Using the Community Mental Health Team as a model and the aims as outlined in the NSF Mental Health, the aims of the CPTT would be to deliver care which offers:

- speedy access with single point of referral
- regular review
- interdisciplinary approach
- flexible contact frequency
- relapse prevention
- relapse management
- support with respect to physical and psychosocial needs

CSAG guidelines for back pain emphasised a biopsychosocial approach to management. Primary care was identified as having a pivotal role.

The CSAG also stated that if patients have not returned to work within 3 months, primary care management has failed and chronic pain and disability are likely. It therefore seems logical to suggest a referral at or around 3 months after the initial presentation with pain if no progress has been achieved.

However, in certain conditions, it may be appropriate to refer sooner, in order to allow for baseline assessment whilst the patient remains relatively ?well' rather than wait for crisis to occur, in conditions such as post-stroke pain (thalamic pain), or others in which there are obvious risk factors for chronicity.

With these aims in mind, the proposed team would comprise:

- Consultant pain specialist (Pain clinic)
- Community pain specialist nurse (CPSN)

- Physiotherapist
- Psychologist
- Social worker
- OT
- GP
- Pain Liaison Nurse (A&E/MAU)
- PMP (Pain Management Programme)
- Support groups (voluntary sector)

POSSIBLE STAFFING LEVELS:

- Consultant pain specialist (Pain clinic): 1
- Non-consultant medical staff: 1
- GP: 1
- Community pain specialist nurse (CPSN): 3
- Physiotherapist: 2 Psychologist: 1
- Social worker: 1-2 OT: 1
- Pain Liaison Nurse (A&E/MAU): 1
- Support groups (voluntary sector)
- 1 of these =Team Leader (would only have 30-50% of caseload of others
- Caseload max. 35 each
- Overall cases 300-350

HOW THE CPTT FUNCTIONS:

- Pre-referral discussion between GP and other CPTT members> Referral for assessment
- Assessment within 4 weeks by pain specialist doctor
- Possible in-patient admission for PMP
- Discharged with Care plan (cf. CPA)
- Assessment at home by CPSN; Physiotherapist Psychologist; Social Worker; OT (whichever appropriate)
- Feedback meeting of CPTT to discuss management
- Care plan established, including proposed relapse prevention & management; care co-ordinator designated
- Care plan discussed and agreed with client and family.
- Implementation of ongoing strategies e.g. regular physio. Counselling etc.
- Regular review as required: CPSN visit; pain clinic appointment
- If relapse (?flare up') causes A&E visit: involvement of Pain Liaison Nurse to implement

previously agreed strategies (admission, change in medication, other measures)

- Client/family can contact service: self-referral for intercurrent problems
- Discharged from service only if CPTT and client are agreed.

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