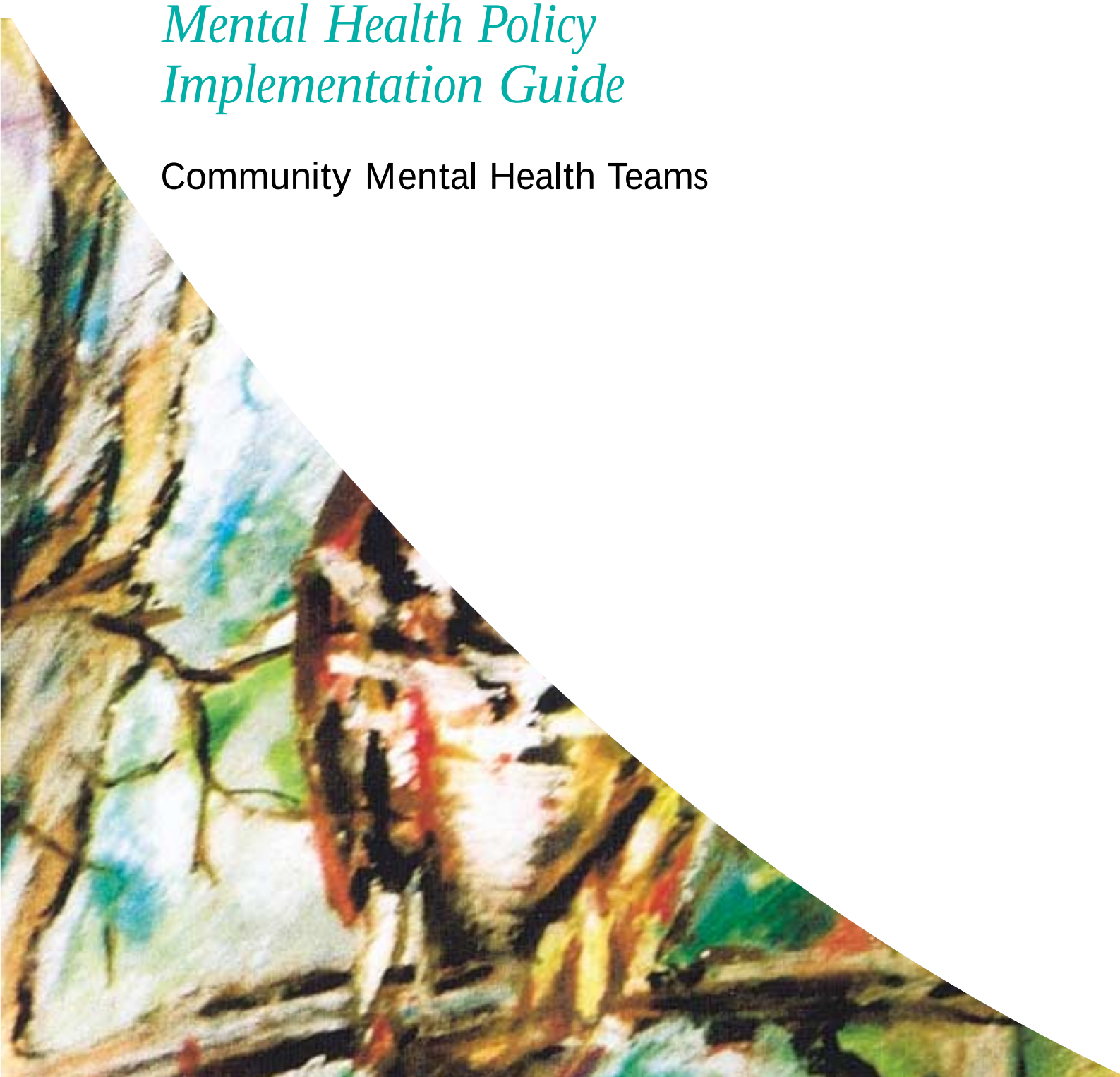
Department of Health

Mental Health Policy Implementation Guide

Community Mental Health Teams



Claire Harris, Nuneaton/Bedworth Mind

I love nature and wildlife, and paint with pastels when I can.

This artwork has been produced with the kind permission of Reflections.

Reflections is the publication supporting the promotion of 'Art Works in Health', a new project that aims to encourage creativity in people who have been affected by mental illness and to promote understanding. The project will lead to a number of art exhibitions throughout the country, which will include examples of painting, drawing, photography, writing, sculpture, pottery and ceramics.

Art Works in Health is sponsored by Pfizer Ltd and collaborating organisations involved are Breakthrough, Coventry Healthcare NHS Trust, Depression Alliance, National Schizophrenia Fellowship, The Northern Centre for Mental Health, South London and Maudsley NHS Trust, PriMHE (Primary care Mental Health Education) and Priory Healthcare Wearside.

Contents

Introduction

When the Mental Health Implementation Guide was launched in March 2001, it declared: "Community Mental Health Teams , in some places known as Primary Care Liaison Teams, will continue to be the mainstay of the system. CMHTs have an important, indeed integral role to play in supporting service users and families in community settings. They should provide the core round which newer service elements are developed."

Sections of the Guide issued at that time included model service specifications for these newer service elements- early intervention, crisis resolution/home treatment and assertive outreach teams.

Many colleagues involved in implementing service change in mental health have asked for similar guidance on CMHTs as they evolve within a whole system which includes functionalised teams. This document aims to respond to those requests.

We know that the level of development of CMHTs varies markedly around the country, as does the level of development of the newer functional teams.

The emphasis in this document is on identifying the *functions* which a CMHT in such a whole system will need to perform rather than on specifying the precise *structure*: local flexibility and close working relationships between all key stakeholders will enable the best arrangements to be developed in each locality.

1. Who is the Service For?

Adults of working age with the full range of mental health problems: age limits to be determined in line with locally agreed protocols for transitions from adolescent to adult and adult to older adult services.

The CMHT performs functions for two groups of people:

1. Most patients treated by the CMHT will have time limited disorders and be referred back to their GPs after a period of weeks or months (an average of 5–6 contacts (Burns et al 1993)) when their condition has improved.

2. A substantial minority, however, will remain with the team for ongoing treatment, care and monitoring for periods of several years. They will include people needing ongoing specialist care for:

    i. Severe and persistent mental disorders associated with significant disability, predominantly psychoses such as schizophrenia and bipolar disorder.

    ii. Longer term disorders of lesser severity but which are characterised by poor treatment adherence requiring proactive follow up.

    iii. Any disorder where there is significant risk of self harm or harm to others (e.g. acute depression) or where the level of support required exceeds that which a primary care team could offer (e.g. chronic anorexia nervosa).

    iv. Disorders requiring skilled or intensive treatments (e.g. CBT, vocational rehabilitation, medication maintenance requiring blood tests) not available in primary care.

    v. Complex problems of management and engagement such as presented by patients requiring interventions under the Mental Health Act (1983), except where these have been accepted by an assertive outreach team.

    vi. Severe disorders of personality where these can be shown to benefit by continued contact and support except where these have been accepted by an assertive outreach team or a specialised personality disorder team where there is one.

2. What is the Service Intended to Achieve?

Most mental health problems are dealt with within Primary Care (Goldberg & Huxley 1992) with less than a fifth of those identified as having such a problem referred on for secondary opinions and treatment.

Three distinct functions are required:

i. Giving advice on the management of mental health problems by other professionals – in particular advice to primary care and a triage function enabling appropriate referral.

ii. Providing treatment and care for those with time-limited disorders who can benefit from specialist interventions.

iii. Providing treatment and care for those with more complex and enduring needs.

In some areas, these functions are provided by separate teams (e.g. a Primary Care Liaison Team providing (i) and (ii) , and a Rehabilitation and Recovery team providing (iii)) In other areas, the CMHT performs all three functions, sometimes by designating sub-teams within the CMHT. The best structure is a matter for local discretion, but clear pathways to care should be described by locally agreed protocols.

Whatever structure is adopted, using an integrated multidisciplinary approach, with adequate outreach, the "CMHT function" can:

- Increase capacity within primary care through collaboration.
- Reduce the stigma associated with mental health care.
- Ensure that care is delivered in the least restrictive and disruptive manner possible.
- Stabilise social functioning and protect community tenure.

The CMHT should be able to:

- Provide support and advice to primary care services to support them in:
  - Providing joint educational facilities for all members of the primary health care team.
  - Ensuring that regular clinical meetings occur between the PHCT and the CMHT to discuss and share the management of patients.
  - Ensuring that there are shared clinical governance topics between the Practice Development Plan of the PHCT and the clinical governance framework of the CMHT.
- Establish effective liaison with local Primary Care Team members and other referring agents to shape referrals and support local care.
- Provide prompt and expert assessment of mental health problems.
- Provide effective, evidence based treatments to reduce and shorten distress and suffering.
- Ensure that inappropriate or unnecessary treatments are avoided.

- Establish a detailed understanding of all local resources relevant to support of individuals with mental health problems and promote effective interagency working.
- Assist patients and carers in accessing such support, both to reduce distress but also to maximise personal development and fulfilment.
- Provide advice and support to service users, families and carers.
- Gain a detailed understanding of the local population, its mental health needs and priorities, and provide a service that is sensitive to this, and religious and gender needs.
- Provide a culturally competent service, including ready access to interpreter services for minority languages and British Sign Language.

3. What does the Service Do?

CMHTs have a number of key components. Each must be in place if the service is to operate effectively.

Key Component	Key Elements	Comments
WORKING WITH PRIMARY CARE	• Pre-referral discussion through regular attendance of link workers at the surgery	• Helps to ensure appropriateness of referrals and support GP in identifying possible alternatives
	• Triage should take place at the surgery whenever possible	• This enables a much more informed post-triage team discussion and allocation
	• All referrals should be to a single point of entry	• Even if referrals are targeted to an individual team member they should go through the same process to ensure appropriateness and good management
ASSESSMENT	• Everyone who is referred should usually be assessed	• Not possible to limit assessments to severely mentally ill – GP skills vary and advice on the management of common disorders and also confirmation that people are not suffering from psychiatric disorder is part of the service
		• If medical staff still conduct outpatient clinics, the relationship between this clinic and the CMHT needs to be clear. Duplicate notes should be avoided
	• Same day crisis response assessment should be available via the team, but will normally be provided by the crisis resolution/home treatment team	• Local arrangements with crisis resolution teams need to be clear and mutually agreed
	• Routine assessments should be prompt	• 4 weeks maximum. but working towards 1 week

Key Component	Key Elements	Comments
	• Most assessments of those with severe mental illness should involve trained medical staff	• Consultant, SpR or staff grade doctor in >70% of medical assessments
	• Those with common mental health problems may more appropriately be assessed by other team members	• Whenever possible, people should have a choice about where they are seen e.g. at GP surgery, at home
	• MHA assessments should be conducted by appropriate members of the CMHT during working hours	
	• The outcome of the assessment should be communicated to patient and referrer promptly	• The user should usually be involved in the assessment so that by the end they already have an understanding of the situation • Letters should be sent within a week to user and GP. For crisis assessments phone contact is indicated

SOCIAL SERVICES ASSESSMENTS	• Social work assessment takes place within the framework of the Care Programme Approach, which is Care Management for those of working age in contact with specialist mental health and social services	• It is essential to work towards an integrated approach across health and social care. There should be:
		  • A single point of referral
		  • A unified health and social care assessment process
		  • Co-ordination of the respective roles and responsibilities of each agency in the system
		  • Access, through a single process, to the support and resources of both health and social care

TEAM APPROACH	• Each user to be assigned a care co-ordinator with overall CPA responsibility for ensuring appropriate assessment, care and review by themselves and others in the team	• CPA should be consistently applied in line with joint Trust/Social Services policies and procedures, which must reflect *Effective Care Co-ordination in Mental Health Services*

Key Component	Key Elements	Comments
	• Assessments and reviews to be routinely discussed by the whole team in a time-tabled weekly meeting	• Allows for appropriate allocation of care co-ordinator reflecting skills and training. Does not rely on individual members to flag up problems but provides peer review and support
	• Case loads managed within the team to ensure effective use of resources	
	• Cross cover is within the team rather than necessarily being profession specific. Continuity of care provided by the team	• Spreads and exploits common knowledge about users. Improves peer review
	• Trainees (e.g. SHOs, nursing students) should not pass longer-term service users between them	• Trainees have a significant contribution to make, but transfer should involve a qualified member of staff
	• Clear clinical and managerial leadership should be established which crosses all the disciplines	• Should reflect Trust Clinical Governance and SSD accountability arrangements with an identified clinical team leader
REGULAR REVIEW	• Weekly team meetings should include the consultant psychiatrist where actions are agreed and changes in treatment discussed by the whole team	
	• Progress and outcomes regularly monitored	• This should include users and carers where possible • Appropriate structured assessments should be used to monitor progress • Risk assessment should be a routine, recorded component
	• Care plans for those with severe mental illness should be formally reviewed and up dated at a frequency determined by need: this should be regarded as an ongoing process, which can be initiated by any member of the care team or the user or carer	• The requirement for a nationally determined review period has been removed, but annual audit should ensure that reviews are carried out

Key Component	Key Elements	Comments
	• Regular reviews should be held with the PHCT at the surgery	• This is a vital and effective way of both supporting PHCT and ensuring that effective communication occurs between primary and secondary care
Note Keeping	• Records should be kept of all contacts with the user and with significant others in relation to the care that the patient receives	• It can also be useful to have protocols for the exchange of relevant information between agencies, especially in relation to the Children Act, the Crime and Disorder Act and mental health legislation
	• There should be a single written record for each service user	
	• Electronic records, where developed should conform with the Mental Health Minimum Data Set	• CMHTs should ensure that ICD-10 codes used are mapped to Read codes used by primary care so that there is the potential for future transfer of electronic health records
INTERVENTIONS – The following interventions should be provided:		
(a) Primarily, but not exclusively, for those with short-term needs		
Psychological Therapies	• Psychological therapies should be routinely considered as an option when assessing mental health problems	• The main treatment approaches are listed in the evidence-based guideline 'Treatment choice in psychological therapies and counselling' (DH 2001)
	• A range of techniques both for reducing the severity of symptoms and for increasing resilience to cope with the illness should be made available to all who might benefit from them. These include CBT, stress management, brief counselling	• This provision does not need to be restricted to clinical psychologists. Post graduate training is available in many of these techniques and staff should be encouraged and supported to obtain these skills
	• Provision of psychological therapies in CMHTs will be determined by: 1. Patient needs 2. Staff training and expertise 3. Resources available in other parts of the service	• Careful consideration of capacity and the use of the guidelines is essential to avoid inappropriate referral, delay, multiple assessments and false starts

Key Component	Key Elements	Comments
	• Most CMHTs should be able to provide Type A and B psychological treatments	• Psychological treatments have been described (NHSE reviews) as follows: • Type A: psychological treatment as an integral component of mental health care: includes social skills training, anxiety management, family therapy, but not stand-alone treatments • Type B: eclectic psychological therapy and counselling: a series of sessions following a formulation of the problem. Can be informed by more than one theoretical framework • CMHTs would not be expected to provide Type C: formal psychotherapy i.e. Psychotherapy practised within a particular theoretical model, but should be able to facilitate access when required
	• An early priority is the establishment of referral arrangements between those responsible for psychological therapies	• Such cross-agency arrangements will also be helpful in support of supervision, education, training and staff development
(b) Primarily, but not exclusively, for those with severe and enduring illness		
Physical health care	• Every patient in the care of the CMHT should be registered with a GP	• Though not always possible, strenuous efforts should be made to achieve this
	• Service users should be actively encouraged and supported in accessing primary health care and health improvement	• This may sometimes involve providing help in keeping appointments etc. Severe mental illness is associated with significantly poorer physical health status
	• Physical health problems should be identified and discussed with GP. Where users will not attend their GP the team may take on some limited responsibility where there is clinical competence, and in collaboration with the GP	• Mortality in people with SMI is greater from physical ill health than from suicide – therefore managing the physical health problems should remain a priority – and be a further reason to link effectively with primary care

Key Component	Key Elements	Comments
Continuity of care	• The care co-ordinator takes responsibility for ensuring continuity of care using home visits, repeat appointments etc	• Clear written instructions on how to contact team members responsible for aspects of the care are made available to all who need them
	• Clear instructions are provided for contact out of hours and who to contact when the care co-ordinator is away	• This will include details about contact with the PHCT if appropriate
	• Contact frequency will vary over time according to need and care co-ordinators require flexibility	• Capacity to increase visits during engagement and crises needs to be protected within care co-ordinator's schedule • This flexible capacity is also needed to cover sickness and joint visiting
	• Contact should be maintained by the care co-ordinator while the patient is admitted	• Standards for 'inreach' may need to be formalised within teams
	• Contact and communication should be maintained with primary care, so that the GP is informed of significant changes in mental health, medication etc, whilst remaining in the care of the CMHT	• This becomes much easier in services operating a more integrated Primary Care Liaison approach
Medication	• The team should be responsible for prescribing, administering and monitoring medication as indicated by clinical need, with blood tests as necessary to monitor therapeutic levels or side effects • Close and effective links needed with Primary care where they prescribe or administer	• Depot antipsychotic administration should be available at the user's home or agreed place • Regular supervision and monitoring of oral medicines should be available, including brief periods of directly observed medication
	• Strategies to improve concordance with medication regime must be in place	• These include dosette boxes, full explanation and negotiation of drug choice, concordance therapy etc
	• Structured side-effect monitoring should be used routinely	

Key Component	Key Elements	Comments
Basics of daily living	• For those with severe and enduring illness, the care plan should include areas of particular vulnerability and identify strategies to address them • Direct practical help should be provided with a range of basic needs such as obtaining benefits, budgeting, shopping etc • This will often involve mental health support workers but may also be a legitimate activity for a trained professional	• Assertive advocacy with other agencies (e.g. landlords, employers) on behalf of the service user is part of a CMHT's remit • Different service users will benefit from direct support or training in these activities • Team members should be able to assess when it is better to 'do for', 'do with' or teach a skill • Respect for users' independence needs to be balanced against risk of demoralisation from repeated failure
Help in accessing local opportunities in work and education	• Users should be encouraged to seek occupation where possible • The team should keep a resource file of local provision and opportunities • Practical help such as with filling in application forms, accompanying to interviews etc, should be provided	• Educational opportunities can both provide useful extra skills and structure the day
Support	• Time to provide emotional support to user and carer needs to be given adequate priority	• Living with a severe mental illness can be demanding and demoralising. Without attention to this, collaboration in specific treatments is likely to be compromised
Family and carer support & help	• Carers should have their needs assessed formally at least once a year if they so wish • Families and carers should be involved in the CPA as much as possible • Assessment on a routine basis of the overall well-being of dependent children whose needs may be compromised by parental illness. Involvement of the appropriate children and families team if indicated • Where dependent children act as carers their own needs require regular and careful attention	• This is independent of the service user's wishes. Practical help should be available e.g. respite • Not all users will accept involvement of their families and tact is needed • Adult CMHT staff are not trained in assessing parenting ability but can recognise when a patient's illness or problems pose a significant burden or risk for a child. They should try and meet with dependent family members and, if concerned, discuss it with the user. The child's needs must take priority

Key Component	Key Elements	Comments
	• Education and information about the illness and treatment need to be provided and repeated • Behavioural Family Therapy should be available for some families	
Treatment of substance abuse	• All team members should conduct assessments of alcohol and drug abuse	• Sometimes teams identify an individual with special interest. Alcohol and drug use complicate a significant proportion of presentations to CMHTs
	• The team should be able to offer advice about seeking alternative help or, where this is not accepted or possible, deliver basic harm minimisation interventions and motivational interviewing	• Links with drug and alcohol services need to be clear and well supported • Where an individual is referred to another team, the GP must be informed (to prevent the individual falling between two services) • Staff should obtain training in substance abuse management • Clarity about CPA responsibility must be explicit • People with a psychotic illness are best cared for by one team that can provide both inputs rather than divided care
Relapse prevention	• Individualised relapse plans should be agreed with all involved (CMHT, ward, GP, carer etc) and kept on file • Efforts should be made to identify and reduce stressors which precipitate relapses	• Some users have highly specific "relapse signatures" and these should be part of the care plan

Key Component	Key Elements	Comments
LIAISON WITH OTHER PARTS OF THE HEALTH SYSTEM		
Inpatient Care	• Patients considered to need admission should be referred to the crisis resolution/home treatment team	• Many potential inpatient admissions may be avoided by the timely provision of home treatment or care in a crisis/respite house • Local inpatient units are an essential part of a whole system and admission should not be seen as a CMHT failure
	• CMHT staff should continue contact with the patient (see continuity) and be involved with the inpatient or home treatment team in regular reviews and treatment planning	
Discharge	• CMHT and PHCT staff should be fully involved in discharge planning • Crisis resolution and home treatment teams, where relevant, need also to be involved in discharge planning	• Prior to discharge all involved agencies need to be consulted and kept up to date • Care plans and crisis plans should be reviewed
	• All patients should have a first follow-up within a week of discharge from inpatient care	• Confidential enquiry into homicides and suicides identifies this as the high risk period and confirms that predicting high risk patients is not safe • Local arrangements to monitor and support this are required
Liaison with Primary Health Care Teams	• Regular face to face liaison between the CMHT and its PHCTs should take place at agreed intervals • This should involve discussion of joint patients and problems • This can also include those patients who are managed entirely in primary care and not known to secondary services (up to 30% of people with a SMI)	• Time tabled meetings (not around emergencies) means that greater understanding can evolve about mutual strengths and weaknesses • Liaison strategies may vary depending on locally agreed arrangements

Key Component	Key Elements	Comments
	• Defining the population served on PHCT lists strengthens joint working • aim for each PHCT relating to one CMHT	• Co-terminosity with local social services needs to be carefully considered, especially in densely populated areas of high morbidity • In most cases practice alignment should take priority over SSD alignment when a choice has to be made
	• A limited number of joint protocols can be agreed for managing common conditions	• Such protocols are simply guidelines to good practice and should never be used to deny assessment
Liaison with other bodies	• CMHTs should be singly managed teams including both health and social care • Social workers in the team should be co-located to the same office and use the same notes • There is still a need to ensure regular structured liaison with other Local Authority services (e.g. housing department, child protection) and voluntary bodies (especially those providing residential care)	• Teams need to make realistic judgements about how much time can be deployed on liaison. They need to protect direct patient care time but not neglect vital interagency working, including work with agencies not specific to mental health which can help promote social inclusion
DISCHARGE AND TRANSFER ARRANGEMENTS		
Discharge from CMHT care	• Patients should be discharged back to primary care promptly when they are recovered. This is essential to protect capacity for new referrals	
	• Discharge letters need to be comprehensive and indicate current treatment and procedures for re-referral • For patients with complicated care needs discussion at the liaison meeting is indicated before discharge	• Relapse signatures and risk assessment/management information should be provided where available

Key Component	Key Elements	Comments
Routine transfer	• Transfer of patients to another CMHT should involve a joint CPA meeting for handover	
	• Disengagement should not occur before the new team has established a relationship	• It is the duty of the team where the service user is now living to ensure that this is not delayed
	• Local procedures for out of area transfers should be mutually agreed and carefully documented	
	• This should also include appropriate primary care transfer of responsibility	
Emergency transfer	• Patients should not be transferred in crisis but where this is inevitable the CMHT will make direct contact with the receiving area and ensure safe transfer	

Liaison and Links with Other Teams (Crisis Resolution/Home Treatment, Assertive Outreach, Early Intervention teams)

CMHTs will increasingly have close working relationships with a range of specialised community mental health teams. A number of these are described in this policy implementation guide. It is not possible to give prescriptive guidance on these relationships. However, mutually agreed and documented responsibilities, liaison procedures and in particular transfer procedures need to be in place when crisis resolutions/home treatment teams, assertive outreach teams and early intervention teams are being established. These arrangements will need to be subject to regular review and revision. Currently in many services the CMHT is the common gateway to these teams (other than the early intervention team where access may be direct.)

Close working with drug and alcohol services will be needed for users with a dual diagnosis, though **people with a severe mental illness and co-morbid substance misuse should receive care from mainstream services**. Reference should be made to the new section of the Mental Health Policy Implementation Guide concerning good practice in dual diagnosis. (DH 2002).

4. Management of Service and Operational Procedures

Model of Service Delivery

CMHTs function best as discrete specialised teams comprising health and social care staff under single management, which have:

- Staff members whose sole (or main) responsibility is working within that team.
- An adequate skill mix within the team to provide all the interventions listed above.
- Strong links with other mental health services and good general knowledge of local resources.
- Clear and explicit responsibility for a local population and links to specified GPs.
- Integrated health and social care staff using one set of notes and clear overall clinical and managerial leadership.
- Fully integrated consultant staff.

Caseload

The following guidance for caseload sizes and team constitution are calculated on a model of a single team for a defined population.

- Each team to have a maximum caseload between 300–350 patients but may be considerably less. Otherwise information exchange becomes unwieldy eroding clinical capacity.
- Full time care co-ordinators to have a *maximum* caseload of 35 and part time staff to have their caseload reduced pro-rata.

However, these figures clearly require modification in the light of such factors as:

- Complexity of need.
- Local demography.
- The stage of development of other functional teams.

For Enhanced CPA, care co-ordinators include:	Not usually to be classified as care co-ordinators for enhanced CPA:
• CPN	• Medical staff *
• ASW	• Support workers
• OT	• Students
• Clinical psychologist	*In some teams medical staff may be care co-ordinators for patients on enhanced CPA, but this needs careful local consideration
• Team leader (team manager)	

Those on standard CPA might have a care co-ordinator from any discipline

The population served by a CMHT may vary between 10,000 and 60,000 depending on local levels of morbidity and travelling distances required. The teams will relate to GP registration lists and to local authority boundaries, with practice alignment taking preference over Social Services alignment when a choice has to be made.

Staffing

A CMHT requires the skills of nursing, social work, psychology and medicine. Different team structures agreed locally will require different staffing structures and there can be a degree of flexibility: for example, the proportions of social workers and CPNs may vary depending on staff availability; some have a higher proportion of support workers to qualified staff. As new types of workers e.g. Support, Time and Recovery workers come on stream, staff complements may vary again. There is no evidence to justify being too prescriptive. However, the team should reflect the ethnic range of the local population, and service users should be involved in staff selection.

As a guide to the likely level of resource required, the table below gives details by way of an example, of levels and skill mix for a team with a case load of 350 patients, over half of whom have severe long-term disorders. In this example, the 8 wte Care Co-ordinators will have up to 280 of the patients on their case loads while the remainder, assumed to be on Standard CPA, may be seeing only the medical members of the team.

• 8 wte Care Co-ordinators each with a maximum caseload of 35. (The team leader would be drawn from one of the above and might carry a personal caseload equivalent to 30-50%, depending on managerial load: some teams find F/T management essential)	• In addition to co-ordinating the care of their 35 patients these staff need the following key skills: • Ability to communicate clearly and effectively across the team • Ability to maintain clear and accurate multidisciplinary notes • Willing and able to cross cover between disciplines and role-blur within the limits of their skills • Broad understanding of the needs of the team's patients, including their range of disorders and cultural backgrounds
• Of these: • 3-4 CPNs • 2-3 social workers including ASWs • 1-1.5 OTs • 1-1.5 clinical psychologists	• ASWs need to maintain strong links with social services as well as being fully integrated team members • Psychology and OT staff make significant contributions but are not always available. In this case, sessions may have to be bought in. Where this happens (and where there is only one member of a discipline in a team) adequate professional support and supervision must be provided. Skills training of other disciplines can be pursued to provide traditional psychology and OT inputs • Psychologists often work both within and without CMHTs. In such cases there is a need for clarity about commitment and CPA responsibility
• 1 wte consultant • 1.0–1.5 wte non consultant medical staff configuration to depend on local circumstances (e.g. SHO manpower etc)	• Medical staff fully integrated in the team and able to act as care co-ordinators for some people on standard CPA.
• 1-3 mental health support workers	• People with health or social care or appropriate life experience or with personal experience of mental health problems/treatment • Where possible support workers should reflect the population served • Number will be determined by team and local availability

Programme support • 1 –1.5 wte administrative assistant/secretary (in addition to reception staff) • IT and audit support from central resources to comply with clinical governance	Adequate administrative support is essential if a CMHT is to deal with the high clinical turn over and its associated paper work

Hours of Operation

- Working hours are generally from 9 – 5 week days with flexible out of hours working for specific tasks (e.g. evening work for a relative support group). Some teams work with moderately extended hours e.g. 8a.m. –7p.m. , embracing G.P. surgery times, and this is to be strongly recommended for improved primary care liaison.
- No crisis provision is made out of hours by the CMHT and patients and carers would access the local emergency services (crisis resolution teams, help lines, A&E etc).

Referrals

- CMHTs are secondary services and accept referrals for assessment from GPs, primary care team members, social services and all other components of the mental health services (e.g. CAMHS, Forensic services, psychology, other specialised mental health teams).

Links should be established with local police and voluntary agencies so that exceptional direct referrals can be facilitated

Risk Assessment and Policy on Violence

- CMHTs should have a written policy outlining procedures for managing different levels of risk (e.g. joint visiting).
- The operational policy should explicitly address issues of staff safety including a statement of zero tolerance for racial or physical abuse. This should ensure adequate assessment to ensure that treatment is not withdrawn inappropriately e.g. when abusive behaviour is a manifestation of psychotic illness.

Staff Training

CMHTs must see that their training needs are given appropriate priority within the joint training plan. Induction periods are needed for new staff (even if they have come from another CMHT) and should include a primary care placement.

Users and carers should be involved in the delivery of staff training, which should include:

- Skills in delivering the interventions listed above.
- Team building, team working and peer support.
- Principles of the service including gender and anti-racist training.

- Medication management – including local policies on administration, storage, legal issues, concordance training and assessment of side effects.
- Use of the Mental Health Act and alternatives to hospitalisation.
- Engaging and interacting with other services – both within the mental health trust (or PCT where it provides the service) and with other agencies such as primary care, or the police and probation services.
- Suicide awareness and prevention techniques and approaches.

Information for People Who Use the Services

All patients and their family and carers should be provided with information on the services both in printed form and also as part of individualised engagement. This should include:

- Description of the service, the range of interventions provided and what to expect.
- Name and contact number and details of the care co-ordinator and other relevant members of the team.
- Contact details for out of hours advice and help.
- Care plan.
- Specific information about their disorder and any drug being used, including side-effects.
- Relapse plan and crisis plan.
- Contingency plans.
- Information on how to express their views on the service and make complaints.
- Information about patient/user forums and PALS.

Continual Service Improvement

Regular audit of the service should be undertaken to ensure that gaps in service provision are filled and that targets are met and incrementally improved. Audit should often involve feedback from service users and carers.

5. Further Reading

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