
**PDU Workforce Development Learning Series Webinar-**

*An Overview of the Journey through the Local Mental Health Teams (LMHT'S): From Referral through to Treatment*

(Tuesday 24th June 2025)

The session was facilitated by Sarah Pitts, Transformation Programme Manager and Natasha Cain, Community Rehab Team Leader from Nottinghamshire Healthcare NHS Foundation Trust.

The webinar gave a basic overview of what services sit under Secondary Adult Mental Health. With a greater focus on the Local Mental Health services (LMHTs), the session provided an overview of the journey through the LMHT from referral through to treatment.

**Below is a summary of the questions asked during the Q&A session, with the answers that were provided by our guest speakers.**

**Q&A**

**Can patients ask to be referred to their Local Mental Health Team?**

If they want to, obviously the GP would discuss that with them first and actually assess what the needs would be and whether there is anything they could do first within primary care before going to secondary service. We don't currently have a self-referral option in the LMHT's at the moment. That may be changing in the future, but as it stands it is usually done through a referral basis, but obviously they can go to their GP to discuss with them.

**What is the average time scale from referral to initial assessment and then to receiving treatment (important when managing Deaf clients' expectations or explaining delays)?**

This will depend on the LMHT because we obviously have 11 and they have different waits for assessments and I don't know what the current wait times are for those across the LMHT's to be able to say but equally time frames for assessments can depend on urgency as well so if a referral was in and someone is felt to be quite complex and needs to be seen sooner it might be that we try and get them in a bit sooner than someone else that would be screened as being able to wait for a routine assessment as well but I would say on average they are probably waiting at least four weeks for an initial assessment within the LMHT's.

**Once a GP referral has been done, how long would you contact the client, we have clients who don't know where they are in the system and haven't heard anything for several months?**

Usually there should be a decision made within a week of the referral going in but the LMHT's have different timeframes at the moment depending on what's going on in the team in terms of vacancies and it might be that they have had a high number of referrals as well that can affect that, but nobody should be left not knowing what the outcome of their referral is. My recommendation would be that if anybody is waiting and doesn't know what is happening and they've not heard anything then what they should do is call their mental health team to get an update.

**Is counselling available as an option when someone is under the LMHT?**

We have psychologists within the LMHT they are a small resource so there can sometimes be a wait for that, but they'll have that as part of the wider local mental health intervention as well we also have psychological therapy services within the Trust that do more specialist therapy, so they are the next step up from talking therapies, step 4 onwards. The LMHT's can refer into the psychological therapy services as well if that is needed for the person.

**If someone goes to their GP first, what would make them suitable or unsuitable for LMHT support?**

That would be based on the level of complexity and the impact on their functioning really. We would expect for people to be more moderate to severe level in terms of their mental health so some people would go and try things in primary care first. We would

hope there are two ways to look at a referral, either that it be stepped care approach so someone might have tried interventions within primary care first that might include psychological, talking therapies, it might include prescribing by the GP, it could be that we have different VCSE options now for example wellness in mind where they might have tried but despite those interventions their mental health isn't getting any better and still getting worse. For those that do have a PCM practitioner, they might also see them as well and do some work with them but once it gets to a point when someone's mental health is becoming a lot more impacted and having a huge increase in their level of functioning and probably increasing their risk to themselves potentially others, there's probably neglect there, it might be that they are not able to go to work, they might have had a job and been off sick for quite a while. In terms of functioning at that point we would kind of expect that they might want to refer to LMHT's. When I talk about matched care it might be that somebody's never had any of those things and presented to their GP at already quite a severe point, we would expect them to refer into the LMHT's. For someone that is experiencing psychosis or something like bipolar disorder and they are having a relapse again we would expect them to be referred into their LMHT's quite quickly. There isn't anything with primary care that we would ask them or services. It might be that the GP could do a little bit with medication with them, but actually with psychosis or bipolar someone would potentially need quite early intervention due to the nature of their conditions.

**Can a housing provider make a direct referral to the inbox?**

No, not at the moment, it would be expected to go through what we would call trusted referrers at the moment in terms of a health professional, so as it stands it would need to go through a GP. The Homelessness Mental Health Team does not have a GP referral pathway so anyone can refer into that if the person is homeless.

**Are there safety mechanisms for patients that have been with the LMHT and then discharged due to improved mental health?**

When someone has been discharged from the LMHT due to improved mental health they should have had a discharge care plan done with them in terms of thinking about what to do if they are concerned about their mental health. Once they're back in primary care there should be a plan in terms of where they will be getting their medication from if they are on medication, who is going to support them and when to refer back in. We are doing a lot of work around safety planning and improving that.

**Can you access the Recovery College if you are being supported by primary care?**

No, not currently. The Recovery College is very much linked to people who are open to secondary mental health. It isn't run by clinicians so they would require a bit of that LMHT wrap around support until they have started on the course and once, they are established they don't need to stay open to the LMHT.

**Can concerns regarding individuals who are waiting for allocation for practitioners be discussed with Duty at the relevant LMHT?**

The LMHT's do have a Duty Service. My advice would be though to ring the LMHT and share why you are calling and then the LMHT will determine who best would be needed to take the call.

**Is it automatic that once a patient has agreed to the LMHT to make contact with other services involved this happens?**

With consent the team can liaise with those other agencies. There may be scenarios if there are concerns or risks that might be different. But yes, that should be done collaboratively working together really.

I think it is one of those things isn't it that you know that person may have another person working with them recorded somewhere and it might get missed, these things happen don't they. So, I think when you say does it automatically happen, it should do but maybe it sometimes doesn't, and you know that is important for joint working to happen. If that's the case, I'd definitely be contacting the LMHT and making sure they are linking in with you.

**What about a patient who goes out of area as a child in an inpatient setting, they become an adult and eventually come back to the LMHT in preparation for discharge to supported living. This closes over several areas, i.e. transition, rehabilitation, peer support and more. How can we make sure these are always joined up?**

That's a good question and sometimes hard and not always done well but obviously the key is communication and making sure that agencies or people involved are linked up and working together. I think it is really important to make sure that the patient and their family are at the centre of that. I think that is a good question as it hasn't always happened well in the past and lots of factors can affect that but there's lots of work going on and ongoing work in terms of how we can improve pathways. Encouraging multi agency meetings just to make sure we have those discussions. It is important at the point of discharge that the MDT meetings happen to plan the discharge and who is

going to be involved and making sure that everybody around the table to join those things up.

**How do LMHT's navigate individuals who have moved from another location into Nottinghamshire NHS Trust or individuals who may have temporarily moved outside Nottinghamshire?**

It would be up to their care provider to arrange a transfer of care so that we can add them to the waiting lists and do assessments and communicate about that patient and moving outside of Nottinghamshire. It is all on an individual basis. We've have arranged for other teams to do someone's depot for example or administer or provide medication. I've known quite a number of times when people have moved into our area and gone to their GP first and said that they have got a mental health history and triggered a referral into our services at which point we will try and make contact with that other provider and information share so we can join those up. We do have a lot of experience of that as well especially where we have student populations where people are coming and moving into area temporarily and maybe straddle between their GP at university and when they go back home.

I know that the SMD client group, I am not a practitioner or anything like that but I've seen it when if somebody does need to move to a different Local Mental Health Team a transfer of care will be done but they might have to wait a little bit until that new mental health team has space but they are then open to their current one until that transfer has happened.

The other thing I didn't realise is if you come completely out of your area that we can't see that person's records, we can only see records for Nottinghamshire. We have to go to the other Trust to where that person's records were held and ask for that information.

**Can the LMHT share care plans with supported housing providers? Also is the LMHT linked to the supported living team?**

In terms of the care plan element of the question, we certainly can share with supported housing providers, we would obviously do this in conjunction with the patients consent.

It will be about trying to work together really in terms of supporting someone and it'll be really important that supported housing providers are involved in the care as they are with the person most of the time, but it is tricky when somebody isn't consenting and it's I suppose how we can share what we can and make that clear.

We work closely with the supported living team.

**Are there any provision for people who don't speak English? Some of my clients struggle to know where they stand or where they are on the waiting list they need some hand holding and come to the drop ins I run and ask if I can find help but can help find out only if I call on behalf and due to confidentiality issues, what could you advise in these situations?**

If they are able to use any kind of translator, email into the LMHT that could be an option as a starter, but you are right it is a barrier. We do have provisions for people who don't speak English in terms of you know that with somebody's help and because of confidentiality reasons it might be that we could arrange to do a call back with a translator and to enable that discussion to happen so that the team know that person is actually consenting themselves and wanting to ask that information.

We've sent out letters in the persons language and if we are given consent to speak to a son for example and have a sort of three-way conversation then we'll do that.

I'd like to think that there is something practical that could be done whereby the consent is pre-arranged where it is ok to talk to you. I'm just wondering if there is something, if it's worth you having a conversation with that team to see if there is something that can be worked out.

I think in terms of referral it is really important to make it really clear where there's communication barriers so that we are aware of that as soon as possible to try and make sure that we make it accessible. But I think ringing the LMHT even if you are doing it on behalf of somebody and explaining the situation then we should be able to look at a practical way to make it work.

**My question is in relation to my own current lived experience of essentially going through my Local Mental Health Teams. I will ask my question first and then provide a bit of context. My question is how can both as a patient and as someone trying to support someone else going through the process of their mental health teams and any other appropriate secondary care in terms of mental health services, do I advocate for both myself and others going through similar experiences when it comes to how mental health teams are managing our individual cases?**

It sounds like you would like to be more involved in maybe shaping how things change in terms of your own experiences and other peoples experiences in the future, so in our Trust we do have an Involvement Hub, now there are a team that work with people with lived experience that you can sign up to, to be part of the involvement and volunteering hub and we do a lot of work with them so when we are looking at improving services and

making things better we really like to have people with lived experience to as part of that to share their experiences with and I know that they want more people that have had some recent experience too https://www.nottinghamshirehealthcare.nhs.uk/involvement-experience-and-volunteering/.

**Deaf people tend to struggle with access to making calls and getting support using sign video for support for accessing NCHT, would you refer them on to sign health, are you aware of sign health?**

We do have people we work with that work with the LMHT who work with deaf client groups. I don't have individual experience of working with the deaf team to know what kind of different things they use to support that but definitely have access to digital means to support people to help.

My experience is that they care coordinate in the same way as another practitioner would but use sign language and another means of communication.

**What support is available for clients who have been declined by LMHT but are too high risk for talking therapies?**

We do have our PCN mental health practitioners within the PCN's but unfortunately, we don't have one in every PCN but I would say cover 70% of the PCN's across Nottinghamshire. The aim of the PCN practitioner is that they see people who fall in the gap so would be seeing people that would probably be being declined by a lot of other can't access talking therapies or other interventions so their role is ideally to support people that fall in the middle and again work directly with the GP practice so the GP's will see somebody and can refer them directly onto that practitioner. It might be that the practitioner does some work with them and if they feel that they are more complex they can step people up into the LMHT as well so they are seen as a trusted assessor because they are lined managed by the LMHT they've got those really strong links and they're very experienced practitioners, obviously they are only a small resource, there's only one person in each PCN.

It's just tricky isn't it when people don't quite meet the threshold and kind of fall between the gaps and like I said that's where those PCN practitioners come in and they are brilliant. I think if your client has been declined and you want to query that then there is nothing stopping you going back to the LMHT and asking for some clarity, asking for them to re look at things if you think that they might not have all the information or you want them to be considered or going back to the GP and saying actually can we re refer.

**Would it have to be mental health social worker to complete a referral for or could a generic social worker refer into the LMHT?**

We don't accept referrals from local authority it would have to come from a GP or other Notts Healthcare Teams.

**Can we have a link to the referral form, and do we send to a central email triage box or do we need to know which LMHT they would sit under first and can we have a list of emails and telephone numbers?**

Each LMHT has its own referral box so there isn't one central inbox for emails. In terms of the referral form that sits within the System One units so for somebody to have that they would need to access it through the System One units or the Arden's template. Sorry I don't know who the person is who has asked this where they are or which team they are from but if you don't have access to that referral form and you are making the referral into the LMHT then other services that can refer in would probably just do a standard kind of type letter with all the details in it.

**Would therapists working in a private practice be considered as trusted referrers or would it be better for the therapist to suggest the client speaks to their GP and go via that route?**

I think it would be better for them to go via their GP because it depends on who the private therapist is and obviously, we don't have any oversight over private kind of therapists and if they are reputable etc in terms of those things so it would be better to align it with the GP.

Please follow the link to be directed to the session presentation slides and recording:

https://www.nottinghamcvs.co.uk/projects/practice-development-unit/learning-series/service-spotlight/overview-of-the-journey-through-local-mental-health-teams

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