestyles *and co-existing* problem drinking or drug taking. They may present a risk to self and others and engage poorly with services. Role functioning is often globally impaired.

Likely primary diagnosis:
Likely to include, (F10-F19) Mental and behavioural disorders due to psychoactive substance use (F20-F29) Schizophrenia, schizotypal and delusional disorders, Bi-Polar Disorder

Unlikely primary diagnosis:
F00-03 Dementias F32 Depressive episode, F33 Recurrent depressive disorder, F40-48 Neurotic, stress-related and somatoform disorders, F50 Eating disorders, F60 Specific personality disorders

Impairment:
Physical Illness or disability problems may be present as a result of Problem drinking or drug taking and possibly cognitively impaired as a consequence of psychotic features or Problem drinking or drug taking. Global impairment of role function likely.

Risk:
Moderate to severe risk to other due to violent and aggressive behaviour. Likely to engage poorly with services. Some risk of accidental death.

Course:
Long term.

Likely NICE Guidance:
Service user experience in adult mental health CG136, Psychosis with coexisting substance misuse CG120, Schizophrenia (update) CG82, Bipolar Disorder CG38, Medicines adherence CG76, Alcohol dependence and harmful alcohol misuse CG115, Alcohol Use Disorders CG100, Drug misuse-psychosocial interventions CG51, Drug-misuse – opioid detoxification CG100, Self-Harm CG16, Self-harm (longer-term management) CG 133.

NO	ITEM DESCRIPTION	RATING				
		0	1	2	3	4
1	Overactive, aggressive, disruptive or agitated behaviour					
2	Non-accidental self-injury					
3	Problem drinking or drug taking					
4	Cognitive Problems					
5	Physical Illness or disability problems					
6	Hallucinations and Delusions					
7	Depressed mood *					
8	Other mental and behavioural problems *					
9	Relationships					
10	Activities of daily living					
11	Living conditions					
12	Occupation & Activities					
13	Strong Unreasonable Beliefs					
A	Agitated behaviour/expansive mood					
B	Repeat Self-Harm					
C	Safeguarding other children & vulnerable dependant adults					
D	Engagement					
E	Vulnerability					

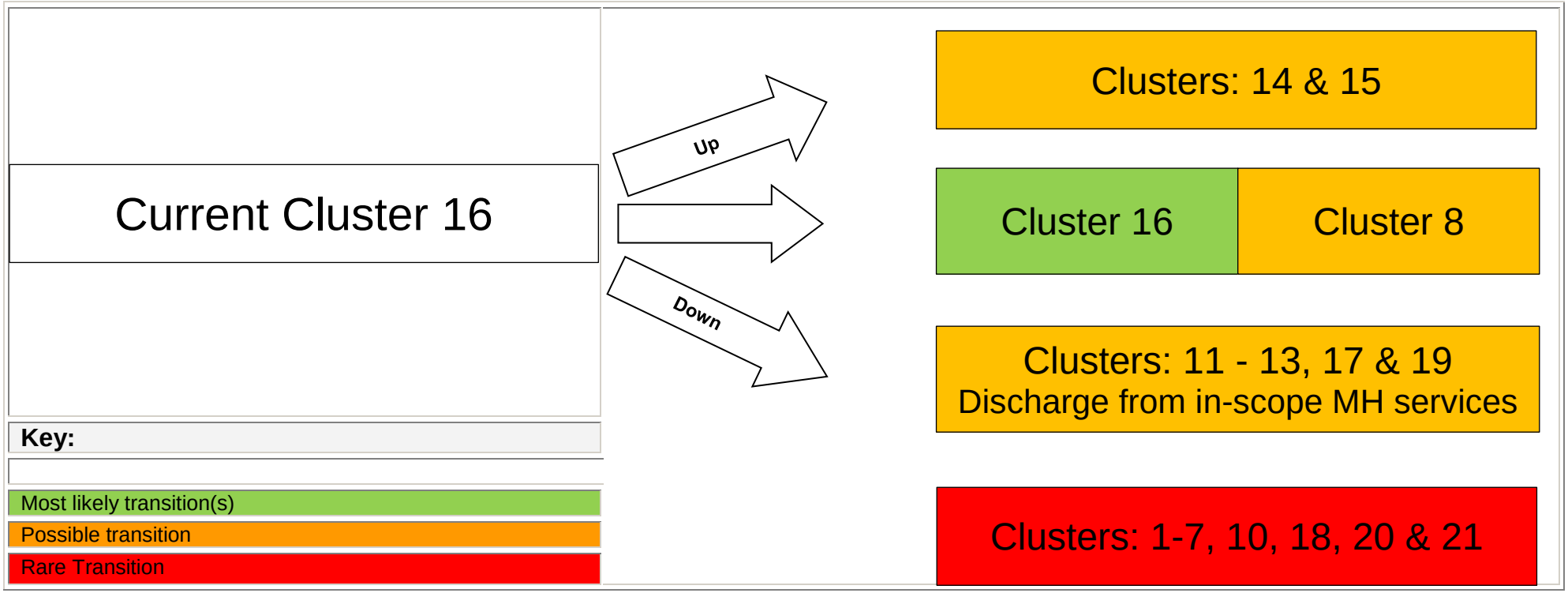
Must score		**Unlikely to score**	
Expected to score		**No data available**	
May score			

***Use the highest rating from Scales 7 & 8 when deciding if the rating fits the range indicated.**

CARE TRANSITION PROTOCOLS - Cluster 16: Psychosis & Affective Disorder (High Substance Misuse & Engagement)

Indicative episode of care: 3 years + **Cluster reviews at least every:** 6 months

Cluster	Step-up Criteria (The following criterion is met)	Example local discharge Criteria for MH services (All of the following criteria are met)	Step-down Criteria (All of the following criteria are met)
16	• Service User fits description and scoring profile of any likely/ possible 'step-up' cluster.	• Has received 2 years of specialist MH intervention. • Requires no psychotropic medication or has been on a stable dose for the past year. • Scores 0-1 on MHCT V1 item 6 (Hallucinations and Delusions) • Has required no inpatient / IHT packages for the past year. • Any residual risks can be managed by primary care • Scores 0-1 on MHCT V1 item 12 (Occupation and Activities). • Level of social inclusion meets service user's expectations. • Scores 0-1 MHCT V1 item D (Engagement).	• Service User has fitted description and scoring profile of any likely/ possible 'step-down' cluster consistently for the past 12 months. • Has required no inpatient / IHT packages for the past year. • Scores 0-1 MHCT V1 item D (Engagement). • Level of support (frequency of visits etc.) has been reduced to a level that can be provided by a less intensive care package for the past 6 months. • MHCT V1 item 3 (Problem drinking or drug taking) has remained at a score of 2 or less for the past 12 months



CARE CLUSTER 17: Psychosis and Affective Disorder – Difficult to Engage

Description:
This group has moderate to severe psychotic symptoms with unstable, chaotic lifestyles. There may be some problems with drugs or alcohol not severe enough to warrant care associated with cluster 16. This group have a history of non-concordance, are vulnerable & engage poorly with services.

Likely primary diagnosis:
Likely to include, (F20-F29) Schizophrenia, schizotypal and delusional disorders, Bi-Polar

Unlikely primary diagnosis:
F00-03 Dementias, F32 Depressive episode, F33 Recurrent depressive disorder, F40-48 Neurotic, stress-related and somatoform disorders, F50 Eating disorders, F60 Specific personality disorders

Impairment:
Possibly cognitively impaired as a consequence of psychotic features or Problem drinking or drug taking including prescribed medication. Likely severe problems with relationships and one or more other area of functioning

Risk:
Moderate to severe risk of harm to others due to aggressive or violent behaviour. Risk of Non-accidental self-injury. Likely to be non-compliant, vulnerable and engage poorly with service.

Course:
Long term.

Likely NICE Guidance:
Service user experience in adult mental health CG136, Schizophrenia (update) CG82, Bipolar Disorder CG38, Medicines adherence CG76 Alcohol Use Disorders CG100, Drug misuse-psychosocial interventions CG51, Psychosis with coexisting substance misuse CG120
Self-Harm CG16, Self-harm (longer-term management) CG 133.

No	Item Description	Rating				
		0	1	2	3	4
1	Overactive, aggressive, disruptive or agitated behaviour					
2	Non-accidental self-injury					
3	Problem drinking or drug taking					
4	Cognitive Problems					
5	Physical Illness or disability problems					
6	Hallucinations and Delusions					
7	Depressed mood *					
8	Other mental and behavioural problems *					
9	Relationships					
10	Activities of daily living					
11	Living conditions					
12	Occupation & Activities					
13	Strong Unreasonable Beliefs					
A	Agitated behaviour/expansive mood					
B	Repeat Self-Harm					
C	Safeguarding other children & vulnerable dependant adults					
D	Engagement					
E	Vulnerability					

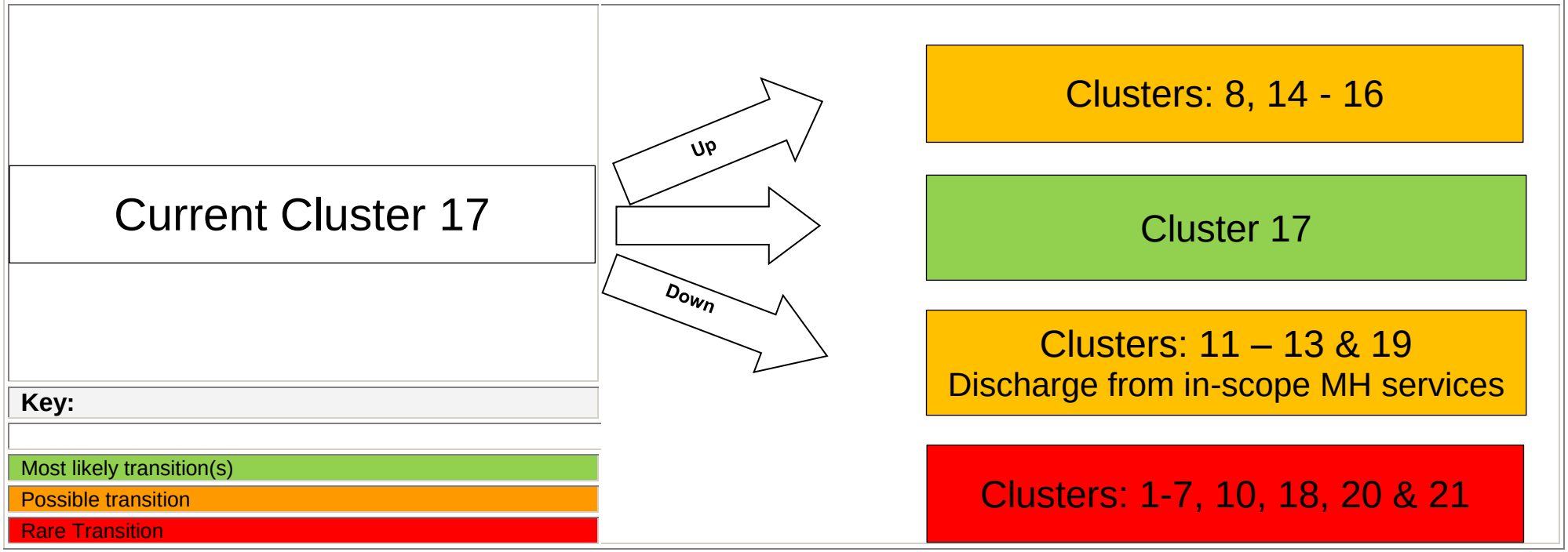
Must score		**Unlikely to score**	
Expected to score		**No data available**	
May score			

***Use the highest rating from Scales 7 & 8 when deciding if the rating fits the range indicated.**

CARE TRANSITION PROTOCOLS - Cluster 17: Psychosis and Affective Disorder Difficult to Engage

Indicative episode of care: 3 years + **Cluster reviews at least every:** 6 months

Cluster	Step-up Criteria (Any of the following criteria are met)	Example local discharge Criteria for MH services (All of the following criteria are met)	Step-down Criteria (All of the following criteria are met)
17	• Patient fits profile for clusters 14 or 15. • Patient scores above 2 on Problem drinking or drug taking item and this results in an inability to deliver the care typically provided to cluster 17 patients without a significant increase in resources.	• Has received 2 years of specialist MH intervention. • Requires no psychotropic medication or has been on a stable dose for the past year. • Scores 0-1 on MHCT V1 item 6 (Hallucinations and Delusions) • Has required no inpatient / IHT packages for the past year. • Any residual risks can be managed by primary care • Scores 0-1 on MHCT V1 item 12 (Occupation and Activities). • Level of social inclusion meets service user's expectations. • Scores 0-1 MHCT V1 item D (Engagement)	• Service User has fitted description and scoring profile of any likely/ possible 'step-down' cluster consistently for the past 12 months. • Has required no inpatient / IHT packages for the past year. • Scores 0-1 MHCT V1 item D (Engagement). • Level of support (frequency of visits etc.) has been reduced to a level that can be provided by a less intensive care package for the past 6 months.



CARE CLUSTER 18: Cognitive Impairment (Low Need)

Description:
People who may be in the early stages of dementia (or who may have an organic brain disorder affecting their cognitive function) who have some memory problems, or other low level cognitive impairment but who are still managing to cope reasonably well. Underlying reversible physical causes have been ruled out.

Likely primary diagnosis:
Diagnoses likely to include: F00 – Dementia in Alzheimer-s disease, F01 – Vascular dementia, F02 – Dementia in other diseases classified elsewhere F03 – Unspecified Dementia, Dementia with Lewy bodies (DLB),

Unlikely primary diagnosis:
F20-29 Schizophrenia, schizotypal and delusional disorders , F30-39 Mood [affective] disorders, F40-48 Neurotic, stress-related and somatoform disorders, F50 Eating disorders, F60 Specific personality disorders

Impairment:
Some memory and other low level impairment will be present. ADL function will be unimpaired, or only mildly impaired. There may be changes in ability to manage vocational and social roles.

Risk:
None or minor.

Course:
Long term

Likely NICE Guidance:
Service user experience in adult mental health CG136, Dementia CG42 Medicines adherence CG76, Anxiety CG113, Depression in adults CG90, Depression with a chronic physical health problem CG91

No	Item Description	Rating				
		0	1	2	3	4
1	Overactive, aggressive, disruptive or agitated behaviour					
2	Non-accidental self-injury					
3	Problem drinking or drug taking					
4	Cognitive Problems					
5	Physical Illness or disability problems					
6	Hallucinations and Delusions					
7	Depressed mood *					
8	Other mental and behavioural problems *					
9	Relationships					
10	Activities of daily living					
11	Living conditions					
12	Occupation & Activities					
13	Strong Unreasonable Beliefs					
A	Agitated behaviour/expansive mood					
B	Repeat Self-Harm					
C	Safeguarding other children & vulnerable dependant adults					
D	Engagement					
E	Vulnerability					

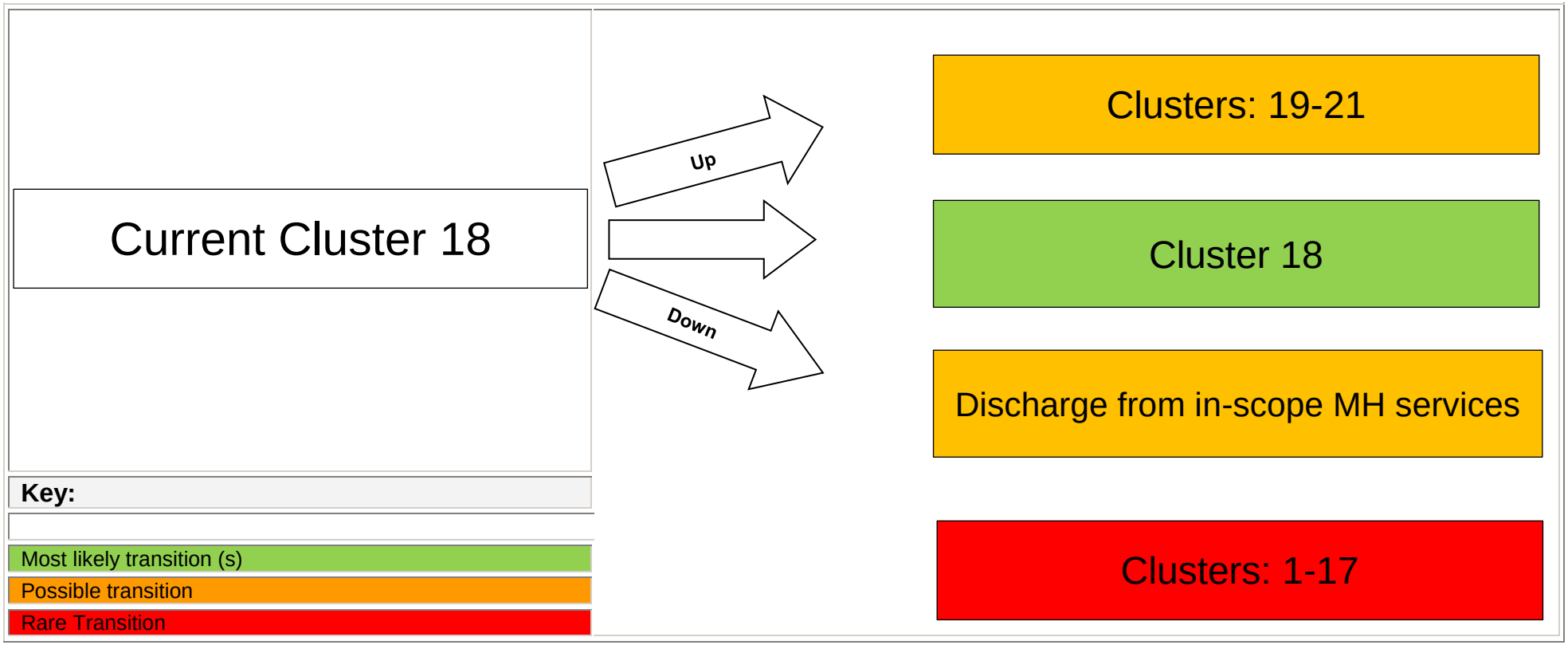
Must score		**Unlikely to score**	
Expected to score		**No data available**	
May score			

***Use the highest rating from Scales 7 & 8 when deciding if the rating fits the range indicated.**

CARE TRANSITION PROTOCOLS - Cluster 18: Cognitive impairment (low need)

Indicative episode of care: 3 years + **Cluster reviews at least every:** Annually

Cluster	Step-up Criteria (The following criterion is met)	Example local discharge Criteria for MH services (All of the following criteria are met)	Step-down Criteria (All of the following criteria are met)
18	• Service User fits description and scoring profile of any likely/ possible 'step-up' cluster.	• Stable rating on MHCT item 4 (Cognitive problems) for the past year • Stable dose of any prescribed ACHEIs for the past 6 months • Level of social inclusion meets Service User's expectation • Any residual risks can be managed by primary care	• Organic causes of memory problems have been excluded. • Service User fits description and scoring profile of any likely/ possible 'step-down' cluster.



CARE CLUSTER 19: Cognitive Impairment or Dementia Complicated (Moderate Need)

Description:
People who have problems with their memory, and or other aspects of cognitive functioning resulting in moderate problems looking after themselves and maintaining social relationships. Probable risk of self-neglect or harm to others and may be experiencing some anxiety or depression.

Likely primary diagnosis:
Likely to include: F00 – Dementia in Alzheimer's disease, F01 – Vascular dementia, F02 – Dementia in other diseases classified elsewhere, F03 – Unspecified Dementia, F09 – unspecified organic or symptomatic mental disorder, Dementia with Lewy bodies (DLB), Frontotemporal dementia (FTD)

Unlikely primary diagnosis:
F20-29 Schizophrenia, schizotypal and delusional disorders , F30-39 Mood [affective] disorders, F40-48 Neurotic, stress-related and somatoform disorders F50 Eating disorders, F60 Specific personality disorders

Impairment:
Impairment of ADL and some difficulty with communication and in fulfilling social and family roles.

Risk:
Risk of self-neglect, harm to self or others. May lack awareness of problems.

Course:
Long term.

Likely NICE Guidance:
Service user experience in adult mental health CG136, Dementia CG42 Medicines adherence CG76, Anxiety CG113, Depression in adults CG90 Depression with a chronic physical health problem CG91.

No	Item Description	Rating				
		0	1	2	3	4
1	Overactive, aggressive, disruptive or agitated behaviour	May score	May score			
2	Non-accidental self-injury	Expected to score	Expected to score			
3	Problem drinking or drug taking	May score	May score			
4	Cognitive Problems			Must score	Must score	
5	Physical Illness or disability problems		Expected to score	Expected to score	Expected to score	
6	Hallucinations and Delusions	Expected to score	Expected to score	Expected to score	Expected to score	
7	Depressed mood *		May score	May score	May score	
8	Other mental and behavioural problems *		May score	May score	May score	
9	Relationships		May score	May score	May score	
10	Activities of daily living			Expected to score	Expected to score	
11	Living conditions		May score	May score	May score	
12	Occupation & Activities			Expected to score	Expected to score	
13	Strong Unreasonable Beliefs	May score	May score	May score		
A	Agitated behaviour/expansive mood	Expected to score	Expected to score	Expected to score		
B	Repeat Self-Harm	May score	May score			
C	Safeguarding other children & vulnerable dependant adults		May score	May score		
D	Engagement	Expected to score	Expected to score			
E	Vulnerability	Expected to score	Expected to score	Expected to score	Expected to score	

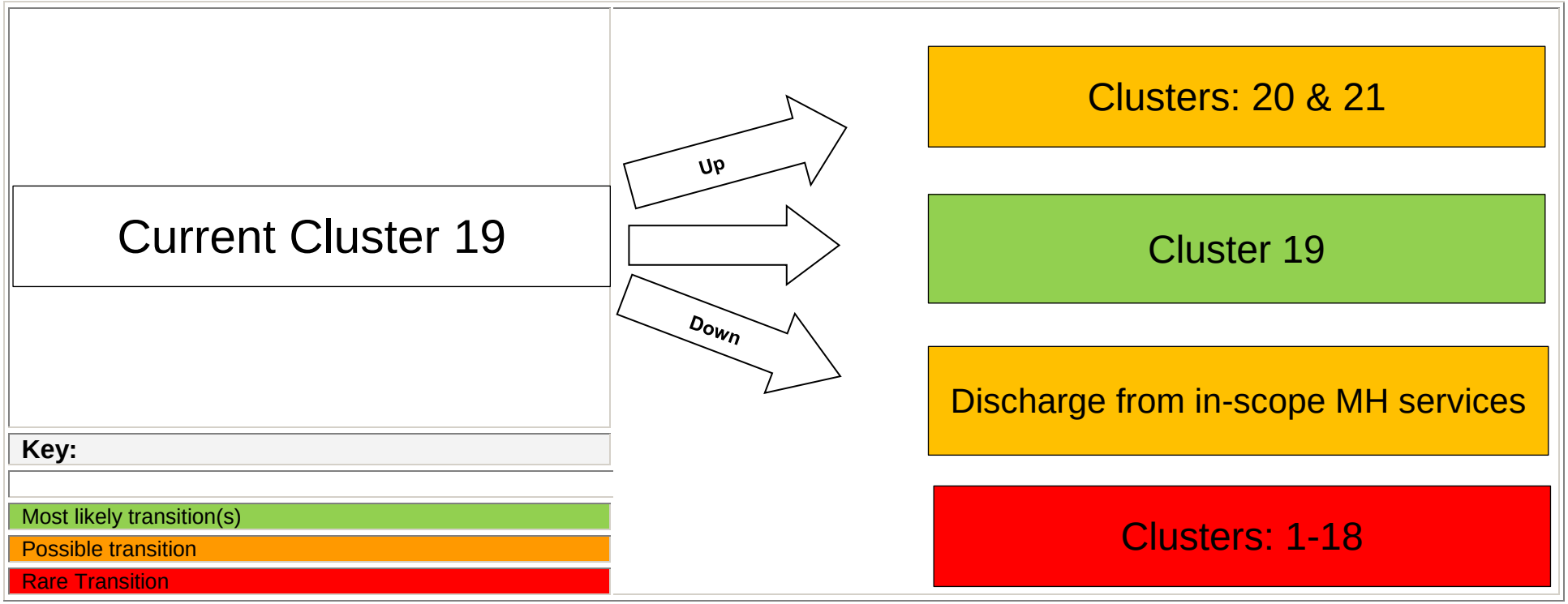
Must score		**Unlikely to score**	
Expected to score		**No data available**	
May score			

***Use the highest rating from Scales 7 & 8 when deciding if the rating fits the range indicated.**

CARE TRANSITION PROTOCOLS - Cluster 19: Cognitive impairment or Dementia Complicated (Moderate need)

Indicative episode of care: 3 years + **Cluster reviews at least every:** 6 months

Cluster	Step-up Criteria (The following criterion is met)	Example local discharge Criteria for MH services (All of the following criteria are met)	Step-down Criteria (All of the following criteria are met)
19	• Service User fits description and scoring profile of any likely/ possible step up cluster	• Stable rating on MHCT item 4 (Cognitive problems) for the past year • Stable dose of any prescribed ACHEIs for the past 6 months • No inpatient / home treatment packages for the last 12 months • Level of social inclusion meets Service User's expectation • Any residual risks (including any comorbidities) can be managed by primary care	N/A



CARE CLUSTER 20: Cognitive Impairment or Dementia Complicated (High Need)

Description:
People with dementia who are having significant problems in looking after themselves and whose behaviour may challenge their carers or services. They may have high levels of anxiety or depression, psychotic symptoms or significant problems such as aggression or agitation. The may not be aware of their problems. They are likely to be at high risk of self-neglect or harm to others, and there may be a significant risk of their care arrangements breaking down.

Likely primary diagnosis:
Likely to include: F00 – Dementia in Alzheimer's disease, F01 – Vascular dementia, F02 – Dementia in other diseases classified elsewhere, F03 – Unspecified Dementia, F09 – unspecified organic or symptomatic mental disorder, Dementia with Lewy bodies (DLB), Frontotemporal dementia (FTD).

Unlikely primary diagnosis:
F20-29 Schizophrenia, schizotypal and delusional disorders ,F30-39 Mood [affective] disorders, F40-48 Neurotic, stress-related and somatoform disorders F50 Eating disorders, F60 Specific personality disorders

Impairment:
Significant impairment of ADL function and/or communication. May lack awareness of problems. Significant impairment of role functioning. Unable to fulfil social and family roles

Risk:
High risk of self-neglect or harm to self or others. Risk of breakdown of care.

Course:
Long term.

Likely NICE Guidance:
Service user experience in adult mental health CG136, Dementia CG42 Medicines adherence CG76, Falls CG21, Anxiety CG113, Violence CG25 Depression in adults CG90, Depression with a chronic physical health problem CG91.

No	Item Description	Rating				
		0	1	2	3	4
1	Overactive, aggressive, disruptive or agitated behaviour					
2	Non-accidental self-injury					
3	Problem drinking or drug taking					
4	Cognitive Problems					
5	Physical Illness or disability problems					
6	Hallucinations and Delusions					
7	Depressed mood *					
8	Other mental and behavioural problems *					
9	Relationships					
10	Activities of daily living					
11	Living conditions					
12	Occupation & Activities					
13	Strong Unreasonable Beliefs					
A	Agitated behaviour/expansive mood					
B	Repeat Self-Harm					
C	Safeguarding other children & vulnerable dependant adults					
D	Engagement					
E	Vulnerability					

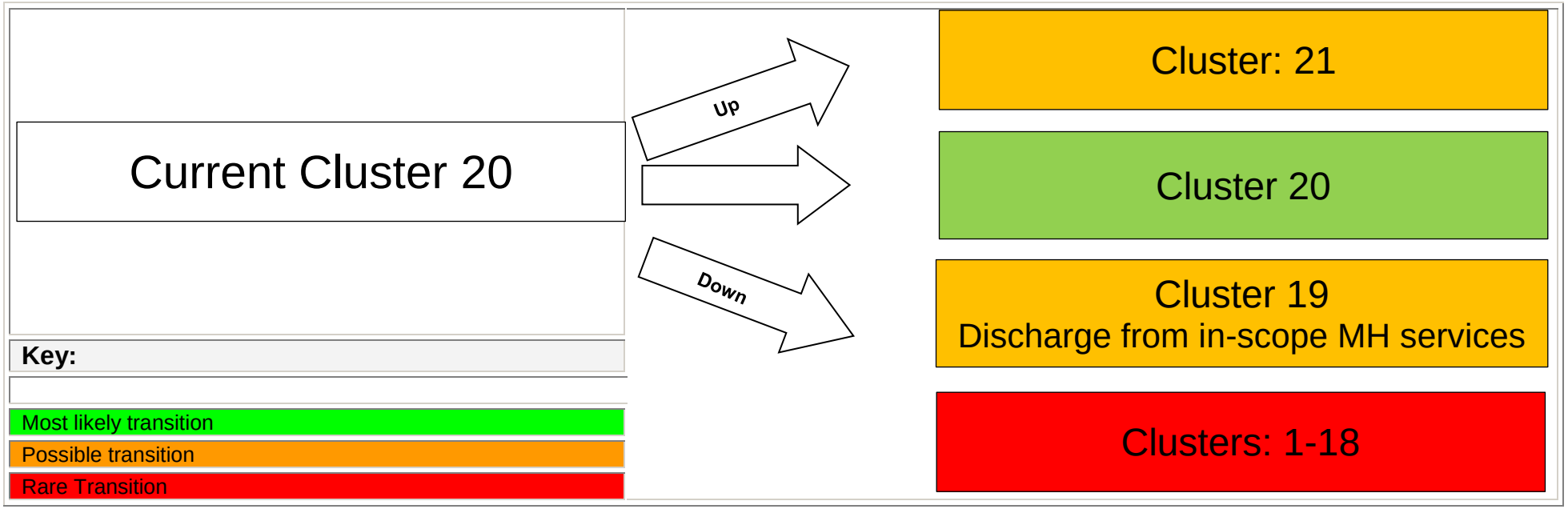
Must score		**Unlikely to score**	
Expected to score		**No data available**	
May score			

***Use the highest rating from Scales 7 & 8 when deciding if the rating fits the range indicated.**

CARE TRANSITION PROTOCOLS - Cluster 20: Cognitive impairment or Dementia Complicated (High need)

Indicative episode of care: 3 years + **Cluster reviews at least every:** 6 months

Cluster	Step-up Criteria (The following criterion is met)	Example local discharge Criteria for MH services (All of the following criteria are met)	Step-down Criteria (All of the following criteria are met)
20	• Service User fits description and scoring profile of and likely/ possible step up cluster.	• Stable rating on MHCT item 4 (Cognitive problems) for the past 12 months • Stable dose of any prescribed ACHEIs for the past 12 months • No inpatient / home treatment packages for the last 12 months • Level of social inclusion meets Service Users and carers expectation • Any residual risks (including any comorbidities) can be managed by primary care with / without other partnerships • Has received at least 1 year of specialist Mental Health intervention	• Service User fits description and scoring profile of any likely/ possible 'step-down' cluster. • Improvement is likely to be sustained until the next planned review



CARE CLUSTER 21: Cognitive Impairment or Dementia (High Physical or Engagement)

Description:
People with cognitive impairment or dementia who are having significant problems in looking after themselves, and whose physical condition is becoming increasingly frail. They may not be aware of their problems and there may be a significant risk of their care arrangements breaking down.

Likely primary diagnosis:
Likely to include: F00 – Dementia in Alzheimer's disease, F01 – Vascular dementia, F02 – Dementia in other diseases classified elsewhere, F03 – Unspecified Dementia, F09 – unspecified organic or symptomatic mental disorder, Dementia with Lewy bodies (DLB), Frontotemporal dementia (FTD)

Unlikely primary diagnosis:
F20-29 Schizophrenia, schizotypal and delusional disorders, F30-39 Mood [affective] disorders, F40-48 Neurotic, stress-related and somatoform disorders, F50 Eating disorders, F60 Specific personality disorders.

Impairment:
Likely to lack awareness of problems. Significant impairment of ADL function. Unable to fulfil self-care and social and family roles. Major impairment of role functioning.

Risk:
High risk of self-neglect. Risk of breakdown of care.

Course:
Long term.

Likely NICE Guidance:
Service user experience in adult mental health CG136, Dementia CG42 Medicines adherence CG76, Falls CG21, Anxiety CG113.

No	Item Description	Rating				
		0	1	2	3	4
1	Overactive, aggressive, disruptive or agitated behaviour	May score	May score	May score	May score	Unlikely to score
2	Non-accidental self-injury	Expected to score	Expected to score	Unlikely to score	Unlikely to score	Unlikely to score
3	Problem drinking or drug taking	May score	May score	Unlikely to score	Unlikely to score	Unlikely to score
4	Cognitive Problems	Unlikely to score	Unlikely to score	Must score	Must score	Must score
5	Physical Illness or disability problems	Unlikely to score	Unlikely to score	Unlikely to score	Expected to score	Expected to score
6	Hallucinations and Delusions	Unlikely to score	Expected to score	Expected to score	Expected to score	Unlikely to score
7	Depressed mood *	Unlikely to score	May score	May score	May score	Unlikely to score
8	Other mental and behavioural problems *	Unlikely to score	Unlikely to score	May score	May score	May score
9	Relationships	Unlikely to score	Unlikely to score	Unlikely to score	May score	May score
10	Activities of daily living	Unlikely to score	Unlikely to score	Unlikely to score	Expected to score	Expected to score
11	Living conditions	Unlikely to score	May score	May score	May score	Unlikely to score
12	Occupation & Activities	Unlikely to score	Unlikely to score	Unlikely to score	Expected to score	Expected to score
13	Strong Unreasonable Beliefs	May score	May score	May score	Unlikely to score	Unlikely to score
		Unlikely to score	Unlikely to score	Unlikely to score	Unlikely to score	Unlikely to score
A	Agitated behaviour/expansive mood	Expected to score	Expected to score	Expected to score	Expected to score	Unlikely to score
B	Repeat Self-Harm	May score	May score	Unlikely to score	Unlikely to score	Unlikely to score
C	Safeguarding other children & vulnerable dependant adults	Unlikely to score	Unlikely to score	Unlikely to score	May score	May score
D	Engagement	Unlikely to score	Unlikely to score	Expected to score	Expected to score	Expected to score
E	Vulnerability	Unlikely to score	Unlikely to score	Unlikely to score	Expected to score	Expected to score

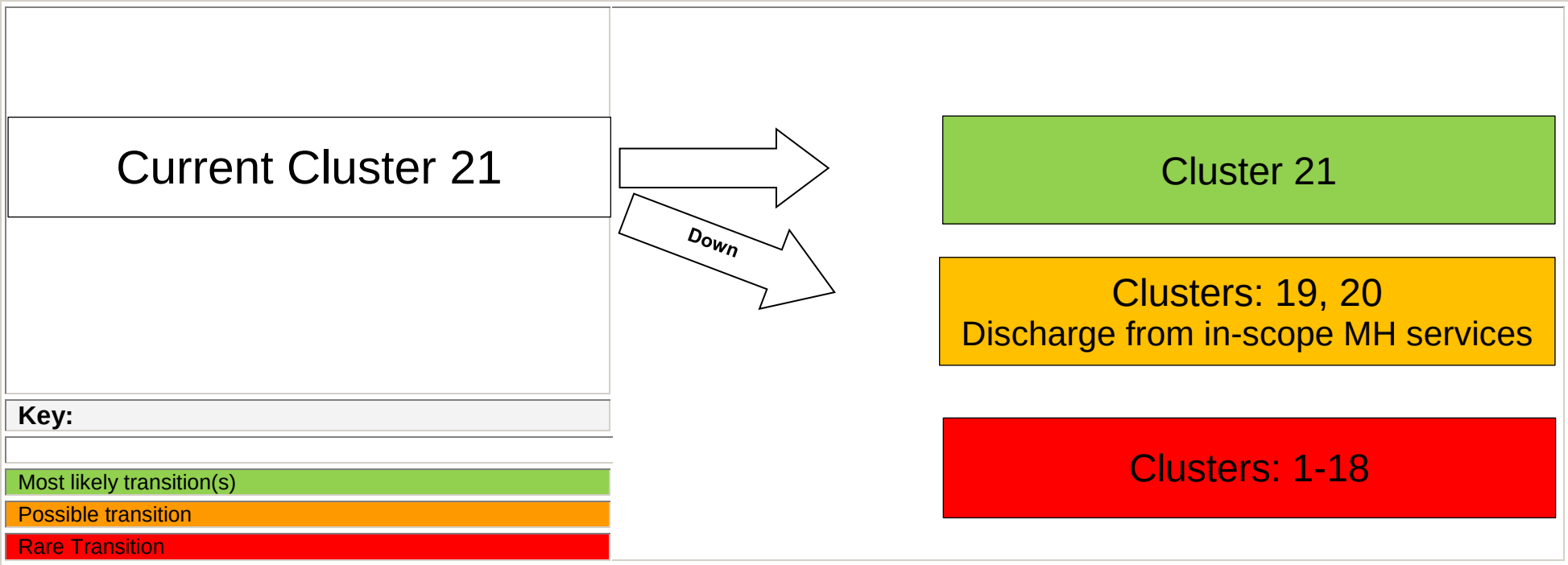
Must score		**Unlikely to score**	
Expected to score		**No data available**	
May score			

***Use the highest rating from Scales 7 & 8 when deciding if the rating fits the range indicated.**

CARE TRANSITION PROTOCOLS - Cluster 21: Cognitive impairment or Dementia (High physical or engagement needs)

Indicative episode of care: 3 years + **Cluster reviews at least every:** 6 months

Cluster	Step-up Criteria (The following criterion is met)	Example local discharge Criteria for MH services (All of the following criteria are met)	Step-down Criteria (All of the following criteria are met)
21	N/A	• No inpatient / home treatment packages for the last 12 months • Level of social inclusion meets Service Users and carers expectation • Any residual risks (including any comorbidities with the use of the Principles of Palliative Care Approach / Specialist Palliative care) can be managed by primary care with / without other partnerships • Has received at least 1 year of specialist Mental Health intervention	• Service User fits description and scoring profile of any likely/ possible 'step-down' cluster. • Improvement is likely to be sustained until the next planned review



Annex 4 - Practice Guidance Note regarding:
Allocation of patients with a bipolar diagnosis to a cluster

Summary
Following requests for additional guidance regarding the allocation of patients with a diagnosis of bipolar disorder to the nationally mandated needs-based clusters, the following statement has been produced.

All patients, including those with a diagnosis of bipolar disorder should be allocated to the cluster which best describes the combination and severity of their primary presenting needs. Patients with the same diagnosis can therefore be accurately allocated to different clusters within a superclass (non-psychotic, psychotic / organic). As a diagnosis of bipolar disorder covers a particularly wide variety of presentations these patients may be allocated to either a psychotic or a non-psychotic cluster depending on your clinical judgement, though consideration of the likely and unlikely diagnoses sections of the clustering booklet should be carefully considered.

See below for a fuller rationale.

Background

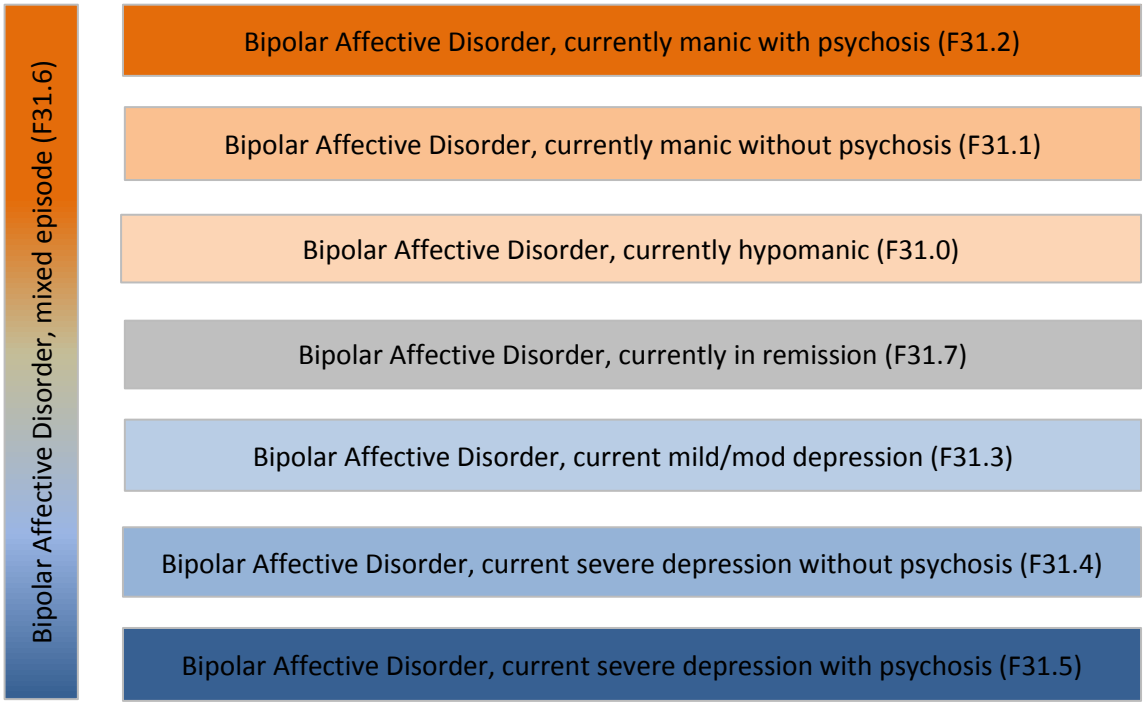
The 21 mandated clusters were originally designed to be a purely needs-led classification system. The concept of diagnosis was included retrospectively as diagnostic labels were a helpful way to succinctly describe super classes. Likely primary diagnoses were also included in order to assist medical staff to understand how the model aligned to their diagnostic classification system.

More recently 'unlikely primary diagnoses' were included primarily to help with retrospective audits of clustering accuracy. It should be noted that the low levels of diagnosis recording nationally meant that the lists of unlikely diagnoses by cluster were initially generated from a single provider organisation's data and then moderated by wider clinical opinion.

The cumulative effect of these developments has incrementally led to some stakeholders wanting to create a 1:1 relationship between cluster and diagnosis. This has become a particular issue for the diagnosis of Bipolar disorder where there is perhaps the most tension between a diagnostic approach and a needs-led classification system.

Bipolar diagnosis

It is well recognised that a single diagnoses can span a number of clusters depending on severity. In the case of bipolar affective disorder, the range of possible presentations makes this particularly likely (see below) as does the distinction between bipolar I and bipolar II (though the latter is yet to appear in ICD 10).



Current state

The clustering process has now been used nationally for some time and queries continue to be raised regarding patients diagnosed with bipolar disorder, and in particular those with the DSM-iv definition of Bipolar II.

Differing local guidance has been established and so, in addition to the wide range of presentations described above, there are an equally wide range of stakeholders and opinions. These range from those who continue to seek a 1:1 relationship between cluster and diagnosis through to those who would seek to completely dissociate the two approaches.

Our advice is that those with a diagnosis of bipolar disorder should be allocated to the cluster which best describes the combination and severity of their primary presenting needs. Patients with the same diagnosis can therefore be accurately allocated to different clusters within a superclass (non-psychotic, psychotic / organic). However, someone with bi-polar should not normally be assigned to clusters 1-4, as the indicative episode of care is likely to be at odds with the course of bi-polar disorder.

Current Generic Guidance

The current national guidance for allocation to cluster is:

Step 1: Based on the information you have gathered during your routine screening/assessment process, rate the individual's identified needs using the Mental Health Clustering Tool - Version 3.0 (Appendix 1).

Step 2: Use the Decision Tree (Appendix 2) to decide if the presenting needs are non-psychotic, psychotic or organic in origin. Then decide which of the next level of headings is most accurate. This will have narrowed down the list of clusters that are likely to describe the person's needs.

Step 3: Look at the rating grids (Appendix 3) to decide which one is the most appropriate by using the colour-coded key.

- Start with the Red ratings. These indicate the type and level of need which must be rated. If the ratings do not match, try another cluster.
- Next, consider the Orange ratings. These represent expected ratings. You may allocate a person to a cluster if the orange ratings do not exactly match the coloured grids. However, this reflects a "weaker fit" to that cluster.
- Finally review the Yellow ratings. These represent ratings that may occur. These scales have significantly less bearing on cluster allocation but may indicate the need for additional care plan interventions.

Remember, the final clustering decision is yours, based on your assessment results and your clinical judgement in applying this guidance.

Case vignettes

The following vignettes are intended to illustrate the application of this guidance:

Bipolar 1 vignette – psychosis pathway

'Harry'

Harry is a 39 year old, single man. He is the eldest of 9 siblings and was fostered from the age of 5 until he was 11, when he was returned to his family. Harry's natural mother was very strict and beat him with a leather belt for minor infractions of her rules. He is close to some of his siblings but no longer has any contact with either biological parent.

Harry had conduct problems at school. He left without any qualifications aged 15 and shortly afterwards he left home. Harry first presented to Mental Health services at the age of 19 and for many years he was admitted to hospital formally on average 2-3 times each year. For the past ten years the frequency of his admissions has decreased but he has a formal admission at least annually and he often requires PICU management. Harry has received

numerous, intensive psychological treatment packages without lasting impact. He is now managed on a community treatment order which enables his clinical team to intervene at an early stage when he relapses.
Harry lives alone in housing association accommodation and a housing support worker helps him to manage the tenancy. He has a poor history of retaining tenancies due to antisocial behaviour when unwell. Harry has a history of drug and alcohol misuse and a history of assault on family members, neighbours, girlfriends, other patients and members of staff. He has attempted suicide on several occasions.
When Harry is well he presents as a charming, engaging and gregarious man. His personal care is good and he often wears designer clothes. He is fully independent with ADL's and takes care of his tenancies but often gets into difficulty with neighbours due to noise nuisance. In the past he has been persuaded to spend his time constructively at day centres and educational / training centres.
When Harry relapses he poses a risk to himself and others. His relapse signature includes defaulting on his mood stabiliser and other medication, often shortly after leaving hospital, and then his mood drops. He then uses street drugs as 'pick me ups' and his mental state deteriorates rapidly. When he is unwell Harry generally presents in a manic state with pressured speech and flights of ideas. He is elated, grandiose and sexually disinhibited. Harry is thought disordered, hostile, agitated and aggressive when unwell. He experiences auditory hallucinations and has paranoid ideas. He denies thought insertion, withdrawal, broadcast or passivity phenomena. His diagnosis has been reviewed on many occasions but bipolar disorder is the most consistent and enduring diagnosis over the years. When Harry relapses he is very vulnerable and has been observed dancing in the traffic on a busy road and then sustaining cuts and bruises when a car collided with him.
Harry is managed on a psychosis care pathway and he is assigned to Care Cluster 16 reflecting his complex presentation, co-morbidities and MHCT scores at assessment. When Harry relapses he is assigned to Cluster 14 for the duration of the acute psychotic crisis before stepping back down to Cluster 16.

Bipolar 2 vignette – non-psychosis pathway
'Elaine'
Elaine is a 29 year old single woman who lives at home with her parents. She works as an accountant in the City of London. Her parents describe Elaine's pre-morbid personality as 'shy' and 'lacking self-confidence'. Elaine does not socialise very much but enjoys the company of a small network of friends and work colleagues. She has never misused drugs or alcohol.
Elaine first came into contact with secondary mental health services at the age of 23 when she was preparing to sit an accountancy exam. Her parents observed that Elaine was unusually cheerful for no apparent reason and was waking very early. She disturbed her parents by making coffee at five in the morning whilst singing along to the radio. When her parents complained that Elaine was disturbing their sleep she became irritable and verbally aggressive, which was quite out of character. During this period, lasting approximately two weeks, Elaine surprised her parents by returning home wearing garish, expensive clothes she had purchased in the West End.
Elaine's work colleagues also noted the change in her demeanour. She was unusually sociable, chatty and enthusiastic about everything. Elaine told them she was destined to succeed in life and was expecting a senior promotion and a substantial salary increase. Her colleagues played along, enthralled by her optimism and unusually witty conversation. Elaine's boss noticed she would spontaneously initiate intense conversations with staff she scarcely knew in adjoining offices and he also noticed a decline in the quality of her work.
One evening after work Elaine attended a leaving party for a colleague at a nearby hotel. As the evening developed Elaine's speech became louder, more pressured and incoherent. She embarrassed several elderly male colleagues by trying to seduce them in a loud, provocative and sexually disinhibited manner. The hotel receptionist called the police after Elaine proposed they have sex, and ignoring his polite refusal tried repeatedly to grope his genitals. Elaine came into hospital informally with the support of her parents. There followed a rapid, dramatic reversal of mood and Elaine became severely depressed and suicidal. Elaine experienced a similar hypomanic episode two years later at the age of 25 in the context of a relationship breakdown.

For the past four years there have been no further hypomanic episodes. Elaine continues to work as an accountant but with a different city firm which has positive policies regarding the employment of people with mental health problems. Elaine receives on-going psychological and medical support from her local community mental health team. Elaine sporadically experiences brief episodes when she feels intensely happy, highly energised and optimistic about the future but these episodes are interspersed with much longer periods of mild to moderate depression. She has no psychotic experiences and she complains that 'I never get high anymore'.

Elaine is now managed on a non-psychosis care pathway. She was assigned to Cluster 5 when severely depressed. Her Care Coordinator has now stepped down to a Cluster 7 care package reflecting Elaine's MHCT scores, the improvement in positive symptoms and the duration / chronicity of her presentation.