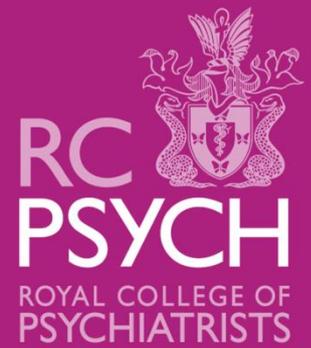


COLLEGE CENTRE FOR  
QUALITY IMPROVEMENT



## **Accreditation for Community Mental Health Services (ACOMHS)**

Standards for Adult Community Mental Health Services –  
First Edition

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# Foreword

We are very pleased to be publishing the First Edition of the Accreditation for Community Mental Health Services (ACOMHS) *Standards for Adult Community Mental Health Services*.

ACOMHS is an accreditation service for teams that provide treatment and care for people with a spectrum of mental health problems, ranging from common and limited conditions through to those that are complex, enduring and severe. The inception of community mental health teams and centres in the early 1980s brought a new way to deliver care and treatment to people in, or close to, their own homes. Since that time there has been a dearth of standard-setting specific to community mental health teams. The ACOMHS standards now offer a means to support benchmarking and quality improvement.

These standards are designed for adult community mental health teams and can also be applied to specialist community mental health teams such as those for older adults, forensic settings, people with intellectual disabilities, rehabilitation and so on. They form a 'core' based on the shared qualities and attributes of these teams. For example, all services are concerned with providing timely access to assessment, care and treatment delivered by competent, caring and compassionate staff.

The standards cover thirty-one areas which include the care pathway through services, collaborative and inclusive practice, service user and carer participation, staffing, team working, training and supervision, and audit and service evaluation. The standards endeavour to reflect exemplary practice in mental health care by drawing on new policy and recent insights into best practice such as; promoting physical health, working within a recovery ethos, and providing psychological and psychosocial therapies.

These standards have been developed in consultation with a range of professionals, carers and service users. The process of creating the standards was guided by staff from the Royal College of Psychiatrists' Centre for Quality Improvement (CCQI). The names of the individuals involved are listed overleaf and we are incredibly grateful for the input, enthusiasm and support they have given to the programme.

Norman Young, ACOMHS Clinical Advisor

On behalf of the ACOMHS team

September 2016

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## Introduction

The accreditation standards, drawn from key documents and expert consensus, have been subject to extensive consultation with professional groups involved in the provision of community mental health services, and with people and carers who have used services in the past.

The standards have been developed for the purposes of review and accreditation as part of the Accreditation for Community Mental Health Services (ACOMHS) scheme, however, they can also be used as a guide for new or developing services. Please refer to the *ACOMHS Accreditation Process* document for information on the process of accreditation.

### Who are these standards for?

These standards are designed to be applicable to all adult community mental health services and can be used to assess the quality of general adult teams, as well as the 'core' functions of specialist teams. In future it is likely that there will be additional standards for specialist teams but all teams will be assessed against the standards included here as a minimum.

Since community mental health services differ widely in their configuration and the models used, these standards focus on the function of a team in order to make them as widely accessible as possible.

### Categorisation of standards

To support their use in the accreditation process, each standard has been categorised as follows:

- **Type 1:** criteria relating to patient safety, rights, dignity, the law and fundamentals of care, including the provision of evidence-based care and treatment;
- **Type 2:** criteria that a service would be expected to meet;
- **Type 3:** criteria that are desirable for a service to meet, or criteria that are not the direct responsibility of the service.

The full set of standards is aspirational and it is unlikely that any service would meet them all. In order to achieve accreditation, a service must meet 100% type 1 standards, at least 80% type 2 standards and 60% type 3 standards. ACOMHS facilitates quality improvement and supports teams to achieve accreditation.

The standards are also available on our website [www.rcpsych.ac.uk/ACOMHS](http://www.rcpsych.ac.uk/ACOMHS)

### Notation

<b>M</b>	Standard <b>modified</b> since last edition of these standards
<b>N</b>	<b>New</b> standard, added since last edition of these standards

### Terms used in this document

In this document, the community mental health service is referred to as '*the service*' or '*the community mental health service*'. People who are cared for by community mental health services are referred to as '*service users*' and their loved ones are referred to as '*carers*', '*family/family members*' or '*friends*'.

## References

Please see the list at the end of this document for full references. These are referred to by their number in the list throughout the document.

## Standards for adult community mental health services

Number	Type	Standard	References
<b>1. Access and referral</b>			
1.1	2	<p>The service reviews access data at least annually. Data are compared with local population statistics and action is taken to address any inequalities of access where identified</p> <p><i>Guidance: These data are used to understand who is accessing the service, identify under-represented groups, promote the service to these groups and improve the accessibility of the service</i></p>	1, 2, 4
1.2 M	1	<p>Clear information is made available, in paper and/or electronic format, to service users, carers and healthcare practitioners on:</p> <ul style="list-style-type: none"> <li>• A simple description of the service and its purpose;</li> <li>• Clear referral criteria;</li> <li>• How to make a referral, including self-referral if the service allows;</li> <li>• Clear clinical pathways describing access and discharge;</li> <li>• Main interventions and treatments available;</li> <li>• Contact details for the service, including emergency and out of hours details</li> </ul>	1
1.3 N	1	A clinical member of staff is available to discuss emergency referrals during working hours	11
1.4 N	2	Where referrals are made through a single point of access e.g. triage, these are passed on to the community team within one working day	11
1.5 M	1	Outcomes of referrals are fed back to the referrer, service user and carer (with the service user's consent). If a referral is not accepted, the team advises the referrer, service user and carer on alternative options	2, 11
1.6	1	<p>Acceptance to the service is based on need and risk; the service does not use specific exclusion criteria</p> <p><i>Guidance: Self-harm, substance misuse, social background, criminal history, learning disability or personality disorder are not barriers to acceptance by the service</i></p>	1
1.7 N	2	There is sufficient car parking for visitors to the service	28
1.8 N	3	Everyone is able to access the service using public transport or transport provided by the service	11

Number	Type	Standard	References
<b>2. Waiting times</b>			
2.1 M	2	Service users receive an assessment within 3 weeks of referral  <i>Guidance: If the service sees people with suspected psychosis, they are assessed within 2 weeks of referral</i>	2, 4, 5, 6, 25
2.2 M	2	There are systems in place to monitor waiting times and ensure adherence to local and national waiting times standards  <i>Guidance: There is accurate and accessible information for everyone on waiting times from referral to assessment and from assessment to treatment</i>	11
2.3 N	2	The team provides service users with information about waiting times for assessment and treatment  <i>Guidance: Service users on a waiting list are provided with updates of any changes to their appointment, as well as details of how they can access further support while waiting</i>	11

Number	Type	Standard	References
<b>3. Preparing for the assessment</b>			
3.1 M	1	For planned assessments the team sends letters in advance to service users that include: <ul style="list-style-type: none"> <li>• An explanation of the assessment process;</li> <li>• Information on who can accompany them;</li> <li>• How to contact the team if they have any queries, require support (e.g. an interpreter), need to change the appointment or have difficulty in getting there</li> </ul>	4, 11
3.2	2	Service users are provided with information and choice about their assessment and appointments  <i>Guidance: This includes choice of time, day, venue, gender of staff or access in another language</i>	7
3.3	1	The service has access to independent advocates to provide information, advice and support to service users, including assistance with assessment, advance statements and Care Programme Approach reviews	3
3.4 M	3	The assessing professional can easily access relevant clinical information (past and current) about the service user from primary and secondary care	3, 11
3.5	1	Service users are given verbal and written information on their rights under the Mental Health Act if under a Community Treatment Order (or equivalent) and this is documented in their notes	11

Number	Type	Standard	References
<b>4. Initial assessment</b>			
4.1 M	1	Service users have a comprehensive assessment which includes their: <ul style="list-style-type: none"> <li>• Mental health and medication;</li> <li>• Psychosocial needs;</li> <li>• Strengths and weaknesses</li> </ul>	3, 4, 8, 11
4.2 M	2	Immediate social stressors and social networks are identified and recorded, including financial, housing, employment, educational and vocational issues	3
4.3 M	1	A physical health review takes place as part of the initial assessment. The review includes but is not limited to: <ul style="list-style-type: none"> <li>• Details of past medical history;</li> <li>• Current physical health medication, including side effects and compliance with medication regime;</li> <li>• Lifestyle factors e.g. sleeping patterns, diet, smoking, exercise, sexual activity, drug and alcohol use;</li> <li>• Consideration of risk of cardiovascular disease, metabolic disorders, and excessive weight gain</li> </ul>	3, 11
4.4 M	2	An assessment of practical problems of daily living is recorded	3
4.5 M	1	Service users have a risk assessment that is shared with relevant agencies (with consideration of confidentiality) and includes a comprehensive assessment of: <ul style="list-style-type: none"> <li>• Risk to self (including self-neglect);</li> <li>• Risk to others;</li> <li>• Risk from others</li> </ul>	3, 11
4.6 N	1	The team discusses the purpose and outcome of the risk assessment with the service user and a management plan is formulated jointly	11
4.7 M	1	The service user is asked if they have a carer, and if so, the carer's name is recorded	3, 9
4.8 M	1	Any dependants are identified and recorded, including their wellbeing, needs, and any childcare issues  <i>Guidance: This includes the names and dates of birth of any young people</i>	3
4.9 N	1	Staff members are easily identifiable (for example, by wearing appropriate identification)	11
4.10 N	1	Staff members address service users using the name and title they prefer	11

Number	Type	Standard	References
<b>5. Completing the initial assessment</b>			
5.1 M	1	All patients have a diagnosis and a clinical formulation  <i>Guidance: The formulation includes presenting problem and predisposing, precipitating, perpetuating and protective factors as appropriate. Where a complete assessment is not in place, a working diagnosis and a preliminary formulation should be devised</i>	11
5.2 M	2	The team sends a letter detailing the outcomes of the assessment to the referrer, the GP and other relevant services within a week of the assessment	1, 11
5.3 N	1	All assessments are documented, signed/validated (electronic records) and dated by the assessing practitioner	11

Number	Type	Standard	References
<b>6. Following up service users who don't attend appointments</b>			
6.1 M	1	The team proactively follows up service users who have not attended an appointment/assessment or who are difficult to engage, with consideration of risk, in line with the service's engagement policy  <i>Guidance: This could include visiting service users at home or another suitable venue, using text alerts, or engaging with their carers</i>	1, 10, 11
6.2 N	1	If a service user does not attend for assessment, the team contacts the referrer  <i>Guidance: If the service user is likely to be considered a risk to themselves or others, the team should contact the referrer immediately to discuss a risk action plan</i>	11
6.3 N	2	Data on missed appointments are reviewed at least annually. This is done at a service level to identify where engagement difficulties may exist  <i>Guidance: This should include monitoring a service user's failure to attend the initial appointment after referral and early disengagement from the service</i>	11

Number	Type	Standard	References
<b>7. Reviews and care planning</b>			
7.1 M	1	The team has a timetabled meeting at least once a week to discuss allocation of referrals, current assessments, reviews and service users on the waiting list  <i>Guidance: Referrals that are urgent or that do not require discussion can be allocated before the meeting</i>	1, 2, 11

Number	Type	Standard	References
7.2 M	1	<p>Every service user has a written care plan, reflecting their individual needs</p> <p><i>Guidance: This clearly outlines:</i></p> <ul style="list-style-type: none"> <li>• Agreed intervention strategies for physical and mental health;</li> <li>• Measurable goals and outcomes;</li> <li>• Strategies for self-management;</li> <li>• Any advance decisions or stated wishes that the service user has made;</li> <li>• Crisis and contingency plans;</li> <li>• Review dates and discharge framework</li> </ul>	3, 11
7.3 N	1	The practitioner develops the care plan collaboratively the service user and their carer (with service user consent)	11
7.4 M	1	The service user and their carer (with service user consent) are offered a copy of the care plan and the opportunity to review this	3, 11
7.5	1	The service uses the Care Programme Approach (CPA) framework (or equivalent) when necessary for the needs of the service user, which is applied in line with Trust/Social Services policy, based on effective care coordination in mental health services	3, 12
7.6 N	1	Managers and practitioners conduct clinical review meetings at least annually, or according to clinical need (in line with the Care Programme Approach)	11
7.7 N	1	Risk assessments and management plans are updated at least annually, or according to clinical need (in line with the Care Programme Approach)	11
7.8	2	There is a single record for each service user and all contacts with the service user and their carers are recorded	2

Number	Type	Standard	References
<b>8. Care and Treatment</b>			
<b>8.1 Therapies and activities</b>			
8.1.1 M	1	<p>Service users are offered evidence-based pharmacological and psychological interventions and any exceptions are documented in the case notes</p> <p><i>Guidance: The number, type and frequency of psychological interventions offered are informed by the evidence base</i></p>	11, 16
8.1.2 N	2	Service users begin evidence-based pharmacological and psychological interventions within 18 weeks of accepting the intervention	28
8.1.3 N	1	Service users' preferences are taken into account during the selection of medication, therapies and activities, and are acted upon as far as possible	11

Number	Type	Standard	References
8.1.4 M	2	Service users have access to occupational therapy	11, 29
8.1.5 N	3	Service users have access to art/creative therapies	11
8.1.6 M	1	The team signposts service users to structured activities such as work, education and volunteering	3, 11, 16
8.1.7 M	2	The team provides information, signposting and encouragement to service users to access local organisations for peer support and social engagement such as: <ul style="list-style-type: none"> <li>• Voluntary organisations;</li> <li>• Community centres;</li> <li>• Local religious/cultural groups;</li> <li>• Peer support networks;</li> <li>• Recovery Colleges</li> </ul>	11
8.1.8 M	1	Service users and carers are offered written and verbal information about the service user's mental illness  <i>Guidance: Verbal information could be provided in a 1:1 meeting with a staff member or in a psycho-education group. Written information could include leaflets, websites, etc.</i>	2, 4, 11, 13, 16
8.1.9	2	Carers are given information on mental health problems, what they can do to help, their rights as carers and an up to date directory of local services they can access	9, 14
8.1.10	2	All healthcare professionals have received training and supervision in providing psychologically informed care, including evidence-based low-intensity talking therapies	15
8.1.11 N	1	All staff members who deliver therapies and activities are appropriately trained and supervised	11
8.1.12	2	The service is able to provide care to people with a personality disorder, or signpost/refer them on for care  <i>Guidance: Care for service users with a personality disorder is provided in a team approach with a consistent clinical model and good understanding of this group</i>	3
8.1.13 N	1	The service user and the team can obtain a second opinion if there is doubt, uncertainty or disagreement about the diagnosis or treatment	11
<b>8.2 Medication</b>			
8.2.1 N	2	When medication is prescribed, specific treatment targets are set for the service user, the risks and benefits are reviewed, a timescale for response is set and service user consent is recorded	11

Number	Type	Standard	References
8.2.2 M	1	Service users and their carers (with service user consent) are helped to understand the functions, expected outcomes, limitations and side effects of their medications, to enable them to make informed choices and to self-manage as far as possible	3, 11
8.2.3 M	1	Service users have their medications reviewed at a frequency according to the evidence base and clinical need. Medication reviews include an assessment of therapeutic response, safety, side effects and adherence to medication regime  <i>Guidance: Side effect monitoring tools can be used to support reviews. Long-term medication is reviewed by the prescribing clinician at least once a year as a minimum</i>	3, 11, 16
8.2.4	1	The service has rapid access to medication during working hours	3
8.2.5	2	The service is able to use or access blood tests and other physical investigations to monitor outcomes and side effects of medications	2
8.2.6 M	2	When service users experience side effects from their medication, this is engaged with and there is a clear plan in place for managing this	2, 11
8.2.7 M	2	The service has a shared care protocol with primary care which defines responsibility for prescription and administration of medication	2, 28
8.2.8 N	1	The safe use of high risk medication is audited at a service level, at least annually  <i>Guidance: This includes medications such as lithium, high dose antipsychotic drugs, antipsychotics in combination and benzodiazepines</i>	11
8.2.9 N	1	There is a written protocol governing the removal and gradual reintroduction of medicines in situations where there is an acute risk of suicide or self-harm, which includes the need to notify the GP	3, 28

Number	Type	Standard	References
<b>9. Physical healthcare</b>			
<b>9.1 Physical healthcare and substance misuse</b>			
9.1.1 M	1	Where concerns about a service user's physical health are identified, the team arranges or signposts the service user to further assessment, investigations and management from primary or secondary healthcare services	11, 12
9.1.2 M	1	The service gives targeted lifestyle advice to service users when appropriate. This includes: <ul style="list-style-type: none"> <li>• Smoking cessation advice;</li> <li>• Healthy eating advice;</li> <li>• Physical exercise advice</li> </ul>	11, 16

Number	Type	Standard	References
9.1.3 N	1	<p>The service has a policy for the care of service users with dual diagnosis of mental health problems and alcohol or substance misuse that includes:</p> <ul style="list-style-type: none"> <li>• Liaison and shared protocols between mental health and substance misuse services to enable joint working;</li> <li>• Drug/alcohol screening to support decisions about care/treatment options;</li> <li>• Liaison between mental health, statutory and voluntary agencies;</li> <li>• Staff training;</li> <li>• Access to evidence based treatments</li> </ul>	11
9.1.4	1	<p>The service has a care pathway for the care of women in the perinatal period (pregnancy and 12 months post-partum) that includes:</p> <ul style="list-style-type: none"> <li>• Assessment;</li> <li>• Care and treatment (particularly relating to prescribing psychotropic medication);</li> <li>• Referral to a specialist perinatal team/unit unless there is a specific reason not to do so</li> </ul>	11
9.1.5 N	1	<p>The team understands and follows an agreed protocol for the management of an acute physical health emergency</p> <p><i>Guidance: This includes guidance about when to call 999 and when to contact the duty doctor</i></p>	11
<b>9.2 Managing the physical health of service users on mood stabilisers or antipsychotics</b>			
9.2.1 N	1	<p>Service users who are prescribed mood stabilisers or antipsychotics are reviewed at the start of treatment (baseline), at 3 months and then annually unless a physical health abnormality arises. The clinician monitors the following information about the service user:</p> <ul style="list-style-type: none"> <li>• A personal/family history (at baseline and annual review);</li> <li>• Lifestyle review (at every review);</li> <li>• Weight (at every review);</li> <li>• Waist circumference (at baseline and annual review);</li> <li>• Blood pressure (at every review);</li> <li>• Fasting plasma glucose/HbA1c (glycated haemoglobin) (at every review);</li> <li>• Lipid profile (at every review);</li> <li>• ECG (at baseline and annual review)</li> </ul> <p><i>Guidance: Service users are advised to monitor their own weight every week for the first 6 weeks and to contact the service if they have concerns about weight gain</i></p>	11

Number	Type	Standard	References
<b>10. Risk and safeguarding</b>			
10.1 M	1	The team receives training, consistent with their roles, on risk assessment and risk management. This is refreshed in accordance with local guidelines. This includes, but is not limited to, training on: <ul style="list-style-type: none"> <li>• Safeguarding vulnerable adults and children including awareness of domestic violence;</li> <li>• Assessing and managing suicide risk and self-harm;</li> <li>• Prevention and management of aggression and violence</li> </ul>	2, 11
10.2	1	All staff have received training on personal safety issues	3
10.3 M	1	Staff members follow inter-agency protocols for the safeguarding of vulnerable adults, and children. This includes escalating concerns if an inadequate response is received to a safeguarding referral	3, 11
10.4 N	1	If a service user drives and their mental state or diagnosis indicates that there is a risk to their driving ability, they are informed of the necessity to report their mental state or diagnosis to the DVLA (or equivalent vehicle licensing authority)	10, 28

Number	Type	Standard	References
<b>11. Discharge planning and transfer of care</b>			
11.1 N	2	Discharge or onward care planning is discussed at the first and every subsequent care plan review	11
11.2 M	1	Service users and their carers (with service user consent) are involved in decisions about discharge or transfer plans  <i>Guidance: This could be through a formal discharge meeting</i>	9, 11
11.3	2	There are agreements with other agencies for service users to re-access the service if needed, without following the initial referral pathway  <i>Guidance: There may be exceptions where service users require a generic assessment and it may be appropriate to follow the initial referral pathway</i>	17
11.4 M	1	A letter setting out a clear discharge plan is sent to the service user and all relevant parties within 10 days of discharge. The plan includes details of: <ul style="list-style-type: none"> <li>• On-going care in the community/aftercare arrangements;</li> <li>• Crisis and contingency arrangements including details of who to contact;</li> <li>• Medication;</li> <li>• Details of when, where and who will follow up with the service user as appropriate</li> </ul>	2, 3, 11

Number	Type	Standard	References
11.5 N	1	The team follows a protocol to manage service users who discharge themselves against medical advice. This includes: <ul style="list-style-type: none"> <li>Recording the service user's capacity to understand the risks of self-discharge;</li> <li>Putting a crisis plan in place;</li> <li>Contacting the relevant agencies to notify them of the discharge</li> </ul>	11
11.6	2	When a service user is admitted to a psychiatric hospital, a community team representative attends and contributes to ward rounds and discharge planning	2, 11
11.7	1	Service users who are discharged from hospital to the care of the community team are followed up within one week of discharge, or within 48 hours of discharge if they are at risk  <i>Guidance: This may be in coordination with the Crisis Resolution/Home Treatment Team</i>	2, 11
11.8 M	1	When service users are transferred between community services there is a handover which ensures that the new team have an up-to-date care plan and risk assessment	3, 11
11.9 N	3	When service users are transferred between community services there is a meeting in which members of the two teams meet with the service user and carer to discuss transfer of care	11
11.10 N	1	There is active collaboration between Child and Adolescent Mental Health Services and Working Age Adult Services for service users who are approaching the age for transfer between services. This starts at least 6 months before the date of transfer	11

Number	Type	Standard	References
<b>12. Interfaces with other services</b>			
12.1 N	1	The team follows a joint working protocol/care pathway with primary health care teams  <i>Guidance: This includes the team informing the service user's GP of any significant changes to the service user's mental health or medication, or of their referral to other teams. It also includes teams following shared prescribing protocols with the GP</i>	11
12.2	2	The service has a physical health care pathway with clearly identified and agreed responsibilities with primary care  <i>Guidance: This could include the agreed use of the Lester UK Adaptation of the positive cardiometabolic health resource, Rethink integrated physical healthcare pathway and NICE guidelines on physical healthcare</i>	12, 16, 28

Number	Type	Standard	References
12.3 M	2	<p>There are regular clinical discussions between the community mental health service and the primary care team to:</p> <ul style="list-style-type: none"> <li>• discuss service users with shared care arrangements;</li> <li>• discuss service users known only to primary care;</li> <li>• provide information and advice to primary care practitioners on managing common mental health conditions;</li> <li>• seek advice from primary care on the management of physical health problems</li> </ul>	12
12.4 M	1	<p>The team follows a joint working protocol/care pathway with the Home Treatment/Crisis Resolution Team, in services that have access to one</p> <p><i>Guidance: This includes joint care reviews and jointly organising admissions to hospital for service users in crisis</i></p>	2, 11, 27, 28
12.5 M	1	<p>The service is able to signpost or refer service users on to:</p> <ul style="list-style-type: none"> <li>• other health services;</li> <li>• advocacy;</li> <li>• peer support;</li> <li>• employment services;</li> <li>• voluntary sector services</li> </ul>	11
12.6 M	1	<p>The team supports service users to access organisations which offer:</p> <ul style="list-style-type: none"> <li>• housing support;</li> <li>• support with finances, benefits and debt management;</li> <li>• social services</li> </ul>	4, 11, 15
12.7 N	1	<p>The team follows an agreed protocol with local police, which ensures effective liaison on incidents of criminal activity/harassment/violence</p>	11
12.8	1	<p>Health records can be easily accessed by other services who may be involved with the service user's care</p> <p><i>Guidance: This could include psychiatric liaison teams, home treatment teams, acute inpatient wards, general wards, primary care and accident and emergency departments</i></p>	3
12.9 N	1	<p>There are arrangements in place to ensure that service users can access help, from mental health services, 24 hours a day, 7 days a week</p> <p><i>Guidance: Joint protocols are agreed, for example, with commissioners, primary healthcare services, emergency medical departments and social services</i></p>	11
12.10 N	3	<p>The service has a meeting, at least annually, with all stakeholders to consider topics such as referrals, service developments, issues of concern and to re-affirm good practice</p> <p><i>Guidance: Stakeholders could include staff member representatives from inpatient, community and primary care teams as well as service user and carer representatives</i></p>	11

Number	Type	Standard	References
<b>13. Capacity and consent</b>			
13.1 M	1	Capacity assessments are performed in accordance with current legislation	11
13.2 N	1	When service users lack capacity to consent to interventions, decisions are made in accordance with current legislation	11
13.3 N	1	There are systems in place to ensure that the service takes account of any advance decisions that the service user has made	11

Number	Type	Standard	References
<b>14. Service user involvement</b>			
14.1	1	Service users and their carers are given the opportunity to feed back about their experiences of using the service, and their feedback has been used to improve the service  <i>Guidance: This might include service user and carer surveys or focus groups</i>	1, 10, 11, 14
14.2 M	2	Service user and carer representatives attend and contribute to local and service level meetings and committees	10, 11

Number	Type	Standard	References
<b>15. Carer engagement and support</b>			
Note: Carer involvement is subject to the service user giving consent and / or carer involvement being in the best interests of the service user			
15.1 M	1	Carers are involved in discussions about the service user's care, treatment and discharge planning	9, 11
15.2	1	Carers are advised how to access a statutory carers' assessment, provided by an appropriate agency  <i>Guidance: This advice is offered at the time of the service user's initial assessment, or at the first opportunity</i>	3, 11, 12, 14
15.3	2	Carers are offered individual time with staff to discuss concerns, family history and their own needs	3, 9, 11
15.4 M	2	The team provides each carer with a carer's information pack  <i>Guidance: This includes the names and contact details of key staff members in the service. It also includes other local sources of advice and support such as local carers' groups, carers' workshops and relevant charities</i>	3, 9, 11

Number	Type	Standard	References
15.5 M	2	Carers have access to a carer support network or group. This could be provided by the service, or the team could signpost carers to an existing network  <i>Guidance: This could be a group/network which meets face-to-face or communicates electronically</i>	11, 14
15.6 M	1	The team follows a protocol for responding to carers when the service user does not consent to their involvement	3, 9, 11, 26
15.7 M	2	The service has a designated staff member dedicated to carer support (carer lead)	9, 11
15.8	2	The service ensures that children and other dependants are supported appropriately  <i>Guidance: This could include offering appropriate written information to children, or supporting the service user to communicate with their children about their mental health</i>	3, 28

Number	Type	Standard	References
<b>16. Treating service users with dignity and respect</b>			
16.1 M	1	Service users are treated with compassion, dignity and respect  <i>Guidance: This includes respect of a service user's race, age, sex, gender reassignment, marital status, sexual orientation, pregnancy and maternity status, disability and religion/beliefs</i>	1, 7, 11, 18
16.2 N	2	Service users feel listened to and understood in consultations with staff members	11
16.3	1	The service can demonstrate that it promotes culturally and spiritually sensitive practice	4, 7, 15

Number	Type	Standard	References
<b>17. Provision of information to service users and carers</b>			
17.1 M	1	Information, which is accessible and easy to understand, is provided to service users and carers  <i>Guidance: Information can be provided in languages other than English and in formats that are easy to use for people with sight/hearing/cognitive difficulties or learning disabilities. For example; audio and video materials, using symbols and pictures and using plain English, communication passports and signers. Information is culturally relevant</i>	10, 11, 16

Number	Type	Standard	References
17.2 M	1	The service has access to translators and interpreters and the service user's relatives are not used in this role unless there are exceptional circumstances <i>Guidance: Exceptional circumstances might include crisis situations where it is not possible to get an interpreter at short notice</i>	4, 10, 11
17.3 N	2	The service uses interpreters who are sufficiently knowledgeable to provide a full and accurate translation	11
17.4 N	1	When talking to service users and carers, health professionals communicate clearly, avoiding the use of jargon so that people understand them	11
17.5 N	1	Service users are asked if they and their carers wish to have copies of letters about their health and treatment	11
Service users are given verbal and written information on:			
17.6 M	1	<ul style="list-style-type: none"> <li>• Their rights regarding consent to care and treatment;</li> <li>• How to access advocacy services;</li> <li>• How to access a second opinion;</li> <li>• How to access interpreting services;</li> <li>• How to raise concerns, complaints and compliments;</li> <li>• How to access their own health records</li> </ul>	2, 4, 11
17.7 M	2	How to make a crisis/contingency plan, or advance decision/statement if they wish	2, 8, 12, 16, 15
17.8	2	Managing their health and wellbeing <i>Guidance: This may include reference to '5 Ways to Wellbeing'</i>	28, 29

Number	Type	Standard	References
<b>18. Service user confidentiality</b>			
18.1	1	Confidentiality and its limits are explained to the service user and carer at the first assessment, both verbally and in writing <i>Guidance: For carers this includes confidentiality in relation to third party information</i>	7, 11
18.2	1	The service has confidentiality policies which are regularly monitored and reviewed, and upheld at all times when exchanging information <i>Guidance: Policies include the provision of information release forms and advanced statements protocols and forms</i>	3, 9, 19, 20, 21

Number	Type	Standard	References
18.3	1	All service user information is kept in accordance with current legislation  <i>Guidance: Staff members ensure that no confidential data is visible beyond the service by locking cabinets and offices, using swipe cards and having password protected computer access</i>	11
18.4 M	1	The service user's consent to the sharing of clinical information outside the team (including with carers) is recorded. If this is not obtained, the reasons for this are recorded  <i>Guidance: If the service user does not wish any information to be shared with their carers, staff regularly check whether they are still happy with this decision. Information already known to carers is not considered to be confidential information</i>	3, 9, 11

Number	Type	Standard	References
<b>19. Service environment</b>			
19.1	2	The environment is comfortable, clean and warm, and areas of privacy are available in the waiting area	4
19.2 N	2	The service entrance and key clinical areas are clearly signposted	11
19.3 N	1	If teams see service users at their team base or other health-based community settings, entrances and exits are visibly monitored and/or access is restricted	11
19.4	1	Clinical rooms are private and conversations cannot be easily over-heard	11
19.5 N	1	There is easy access to suitable toilet facilities	10, 28
19.6	1	The environment complies with current legislation on disabled access  <i>Guidance: Relevant assistive technology equipment, such as hoists and handrails, are provided to meet individual needs and to maximise independence</i>	11
19.7 M	1	Furniture is arranged so that doors, in rooms where consultations take place, are not obstructed	11
19.8 N	1	There is an alarm system in place (e.g. panic buttons) and this is easily accessible	11
19.9	2	There are sufficient IT resources (e.g. computer terminals) to provide all practitioners with easy access to key information e.g. information about services, conditions and treatment, service user records, clinical outcome and service performance measurements	11

Number	Type	Standard	References
19.10 M	1	Staff members follow a lone working policy and feel safe when conducting home visits	2, 11, 22
19.11	1	An audit of environmental risk is conducted annually and a risk management strategy is agreed	7, 11
19.12 N	1	A collective response to alarm calls and fire drills is agreed before incidents occur. This is rehearsed at least 6 monthly	11
19.13 N	1	Emergency medical resuscitation equipment (crash bag), as required by Trust/organisation guidelines, is available at the team's base within 3 minutes	11
19.14 N	1	The crash bag is maintained and checked weekly, and after each use	11

Number	Type	Standard	References
<b>20. Leadership and culture</b>			
20.1 M	1	There are written documents that specify professional, organisational and line management responsibilities	1, 2, 10, 11, 12
20.2 M	2	Staff members can access leadership and management training appropriate to their role and specialty	3, 11
20.3 M	2	Staff members have an understanding of group dynamics and of what makes a therapeutic environment	11, 28
20.4 N	3	The organisation's leaders provide opportunities for positive relationships to develop between everyone  <i>Guidance: This could include service users and staff members using shared facilities at the team base</i>	11
20.5 N	2	Team managers and senior managers promote positive risk-taking to encourage service user recovery and personal development	11
20.6 N	1	Staff members and service users feel confident to contribute to, and safely challenge decisions  <i>Guidance: This includes decisions about care, treatment and how the service operates</i>	11
20.7 M	1	Staff members feel able to raise any concerns they may have about standards of care	11, 23

Number	Type	Standard	References
<b>21. Teamworking</b>			
21.1 N	2	Staff members work well together, acknowledging and appreciating each other's efforts, contributions and compromises	11
21.2 M	2	The team has protected time for team-building and discussing service development at least once a year	2, 11

Number	Type	Standard	References
<b>22. Staffing levels and skill mix</b>			
The team has dedicated sessional time from:			
22.1	2	A Service Lead	3
22.2	2	Registered Mental Health Nurse(s)	3
22.3	2	Social Worker(s)	3
22.4	2	Occupational Therapist(s)	3
22.5	2	Psychologist(s)	3
22.6	2	Support Worker(s) <i>Guidance: An unqualified professional, e.g. healthcare assistant, occupational therapy assistant, psychology assistant etc.</i>	3
22.7	2	Consultant Psychiatrist(s)	3
22.8	3	GP Link Worker(s)	28
22.9	3	Independent Prescriber(s)	3
The team has dedicated sessional time from:			
22.10	3	Pharmacist(s)	3
22.11	2	Employment Advisor(s)	2, 3
The team has adequate access to:			
22.12	3	Peer Support Worker(s) <i>Guidance: A service user or carer employed by the team to support other service users and/or carers</i>	3
22.13	2	Approved Mental Health Professional(s) (AMHPs)	3
22.14	3	Welfare and Benefits Advisor(s)	2
22.15	2	Administrative assistance to meet the needs of the service	10

22.16	3	Full-time care co-ordinators have a caseload of no more than 35 (reduced pro-rata for part-time staff)	2
22.17 M	1	There is an identified duty doctor available at all times. They are able to attend the team base within 1 hour	3, 11
22.18 M	2	There has been a review of the staff members and skill mix of the team within the past 12 months. This is to identify any gaps in the team and to develop a balanced workforce which meets the needs of the service	3, 11
22.19	1	The service has a nominated medicines management lead	3
22.20	2	The service includes individuals with special interests that cover a range of needs <i>Guidance: This includes physical health, substance or alcohol misuse, access to and engagement with psychological interventions</i>	16, 28
22.21 N	1	The service has a mechanism for responding to low staffing levels, including: <ul style="list-style-type: none"> <li>• A method for the team to report concerns about staffing levels;</li> <li>• Access to additional staff members;</li> <li>• An agreed contingency plan, such as the minor and temporary reduction of non-essential services</li> </ul>	11
22.22 N	1	There are systems in place to ensure that staffing is sufficient, and caseloads are covered and monitored when members of the team are absent for planned or unplanned periods	30

Number	Type	Standard	References
<b>23. Staff recruitment and induction</b>			
23.1	2	Service user or carer representatives are involved in interviewing potential staff members during the recruitment process	2, 11, 15
23.2 M	1	Staff members receive an induction programme specific to the service, which covers: <ul style="list-style-type: none"> <li>• The purpose of the service;</li> <li>• The team's clinical approach;</li> <li>• The roles and responsibilities of staff members;</li> <li>• The importance of family and carers;</li> <li>• Care pathways with other services</li> </ul> <i>Guidance: This induction should be over and above the mandatory Trust or organisation-wide induction programme</i>	2, 10, 11, 13

Number	Type	Standard	References
23.3 N	1	<p>New staff members, including agency staff, receive an induction based on an agreed list of core competencies</p> <p><i>Guidance: This should include arrangements for:</i></p> <ul style="list-style-type: none"> <li>• <i>Shadowing colleagues on the team;</i></li> <li>• <i>Jointly working with a more experienced colleague;</i></li> <li>• <i>Being observed and receiving enhanced supervision until core competencies have been assessed as met</i></li> </ul>	11
23.4 N	1	<p>All newly qualified staff members are allocated a preceptor to oversee their transition into the service</p> <p><i>Guidance: This should be offered to recently graduated students, those returning to practice, those entering a new specialism and overseas-prepared practitioners who have satisfied the requirements of, and are registered with, their regulatory body</i></p>	11
23.5 N	2	<p>All new staff members are allocated a mentor to oversee their transition into the service</p>	11

Number	Type	Standard	References
<b>24. Appraisal, supervision and support</b>			
24.1 M	1	<p>All staff members receive an annual appraisal and personal development planning (or equivalent)</p> <p><i>Guidance: This contains clear objectives and identifies development needs</i></p>	3, 10, 11
24.2 M	1	<p>All clinical staff members receive clinical supervision at least monthly, or as otherwise specified by their professional body</p> <p><i>Guidance: Supervision should be profession-specific as per professional guidelines and be provided by someone with appropriate clinical experience and qualifications</i></p>	3, 11, 27, 28
24.3 M	1	<p>All staff members receive monthly line management supervision</p>	3, 11, 27, 28
24.4	2	<p>All supervisors have received specific training to provide supervision</p> <p><i>Guidance: This training is refreshed in line with local guidance</i></p>	7, 11
24.5 N	2	<p>Staff members in training and newly qualified staff members are offered weekly supervision</p>	11
24.6 N	2	<p>The quality and frequency of clinical supervision is monitored quarterly by the clinical director (or equivalent)</p>	11

Number	Type	Standard	References
<b>25. Staff wellbeing</b>			
25.1	1	The service actively supports staff health and wellbeing <i>Guidance: For example, providing access to support services, monitoring staff sickness and burnout, assessing and improving morale, monitoring turnover, reviewing feedback from exit reports and taking action where needed</i>	7, 11
25.2 M	2	Staff members have access to reflective practice groups	11, 23, 24
25.3	2	There are systems in place to monitor individual caseloads of staff members	2
25.4 N	1	Staff members are able to take breaks during their shift that comply with the European Working Time Directive	11

Number	Type	Standard	References
<b>26. Staff training and development</b>			
26.1 N	1	Clinical staff members have received formal training to perform as a competent practitioner, or, if still in training, are practising under the supervision of a senior qualified clinician	11
26.2	1	All staff have received training on medication as required by their role <i>Guidance: This includes storage, administration, legal issues, encouraging concordance and awareness of side effects</i>	2
26.3	1	All practitioners who administer medications have been assessed as competent to do so. This is repeated on a yearly basis using a competency based tool	3
26.4	2	All staff have received training in reflective practice and debriefing	3
26.5 M	1	All staff have received training in the use of legal frameworks, such as the Mental Health Act (or equivalent) and the Mental Capacity Act (or equivalent)	2, 11
26.6 M	1	All staff have received training in physical health assessment <i>Guidance: This could include training in understanding physical health problems, physical observations and when to refer the service user for specialist input</i>	2, 3, 11
26.7 M	1	All staff have received statutory and mandatory training <i>Guidance: This includes equality and diversity and information governance</i>	2, 11
26.8 M	2	All staff have received training in carer awareness, family inclusive practice and social systems, including carers' rights in relation to confidentiality	3, 9, 11
26.9 N	1	All staff have received training in recognising and communicating with service users with special needs, e.g. cognitive impairment or learning disabilities	11

Number	Type	Standard	References
26.10 N	2	All staff have received training in clinical outcome measures	11
26.11 N	3	Shared in-house multi-disciplinary team training, education and practice development activities occur in the service at least every 3 months	11
26.12	2	Service users, carers and staff are involved in devising and delivering training face-to-face	3, 4, 11

Number	Type	Standard	References
<b>27. General management</b>			
27.1	2	The service has an operational policy which covers the purpose and aims of the service, ways of working and defined catchment population	2, 12
27.2 N	2	The team attends business meetings that are held at least monthly	11
27.3 N	3	The team reviews its progress against its own plan/strategy, which includes objectives and deadlines in line with the organisation's strategy	11
27.4 N	2	Front-line staff members are involved in key decisions about the service provided	11
27.5 N	2	Managers ensure that policies, procedures and guidelines are formatted, disseminated and stored in ways that the team finds accessible and easy to use	11

Number	Type	Standard	References
<b>28. Clinical outcome measurement</b>			
28.1 M	1	Clinical outcome measurement data is collected at two time points (initial assessment and discharge) as a minimum, and at clinical reviews where possible	2, 11, 27
28.2 M	2	Outcome data is used as part of service management and development, staff supervision and caseload feedback <i>Guidance: This should be undertaken every 6 months as a minimum</i>	3, 11
28.3 N	2	Clinical outcome monitoring includes reviewing service user progress against service user-defined goals in collaboration with the service user	11

Number	Type	Standard	References
<b>29. Audit and service evaluation</b>			
29.1 M	2	A range of local and multi-centre clinical audits is conducted which include the use of evidence-based treatments, as a minimum	3, 11, 28

Number	Type	Standard	References
29.2	3	The service has audited the provision of carer education and support programmes in the last 3 years	28
29.3	3	An assessment of the extent to which the service is recovery-focused has taken place, using an identified tool within the last 2 years  <i>Guidance: e.g. Scottish Recovery Indicator, Developing Recovery Enhancing Environments Measure (DREEM) or Implementing Recovery through Organisational Change (IMROC)</i>	27
29.4 M	1	The team reviews and updates care plans according to clinical need or at a minimum frequency that complies with College Centre for Quality Improvement specialist standards	2, 11
29.5	2	An audit of adherence to Mental Health Act guidance has been undertaken in the last year	25
29.6 N	3	The team, service users and carers are involved in identifying audit topics in line with national and local priorities and service user feedback	11
29.7 N	2	Key information generated from service evaluations and key measure summary reports (e.g. reports on waiting times) are disseminated in a form that is accessible to all	11

Number	Type	Standard	References
<b>30. The service learns from complaints and serious incidents</b>			
30.1 M	1	Staff members share information about any serious untoward incidents involving a service user with the service user themselves and their carer, in line with the Statutory Duty of Candour	11
30.2 M	1	Staff members, service users and carers who are affected by a serious incident are offered post-incident support	3, 11
30.3	1	Systems are in place to enable staff members to quickly and effectively report incidents. Managers encourage staff members to do this	11, 23
30.4 N	1	Lessons learned from incidents are shared with the team and disseminated to the wider organisation	11
30.5 N	2	Key clinical/service measures and reports are shared between the team and the organisation's board, e.g. findings from serious incident investigations and examples of innovative practice	11

Number	Type	Standard	References
<b>31. Commissioning and financial management</b>			
31.1 N	2	The service is explicitly commissioned or contracted against agreed standards  <i>Guidance: This is detailed in the Service Level Agreement, operational policy, or similar and has been agreed by funders</i>	11
31.2 N	3	Commissioners and service managers meet at least 6 monthly	11

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## Glossary

Acute episode	Also referred to as a mental health 'crisis'. An episode of mental illness which is severe enough that the person experiencing it would usually be admitted to hospital
Acute inpatient care	Care provided on a residential psychiatric ward in a hospital
Administer medication	To prepare and check medications, ensuring that the right amount goes to the right person at the right time
Advance statement/ directive	A document drawn up by a person when they are well, saying how they want to be cared for if they become unwell
AMHP	Approved Mental Health Professional. Staff trained in the use of the Mental Health Act
Assertive outreach team	A team which works with people with long-term mental health problems in the community
Care pathway	A journey of care and treatment planned over time which is written and agreed by a multidisciplinary team <sup>1</sup>
Carer	A person who looks after a person with mental health problems. In this document usually refers to an informal carer, e.g. a relative or friend
Carer link/lead/champion	A staff member within a team nominated to promote recognition of, and support for, carers
Carers' assessment	An assessment that looks at how caring affects their life, including for example, physical, mental and emotional needs, support they may need and whether they are able or willing to carry on caring <sup>2</sup>
Carer Support Service	A local service which may provide information, individual support and peer support for carers
Clinical supervision	A professional relationship between a staff member and their supervisor. A clinical supervisor's key duties are: <ul style="list-style-type: none"> <li>● monitoring employees' work with patients;</li> <li>● maintaining ethical and professional standards in clinical practice</li> </ul>
Conflict resolution/de-escalation	Resolving a conflict situation and preventing it from becoming a major incident
CPA	Care Programme Approach - a way of coordinating care for people with mental health problems and/or a range of different needs
CPN	Community psychiatric nurse. A nurse specifically trained in mental health problems who sees people outside of hospital
Crisis	See 'acute episode'
Crisis plan	A document drawn up by a person when they are well, usually with their Care Co-ordinator. It includes relapse warning signs, what they can do to manage the situation themselves, who to contact and when, and what has been helpful and unhelpful in the past

<sup>1</sup> Royal College of Nursing (2012). Care pathways.

<sup>2</sup> Carers UK (2015). Assessments and the Care Act.

Crisis resolution/home treatment team	Some teams call themselves 'crisis resolution', others call themselves 'home treatment', and some are both. These teams all treat people with severe mental health problems outside hospital - in their own homes or in suitable residential facilities
Dedicated sessional time	An agreement that a member of staff works a certain number of hours per week for the team. This should be written into their job description. A session is half a working day
Dependants	Children or adults who depend on a person (i.e. the service user) for everyday care
District nurse	A senior nurse specialising in physical health who sees people outside of hospital
Dual diagnosis	Experiencing both severe mental illness and problematic drug and/or alcohol use
Early intervention team	A team which works with people who are at risk of, or currently experiencing, their first severe mental health episode
Evidence based treatments	Any practice that has been established as effective through robust research
GP	General practitioner or 'family doctor'
Independent advocate	A person who helps views of service users to be heard by service managers and protects vulnerable people
Lone Worker Policy	A policy to ensure the health, safety and welfare and reduce the risk to people who work alone i.e. when making visits in the community
Low intensity talking therapies	Therapies that involve shorter, less frequent contact with a professional than other therapies <sup>3</sup>
Managerial supervision	Usually a one-to-one meeting in which a staff member is supported by a more senior staff member to reflect on their work practice
MDT	Multidisciplinary team - a team made up of different kinds of health professionals
Mental Capacity Act	The Act aims to empower and protect people who may not be able to make some decisions for themselves. It also enables people to plan ahead in case they are unable to make important decisions for themselves in the future <sup>4</sup>
Mental Health Act	A law under which people can be admitted or kept in hospital, or treated against their wishes, if this is in their best interest or for the safety of themselves or others
Mental health advocacy	A group of people with similar experiences who meet to discuss and put forward shared views to service managers
NICE	National Institute for Health and Clinical Excellence. Publishes guidance for health services
Operational policy	A policy document that outlines the role and aims of services
OT	Occupational therapist. They aim to promote independence by providing help for people to complete activities in daily life
Outpatient	A patient who visits a hospital for treatment without staying there overnight
Peer support worker	A service user or carer employed by the team to support other service users and/or carers

<sup>3</sup> Department of Health (2013). Which talking therapy for depression?

<sup>4</sup> Mental Health Foundation (2015). The Mental Capacity Act.

Perinatal	The perinatal period includes women who are pregnant, or who have given birth recently
Person-centred care	A whole-person approach to care that prioritises respect for the individual and his/her unique experience and needs.
Polypharmacy	The use of four or more medications by a patient, generally in adults aged over 65 years
Primary care	Usually the first port of call for health problems. Includes general practitioners (GPs), dentists, community pharmacies and high street optometrists
PRN Medication	<i>Pro re nata</i> (PRN) medication is used as needed. The decision of when to take the drug is left to the nurse, caregiver or the patient
Psychiatric liaison team	A team that works in general hospitals and provides psychiatric assessment and treatment to people being treated for physical health problems that also have mental health problems, or people who come to A&E having deliberately self harmed or with suicidal thoughts or behaviour <sup>5</sup>
Psychoeducation	Education offered to individuals with a mental health condition and their families to help empower them and deal with their condition in an optimal way <sup>6</sup>
Psychosocial interventions	Therapies that do not use drugs. Psychological or social techniques which are used to improve mental health
Psychosis	If you have psychosis, you might see or hear things, or hold unusual beliefs, that other people do not. Typical examples of psychosis include hallucinations and delusions <sup>7</sup>
Psychotropic medication	Psychiatric medicines that change the chemical balance in the brain to affect mood and behaviour, e.g. antipsychotics
Recovery college	A project which offers a variety of free educational courses and opportunities targeted at people who have mental health needs
Risk assessment	A systematic way of looking at the potential risks that may be associated with an activity
Safeguarding	Protecting people's health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect <sup>8</sup>
Signpost	To tell a person how they can access a related service
Substance misuse	Can include the excessive or illegal use of alcohol or drugs
Support worker	An unqualified professional, e.g. healthcare assistant, occupational therapy support worker, psychology assistant, etc.
Team supervision	A group of staff meet to discuss and support each other regarding patients and other matters
Triage	To screen information about a person referred to a service to see if they are appropriate for the service
Young Carers Service	A service which may provide information, individual support and peer support for carers under the age of 25

<sup>5</sup> Royal College of Psychiatrists (2015). Psychiatric Liaison Accreditation Network.

<sup>6</sup> Rethink Mental Illness (2014). Schizophrenia Factsheet.

<sup>7</sup> Rethink Mental Health (2015). Psychosis – what is psychosis?

<sup>8</sup> Care Quality Commission (CQC) (2015). Safeguarding people.

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