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EARLY INTERVENTION IN PSYCHOSIS NETWORK

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Standards for Early Intervention in Psychosis Services - 1st Edition

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Contents

Foreword

Guidance to support the implementation of the new Early Intervention in Psychosis (EIP) access and waiting time standard was published in 2016. Co-produced by a wide range of experts, including people with lived experience of services, policy-makers, clinicians, managers and leaders from the health and social care field, the guideline is the first formal review of this specialism since the National Service Framework Policy Implementation Guide over fifteen years ago.

From this guidance, as well as a range of other available literature, the Royal College of Psychiatrists' College Centre for Quality Improvement (CCQI) has developed a comprehensive set of standards for Early Intervention in Psychosis teams, incorporating key standards on access, waiting times and NICE-recommended treatment. It aims to support commissioners and providers of mental health services to develop Early Intervention services to the standard necessary for full effectiveness. With the publication of this framework, service providers and commissioners have the means to ensure that they provide high quality care to people experiencing their first episode of psychosis. This framework sets out clearly how progress will be measured and provides the important detail by which EIP services will be evaluated.

Psychosis impacts people in many ways and, consequently, the interventions required to successfully treat the condition are manifold. The latest NICE guidelines have provided a foundation of proven psychiatric and psychological interventions on which to build these new standards. Support programmes for carers and new vocational interventions now have NICE endorsement, and screening and intervening to prevent the physical health risks associated with psychosis and its treatment are now a requirement. And, for the first time we are required to help people with at-risk mental states at the first signs of psychosis.

This framework has sought to incorporate both the function and ethos of Early Intervention. As well as the clinical interventions endorsed in the latest NICE guidelines, it includes standards for some vital service design elements, such as team configuration, and contains some harder to quantify, but nonetheless essential service components such as engagement styles and team culture.

The publication of this framework marks the culmination of years of work to re-define the national standard for Early Intervention in Psychosis. It represents a synthesis of the latest NICE guidelines and the accumulated wisdom of more than a decade of service delivery experience in this country. It has been a long, sometimes difficult, but hugely worthwhile process. Early Intervention is still a new specialism; psychosis and its causes continue to be hotly debated and some of the recommended therapies remain contentious. Achieving the consensus required for the guideline and this framework of standards is, therefore, a remarkable accomplishment, which ultimately demonstrates the shared

commitment of everyone involved to ensure the highest quality of care and the best possible outcomes for people with first episode psychosis.

With the right care and treatment people can and do make good recoveries from a first episode of psychosis. These standards embody the very best of our knowledge to date. They are comprehensive, clear and practical. As such, this framework represents one of the most useful resources in our toolkit for mental health reform.

Stephen McGowan, National Lead for the IRIS Early Intervention in Psychosis Network

Introduction

These standards have been developed from recommendations in key literature, research and in consultation with a range of stakeholders. Care has been taken to ensure that the development of these standards has taken into consideration a wide range of sources, along with the perspectives of researchers, policy makers, professionals working in early intervention in psychosis services, people who receive care from services and their loved ones.

These standards have been developed for the purpose of review as part of the Early Intervention in Psychosis Network (EIPN), however they can also be used as a guide for new or developing services. Please refer to the EIPN Review Process document for further information about the process of review and accreditation.

Who are these standards for?

These standards are for service providers and commissioners of mental health services to help them ensure they provide high quality care to people experiencing their first episode of psychosis and their loved ones. The standards detailed here focus on the function and ethos of early intervention in psychosis services, and are applicable to all early intervention in psychosis services.

Categorisation of standards

Each standard has been categorised as follows:

Type 1: failure to meet these standards would result in a significant threat to service user safety, rights or dignity and/or would breach the law. These standards also include the fundamentals of care, including the provision of evidence based care and treatment;

Type 2: standards that a service would be expected to meet;

Type 3: standards that are desirable for a service to meet, or standards 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. To achieve accreditation, a service must meet 100% of type 1 standards, at least 80% of type 2 standards and 60% of type 3 standards. The Network facilitates quality improvement and will support teams to achieve accreditation.

Terms

In this document, early intervention in psychosis teams are referred to as *'the service'* or *'the early intervention in psychosis service'.* People who are cared for by the early intervention service are referred to as *'service users'*, and their loved ones are referred to as their *'family, friends or carers'* and include parents, carers, siblings, partners and friends who live with or are in close contact with a person experiencing a first episode of psychosis.

References

A full list of the references relating to these standards can be found on page 55. References are indicated by number throughout this document.

Care Quality Commission (CQC)

These standards have been mapped to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as outlined in the CQC's guidance for service providers and managers (2014).

Access and Waiting Times standards for Mental Health Services

These standards support a programme of work commissioned by NHS England to develop a national quality improvement network, supporting services to improve their access, waiting times and the availability of NICE concordant treatment. Throughout this document, the shaded standards relate to the Access and Waiting Times programme and are being measured by a separate annual self-assessment audit. For further information, please refer to the Implementing the Early Intervention in Psychosis Access and Waiting Time Standard: Guidance document.

Standards for Early Intervention in Psychosis Services

No.	Type	Standard	CQC	References
ACCESS AND REFERRAL				
1.1	2	The service has a local strategy in place to promote and monitor equality and diversity, prevent discrimination and to address any barriers to access.	17.2b	(1), (2)
1.2	1	A clinical member of staff is available to discuss emergency referrals during working hours.	18.1	(1)
1.3	2	The service accepts all people aged 14-65 with first episode psychosis (FEP) or suspected psychosis, with consideration of individual needs and risk. Reasonable exceptions may be made where psychosis is not the primary disorder (e.g. primary personality disorder with psychotic symptoms).		(3), (4), (5), (6)
1.4	2	The service does not exclude people based on their age, gender, history of self-harm, substance misuse, social background, duration of untreated psychosis, criminal history, or co-morbid learning disability or personality disorder.		(1), (3), (4), (5), (6)
1.5	1	Clear information is made available, in paper and/or electronic format, to service users, their family, friends and carers, youth agencies, childrens' services, education providers and healthcare practitioners on: • A simple description of the service and its purpose; • Clear referral criteria; • How to make a referral, including self-referral if the service allows; • Clear clinical pathways describing access and discharge (and how to navigate them); • Main interventions and treatments available; • Contact details for the service, including emergency and out of hours details. *Guidance: The information is co-produced with service users.*	9.3g	(1), (3), (7), (8), (9), (21)
1.6	2	The service accepts referrals from people with suspected first episode of psychosis, carers and other agencies who provide care. *Guidance: Information on how to self-refer is actively promoted to potential service users, carers, and community agencies (e.g. youth services). Where referrals are received from a single point of access, e.g. triage, these are passed on to the early intervention in psychosis service within one working day.*		(3), (5), (7), (10)

NHS England Access & Waiting Time standards [2]

No.	Type	Standard	CQC	References
1.7	2	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 service advises the referrer, service user and carer on alternative options.	9.3g	(1), (11)
1.8	3	Everyone is able to access the service, through home visits, using public transport or transport provided by the service.		(1)
WAITING TIMES				
2.1	1	Service users referred with suspected first episode psychosis receive an initial assessment within 2 weeks of receipt of referral. *Guidance: Please refer to standards 4.3, 4.5a-4.5b (on page 14) for information on guidelines for the initial assessment.*		(1), (12), (2), (13), (14)
2.2	1	Service users with first episode psychosis are allocated to, and engaged with, an Early Intervention in Psychosis (EIP) care coordinator within 2 weeks of receipt of referral.		(1), (2), (5), (12)
2.3	1	Service users referred with, but found not to have first episode psychosis but have suspected At Risk Mental State for Psychosis (ARMS), are offered a specialist ARMS assessment within 2 weeks of receipt of the original referral. Assessment of ARMS is carried out by a trained specialist. *Guidance: The assessment includes the use of structured at-risk mental state assessment tools, e.g. the Comprehensive Assessment of At-Risk Mental States (CAARMS) tool.*		(2), (12)

NHS England Access & Waiting Time standards [2]

No.	Type	Standard	CQC	References
PREPARING FOR THE INITIAL ASSESSMENT				
3.1	1	For planned assessments, the team communicates information in advance to service users that include: • The name and designation of the professional they will see; • An explanation of the assessment process; • Information on who can accompany them; • 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.		(1), (15)
3.2	2	Service users are provided with choice for their assessment and appointments, as appropriate. *Guidance: This includes choice of time, day, and venue, gender of staff or access in another language.*		(11), (15), (21)
3.3	1	Service users are given accessible written information which staff members talk through with them as soon as is practically possible. This includes: • Their rights regarding consent to care and treatment; • How to access advocacy services (including independent mental capacity advocate and independent mental health advocate); • How to access a second opinion; • How to access interpreting services; • How to raise concerns, complaints and compliments; • How to access their own health records.	9.3g 16.2	(1), (5), (6)
3.4	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 (CPA) reviews.		(15)

NHS England Access & Waiting Time standards [2]

No.	Type	Standard	CQC	References
ASSESSMENT				
4.1	1	Service users find staff members friendly and approachable. *Guidance: Staff members introduce themselves to service users, address service users using the name and title they prefer.*	10.1	(1)
4.2	1	Staff members carry their Trust ID at work and during home visits.		(1)
4.3	1	Service users have a comprehensive evidence based assessment which includes their: • Mental health and medication; psychosocial and psychological needs; strengths and areas for development; • A history of the presenting problems; • The identification of clinical signs and symptoms, and any recent changes in functioning; • The identification of social situation and context, including social support and stressors in relation to finance, housing, education, abuse, relationships, bullying and vocation.		(1), (4), (5), (7), (10) (15), (17)
4.4	2	Staff and service users are satisfied with the length of time available to spend on assessments.		(3)
Within two weeks of receipt of the referral, an initial assessment is completed which includes:				
4.5a	1	Service users have a documented risk assessment and management plan which is co-produced and shared where necessary with relevant agencies (with consideration of confidentiality). The assessment considers: • Risk to self; • Risk to others; • Risk from others.	12.2a 9.3b	(1), (4) (5), (7), (15), (17)
4.5b	1	Identification of dependants or siblings including their needs and wellbeing, and any safeguarding or childcare issues. *Guidance: This includes the names, dates of birth and schools of any young people.*	9.3a 13.2	(3), (15)

NHS England Access & Waiting Time standards [2]

No.	Type	Standard	CQC	References
By the end of the initial assessment:				
4.6a	1	A working diagnosis is recorded in their case notes.		(4), (5), (15)
4.6b	2	Service users (and their family, friends or carers with consent) are provided with verbal feedback on the next steps the assessor will take and this is included in the service user's case notes. *Guidance: This may include further discussion with the multidisciplinary team on the most appropriate care pathway/interventions/plan to meet the needs of the service user.*		(3), (15)
4.6c	2	Where a full assessment is not possible but there is suspicion of an emerging or covert psychotic illness, the service conducts an extended assessment.		(4), (5), (7)
4.6d	2	The service sends a letter detailing the outcomes of the assessment to the referrer, the GP and other relevant services within a week of the assessment.	12.2i	(1)
Once accepted onto the caseload of the service, a detailed assessment is completed within 12 weeks which includes:				
4.7a	1	A documented diagnosis and a clinical formulation. *Guidance: The formulation includes the 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 is devised.*		(1),(4), (15)
4.7b	2	An exploration of practical problems of daily living. *Guidance: This includes an assessment of their ability to self-care, motivation and engagement in leisure and vocational activities, situational, physical and environmental inhibitors, communication needs and a comparison of their current lifestyle to the past and the future.*	9.3	(3), (4), (5), (15), (18)
4.7c	2	An exploration and assessment of co-morbid conditions.	9.3a	(3), (7), (10)
4.7d	2	An exploration of prior trauma.	9.3a	(3), (4), (7), (10)
4.7e	2	An assessment of alcohol and substance use, including consideration of drug and alcohol use disorders when necessary.	9.3a	(4), (7), (15)

NHS England Access & Waiting Time standards [2]

No.	Type	Standard	CQC	References
4.7f	1	Identification and recording of the service user's primary sources of support (e.g. their family, friends or carers), or lack thereof. *Guidance: There is a record for each service user where all contacts with the service user and their family, friends or carers are recorded.*	9.3a	(15), (19)

No.	Type	Standard	CQC	References
FOLLOWING UP SERVICE USERS WHO DON'T ATTEND APPOINTMENTS				
5.1	1	If a service user does not attend for assessment, the service contacts the referrer. *Guidance: If the service user is likely to be considered a risk to themselves or others, the service contacts the referrer immediately to discuss a risk action plan.*	12.2i	(1)
5.2	1	The team follows up service users who have not attended an appointment/assessment or who do not want to engage, as per local policy. *Guidance: This could include phone calls, text alerts, letters, visiting service users at home or another suitable venue, or engaging with their carers. If service users continue not to engage, a decision is made by the assessor/team, based on service user need and risk, as to how long to continue to follow them up.*	12.2b	(1), (5), (10), (11), (15), (17)
5.3	2	The service focusses on engagement and applies assertive outreach principles when appropriate. *Guidance: This includes persistence and minimising discharge due to disengagement, taking a persistent and flexible approach to working with service users and their family, friends or carers, and focussing on building excellent therapeutic relationships.*		(2), (3), (5), (6) (10), (16), (17)
5.4	2	Where service users are reluctant to engage with assessment or treatment, the service offers information and guidance to their family, friends or carers, with consideration of confidentiality.		(5), (10), (20), (21)
REVIEWS AND CARE PLANNING				
6.1	1	The service meets for a clinical team meeting, at least weekly, which includes a discussion of service users' needs, risks and management plans.		(1)

NHS England Access & Waiting Time standards [2]

No.	Type	Standard	CQC	References
6.2	2	The service utilises a team approach to care; service users have an allocated care coordinator but receive input from other members of the team appropriate to their needs.		(3), (10)
6.3	1	The service has the capacity for daily multidisciplinary discussions regarding referrals, current assessments, reviews, service user's needs, risks and care plans. *Guidance: Referrals that are urgent or that do not require discussion can be allocated before the meeting*.		(1)
6.5	2	If the service uses electronic records, they meet the requirements of the national Mental Health Services Dataset (MHSDS) and the Care Programme Approach (CPA).		(15)
6.6	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'.		(15)
6.7	1	Risk assessments and management plans are updated according to clinical need or at least every six months. *Guidance: This may be more frequently (e.g. weekly or daily) if risk is significant.*		(1)
6.8	1	Service users know who is co-ordinating their care and how to contact them if they have any questions.		(1)
6.9	1	Every service user has a written care plan, reflecting their individual needs. Staff members actively seek to collaborate with service users and their carers (with service user consent) when developing the care plan.	9.3d	(1), (5), (10), (15), (17) (21), (22)
6.10	1	The service user (and carer, with the service user's consent) are offered a copy of the care plan and the opportunity to review this.	9.3b 9.3e 9.3d 9.3g	(1), (4), (7), (14), (15), (17), (23)
6.11	1	An initial care plan is produced within two weeks of acceptance by the service.		(3), (5), (17)
6.12	2	Initial care plans are reviewed within 3 months of acceptance to the service.		(3), (5), (17)
6.13	1	The service reviews and updates care plans at least every six months, or according to clinical need.	9.3b	(5)

NHS England Access & Waiting Time standards [2]

No.	Type	Standard	CQC	References
6.14	2	Once the service user is engaged and clinically improving, the service develops a flexible agreement with the service user about frequency and mode of contact.		(10)
6.15	1	All service users are offered and supported to develop a personal recovery plan using a structured tool. *Guidance: The plan focuses on the persons' strengths, self-awareness, sustainable resources, support systems and distress tolerance skills and references the management of transitions.*		(2), (3), (23)
6.16	1	Service users are supported to develop a structured safety and staying well (crisis and relapse prevention) plan in collaboration with their family, friends or carers (where appropriate), which is shared with primary care and other organisations involved in their care, with their consent.		(2), (3), (5), (10), (17)
6.17	2	Where identified/possible, the service makes contact with service users' family, friends or carers at least once a month or more frequently depending on need.		(5), (10)
CARE AND TREATMENT				
Therapies and Activities				
7.1.1	1	Service users begin evidence-based interventions, which are appropriate for their bio-psychosocial needs, in a timely manner. Any exceptions are documented in their case notes.	9.1a	(1), (4), (6), (10)
7.1.2	2	Sessional input from psychologists and accredited psychological therapists is sufficient to: • Provide assessment and formulation of service users' psychological needs; • Ensure the safe and effective provision of evidence based psychological interventions adapted to service users' needs through a defined pathway; • Support a whole team approach to the provision of a stepped care model that provides service users with the appropriate level of psychological intervention for their needs.		(1)
7.1.3	3	The service has a strategy for monitoring and promoting a high quality therapeutic relationship between service users, their families, friends or carers, and staff.		

NHS England Access & Waiting Time standards [2]

No.	Type	Standard	CQC	References
7.1.4	1	Service users with first episode psychosis are offered Cognitive Behavioural Therapy for Psychosis (CBTp). *Guidance: Clinicians providing CBTp have completed an approved training course, can demonstrate the required competencies for providing CBTp* [20] *and receive clinical supervision at least monthly. The service actively monitors wait for treatment.*	9.1a	(2), (4), (5), (6), (10), (13), (14), (17)
7.1.5	1	Service users with an At-Risk Mental State for psychosis (ARMS) are offered Cognitive Behavioural Therapy for their ARMS.	9.1a	(2), (17)
7.1.6	1	Service users with coexisting mental health problems (e.g. depression, anxiety, and trauma related disorders) are offered NICE-recommended interventions for these.	9.1a	(2), (4), (10)
7.1.7	1	Service users (and carers, with service user consent) are offered written and verbal information about the service user's mental illness and treatment. *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 or websites.*	9.3g	(1), (2), (4), (5), (6), (19)
7.1.8	2	Services demonstrate that input from occupational therapists is sufficient to: • Provide an occupational assessment for those service users who require it; • Ensure the safe and effective provision of evidence based occupational interventions adapted to service users' needs.	9.1a	(1), (4)
7.1.9	3	Service users have access to community based services which provide art/creative therapies.	9.1a	(1), (4)
7.1.10	2	The service works with service users to develop their social networks. *Guidance: The service is able to offer an activity programme that promotes social inclusion, activity and peer support. Service users who remain socially isolated have individual plans developed to address this.*		(4), (7), (10)

NHS England Access & Waiting Time standards [2]

No.	Type	Standard	CQC	References
7.1.11	1	The team provides information and encouragement to service users to access local organisations for peer support and social engagement. This is documented in the service user's notes and includes access to: • Voluntary organisations; • Community centres; • Local religious/cultural groups; • Peer support networks; • Recovery colleges.	10.2b	(1), (4), (5), (15)
7.1.12	3	Service users are offered the opportunity to meet and engage with other service users. *Guidance: These opportunities are directed by service users' preferences and needs and may include social outings, mutual learning opportunities, group meetings etc.*		(3)
7.1.13	1	Service users with first episode psychosis are offered supported employment programmes. *Guidance: These may include programmes such as Individual Placement Support (IPS), employment placements, back to work support and employment preparation programmes.*	9.1a	(4), (6), (10), (13)
7.1.14	2	For service users who are unable to attend mainstream education, training or work, the service facilitates alternative educational or occupational activities (including pre-vocational training) according to their individual needs and capacity to engage with such activities, with an ultimate goal of returning to mainstream education, training or employment.		(4), (5), (10), (14), (24)
7.1.15	2	Where service users are in education, the service liaises with the service user's school, education and support services (e.g. school counsellor, nurse), and local authority, with the service user's consent, to support them to continue their education.		(5), (7), (11), (24)
7.1.16	3	The service utilises technology to support service users to monitor and manage their mental health. *Guidance: This may include the use of apps for mindfulness, self-reporting of symptoms to prevent relapse, sharing tips and strategies for maintaining wellness, identifying early signs of relapse and medication reminders.*		(11)

NHS England Access & Waiting Time standards [2]

No.	Type	Standard	CQC	References
7.1.17	1	Service users with first episode psychosis and their families are offered family interventions. *Guidance: Clinicians providing family interventions have completed an appropriate level of competence and training and receive clinical supervision at least monthly.*	9.1a	(4), (6), (10), (11), (13), (14)
Medication				
7.2.1	1	Service users with first episode psychosis are offered antipsychotic medication.	9.1a	(4), (6), (10)
7.2.2	1	Service users and their family, friends or carers (with service user consent) are helped to understand the functions, expected outcomes, limitations and side effects of the medications and to self-manage as far as possible.	9.3c 9.3e	(1), (4), (6)
7.2.3	2	Service users and their family, friends or carers are given written information, appropriate to their needs, about medication and are supported to be involved in making informed choices. *Guidance: This includes a clear explanation of likely benefits, possible side effects, their right to choose not to take medication, or to reduce their medication.*	9.3g	(4), (5), (6), (7), (10), (15)
7.2.4	1	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.	12.2b	(1), (4)
7.2.5	2	Medication reviews take place at a frequency according to the evidence base and individual need. *Guidance: This includes an assessment of therapeutic response, safety, side effects monitoring using a standardised tool and adherence to medication regime. Long-term medication is reviewed by the prescribing clinician at least once a year as a minimum.*		(1), (5), (10), (11), (14), (15)
7.2.6	1	When service users experience side effects from their medication, this is engaged with and there is a clear plan in place for managing this.	9.3b 12.2b	(1), (5), (10)
7.2.7	1	Service users have their medications reviewed at 3 months initially and thereafter at least every 6 months. Medication reviews include an assessment of therapeutic response, safety, side effects and adherence to medication regime. *Guidance: Side effect monitoring tools can be used to support reviews.*	12.2a	(1), (3), (4)

NHS England Access & Waiting Time standards [2]

No.	Type	Standard	CQC	References
7.2.8	1	If the service user's illness does not respond to an adequate trial of 2 different antipsychotic medicines given sequentially, they are offered clozapine. *Guidance: Each medicine is given in a treatment dose for an adequate duration of time and with objective evidence of adherence. A comprehensive review of reasons for a non-response (e.g. misdiagnosis, untreated co-morbidities) is undertaken.*	9.1a	(4), (6), (13)
7.2.9	2	The service provides advice for service users (and their family, friends and carers), appropriate to their needs, to enable them to manage their medication. *Guidance: This includes information on dosage, mode of administration (e.g. depot), frequency and storage.*		(15)
7.2.10	3	Service users, carers and prescribers are able to contact a specialised pharmacist and/or pharmacy technician to discuss medications.		(1), (3)
7.2.11	1	The service collects data on the safe prescription of high risk medications such as; lithium, high dose antipsychotic drugs, antipsychotics in combination and benzodiazepines. The service uses this data to make improvements and continues to monitor the safe prescription of these medications on an ongoing basis. *Guidance: This may include the POMH audit.*	17.2a	(1)
7.2.12	1	Service users are not prescribed more than one antipsychotic drug; if they are, a rationale is recorded for this. *Guidance: Exceptions include a short period of overlap while changing medication or because clozapine is co-prescribed with a second antipsychotic.*		(4)
7.2.13	1	For service users who are taking antipsychotic medication, the team maintains responsibility for monitoring their physical health and the effects of antipsychotic medication for at least the first 12 months or until the person's condition has stabilised, whichever is longer. Thereafter, the responsibility for this monitoring may be transferred to primary care under shared care arrangements.		(1)

NHS England Access & Waiting Time standards [2]

No.	Type	Standard	CQC	References
7.2.14	1	Dosages of antipsychotic drugs do not exceed British National Formulary (BNF), British National Formulary for Children (BNFC) or Summary of Product Characteristics (SPC) recommendations; if they do, a rationale is recorded for this. *Guidance: For FEP, best practice guidance (e.g. Maudsley Prescribing Guidelines) for prescribing is used, noting that the doses of antipsychotics known to be effective in first episode are generally lower than those that are needed in multi-episode service users*.		(3), (4), (6) (10), (21)
7.2.15	2	If medication is prescribed or administered by the primary care team, the service has a protocol covering this and responsibility is clearly documented in the service user's notes.		(4), (15)
7.2.16	1	For service users prescribed depot medication, a full discussion takes place between the service user and their clinician. A clear rationale for this method of administration and the service user's preferences are taken into account and recorded in their case notes. *Guidance: This includes the attitude of the service user towards this method of administration and documentation of agreed procedures in place for administration (e.g. location of clinics, site of administration etc.).*		(4)
PHYSICAL HEALTHCARE				
8.1.1	1	Service users are offered personalised healthy lifestyle interventions, including and where indicated pharmacological interventions in line with the Lester tool recommendations. Such interventions may include advice on healthy eating, physical activity and access to smoking cessation services in collaboration with primary care. This is documented in the service user's care plan.	9.1a	(1), (2), (4), (10), (13), (14)
8.1.2		Staff members arrange for service users to access screening, monitoring and treatment for physical health problems through primary/secondary care services. This is documented in the service user's notes.		(1)
8.1.3	1	Physical health reviews are repeated at least annually and there is clear evidence of intervention where appropriate.		(4), (13)

NHS England Access & Waiting Time standards [2]

No.	Type	Standard	CQC	References
8.1.4	2	Copies of the physical healthcare monitoring results are sent to the care coordinator, GP, psychiatrist and service user.		(4)
8.1.5	1	The team understands and follows an agreed protocol for the management of an acute physical health emergency. *Guidance: This includes guidance about when to call 999 and when to contact the duty doctor.*	12.2b	(1)
8.1.6	2	The Trust/service have a policy for the care of service users with dual diagnosis that is in line with NICE Guidance. The policy includes: • Liaison and shared protocols between mental health and substance misuse services to enable joint working; • Drug/alcohol screening to support decisions about care/treatment options; • Liaison between mental health, statutory and voluntary agencies; • Staff training; • Access to evidence based treatments.	12.2b 12.2i	(6)
8.1.7	1	The service has a care pathway for the care of women in the perinatal period (pregnancy and 12 months post-partum) that includes: • Assessment; • Care and treatment (particularly relating to prescribing psychotropic medication); • Referral to a specialist perinatal team/unit for shared care and support unless there is a specific reason not to do so.	12.2b	(1)

NHS England Access & Waiting Time standards [2]

No.	Type	Standard	CQC	References
8.1.8	1	Service users have their physical health reviewed at the start of treatment (baseline), at 3 months and then annually (or 6 monthly for young people) unless a physical health abnormality arises. The clinician monitors the following information about the service user: • A personal/family history (at baseline and annual review); • Lifestyle review (at every review); • Weight (at every review) and height (baseline and every 6 months for young people); • Waist circumference (at baseline and annual review for adults; at baseline and 6 monthly for young people); • Blood pressure (at every review); • Fasting plasma glucose/HbA1c (glycated haemoglobin) (at every review); • Lipid profile (at every review). *Guidance: Service users taking mood stabilisers or antipsychotics 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.*	12.2a	(1), (4), (10), (14)
RISK AND SAFEGUARDING				
9.2	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.	12.2b 12.3 13.2	(1)
DISCHARGE PLANNING AND TRANSFER OF CARE				
10.1	1	The service offers an optimum treatment package of 3 years, with consideration of service user need.		(5), (10)
10.2	1	A discharge letter is sent to the service user and all relevant parties within 10 working days of discharge. The letter includes the plan for: • On-going care in the community/aftercare arrangements; • Crisis and contingency arrangements including details of who to contact; • Medication, including monitoring arrangements; • Details of when, where and who will follow up with the service user as appropriate.	9.3g	(1), (5)

NHS England Access & Waiting Time standards [2]

No.	Type	Standard	CQC	References
10.3	3	The service has access to alternatives to inpatient care, appropriate to service users' age and needs. *Guidance: This may include crisis resolution/home treatment teams, respite beds, a crisis house, community hostel, cluster home or day care.*		(4), (5), (7), (11), (14), (17)
10.4	2	When a service user is admitted to hospital, a service representative attends and contributes to care plans, ward rounds and discharge planning.	12.2i	(1)
10.5	2	If inpatient care is required, service users are admitted to a setting which is appropriate for their age and needs.		(4), (5), (10), (17)
10.6	2	If inpatient care is required, staff from the service continue to work actively with the service user in the inpatient setting.		(7), (11)
10.7	2	If inpatient care is required, regular formal joint reviews take place between ward staff and the service, with the involvement of their family, friends or carers, to ensure the person is transferred into the least restrictive environment as early as clinically possible.		(4), (5), (11)
10.8	1	Service users who are discharged from hospital to the care of the early intervention in psychosis service are followed up within one week of discharge, or within 48 hours of discharge if they are at risk. *Guidance: This may be in coordination with the crisis resolution/home treatment team.*	12.2i 12.2b	(1)
10.9	2	There is a clear protocol to minimise and effectively manage transitions of care for children and young people.	12.2i	(3)
10.10	2	There is active collaboration between Child and Adolescent Mental Health Services (CAMHS) 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.	12.2i	(1)

NHS England Access & Waiting Time standards [2]

No.	Type	Standard	CQC	References
10.11	2	People who transition between child and adolescent, early intervention and adult community teams are provided with a transition pack which contains information on: • The roles of adult mental health staff (for example general adult psychiatrist, community psychiatric nurse); • Who to contact if there is a problem.		(3)
10.12	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.	12.2i	(1)
10.13	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 their family, friends or carers to discuss transfer of care.	12.2i	(1)
10.14	3	Teams provide specific transition support to service users when their care is being transferred to another community mental health team, or back to the care of their GP. *Guidance: The team provides transition mentors; transition support packs; or training for services users on how to manage transitions.*		(1)
10.15	1	Upon transfer of care or discharge, the service provides the service user's GP and the accepting service (if relevant) with the following information about the service user: • Summary of history; • Diagnosis and personal formulation; • Medication or psychological therapies undertaken, and advice on future management; • Assessment of current safety; • Crisis plan including relapse signs.	9.3g	(15), (17)
10.16	2	There are agreements with other agencies for service users to re-access the service if needed, without following the initial referral pathway. *Guidance: There may be exceptions where service users require a generic assessment and it may be appropriate to follow the initial referral pathway.*		(10), (15)

NHS England Access & Waiting Time standards [2]

No.	Type	Standard	CQC	References
INTERFACES WITH OTHER SERVICES				
11.1	2	The service has an agreed care pathway, policies, procedures and joint protocols defining ways of working with other physical and mental health services. *Guidance: This includes assertive outreach teams, child and adolescent teams, substance misuse, youth offending teams, education services, social services, inpatient, outpatient and other community services where applicable.*	12.2i	(1), (5), (15)
11.2	2	There is regular communication between the early intervention in psychosis service, Child and Adolescent Mental Health Services (CAMHS) and the primary care team to: • Discuss service users with shared care arrangements; • Discuss service users where CAMHS or primary care have concerns about possible psychosis.		(5), (15)
11.3	2	The team follows a joint working protocol/care pathway with primary health care teams. *Guidance: This includes shared prescribing protocols with the GP, the team informing the GP of any significant changes in the service user's mental health or medication, or of their referral to other teams.*	12.2i	(1), (5)
11.4	1	Service users can access help, from mental health services, 24 hours a day, 7 days a week. *Guidance: Out of hours, this may involve crisis/home treatment teams, psychiatric liaison teams and telephone helplines.*	12.2i	(1)
11.5	1	The service can access a crisis assessment from the crisis resolution/home treatment team (or equivalent) within four hours.		(4), (15)
11.6	2	The service is able to provide care to people with a secondary diagnosis, and/or signpost/refer them on for care. *Guidance: Care for service users also under the care of another service is provided in a team approach with a consistent clinical model and good understanding of their needs.*		(3)
11.7	1	Service users with drug and alcohol problems have access to specialist help e.g. drug and alcohol services.		(1),

NHS England Access & Waiting Time standards [2]

No.	Type	Standard	CQC	References
11.8	2	Where service users have a primary psychotic disorder but are referred to other specialist services (e.g. substance misuse), the early intervention in psychosis service continues to have overall responsibility for the service user. *Guidance: An exception may exist for postpartum psychosis where a perinatal mental health service exists.*		(3)
11.9	1	The service supports service users to access organisations which offer: • Housing support; • Support with finances, benefits and debt management; • Social services.		(1)
11.10	2	The service has a formal link with an advocacy service for use by service users.		(1),
11.11	2	Service users are supported to access personalised budgets and self-directed support, if eligible.		(10), (15)
11.12	2	Health records can be accessed by other services who may be involved with the service user's care. *Guidance: This could include psychiatric liaison teams, crisis resolution/home treatment teams, acute inpatient wards, and accident and emergency departments.*		(15)
11.13	3	The service provides training to other professionals and agencies (e.g. teachers, youth workers, police and criminal justice services) that may come into contact with people with early stage presentations of psychosis, about signs and symptoms of illness and how to refer to the service.		(5), (11)
CAPACITY AND CONSENT				
12.1	1	Capacity assessments are performed in accordance with current legislation and documented in the service user's notes.		(1)
12.2	1	When a decision is required about a service user's care, an assessment of the person's capacity and/or competency is recorded. If the service user is able to consent, their consent to treatment is recorded.	11.1	(8)
12.3	1	When service users are unable to consent, their views are taken into account and the reason for the proposed treatment is explained to them.		(1), (8)

NHS England Access & Waiting Time standards [2]

No.	Type	Standard	CQC	References
12.4	1	There are systems in place to ensure that the service takes account of any advance decisions that the service user has made.	11.1 13.4d	(1)
SERVICE USER INVOLVEMENT				
13.1	1	Service users and their carers are encouraged to feed back confidentially about their experiences of using the service, and their feedback is used to improve the service. *Guidance: Feedback is independently sought (ideally not by the clinical team). Their feedback is triangulated with other feedback to make it as accurate as possible. Staff members are informed of feedback from service users.*	9.3f 17.2e 17.2f	(1)
13.2	2	Services are developed in partnership with service user and carer representatives. *Guidance: This might involve service user and carer representatives attending and contributing to local and service level meetings and committees.*	17.2e	(1)
13.3	1	Service users are actively involved in shared decision-making about their mental and physical health care, treatment and discharge planning and supported in self-management.		(1)
13.4	3	Service users are actively involved in co-production for the service, or there is a service user reference group.		(3)
CARER ENGAGEMENT AND SUPPORT				
Note: Family, friend or carer involvement in the service user's care and treatment is subject to the service user giving consent and/or their involvement being in the best interests of the service user.				
14.1	1	Family, friends or carers (with service user consent) are involved in discussions and decisions about the service user's care, treatment and discharge planning.		(1), (4), (7), (10), (15), (17), (19)
14.2	1	The team follows a protocol for responding to family, friends or carers when the service user does not consent to their involvement.		(1)
14.3	1	Carers are advised on how to access a statutory carers' assessment, provided by an appropriate agency. *Guidance: This advice is offered at the time of the service user's initial assessment, or at the first opportunity.*		(1), (2), (4), (10), (19)

NHS England Access & Waiting Time standards [2]

No.	Type	Standard	CQC	References
14.4	2	The team provides family, friends and carers with carer's information. *Guidance: Information is provided verbally and in writing (e.g. carer's pack). This includes the names and contact details of key staff members in the team and who to contact in an emergency. It also includes other local sources of advice and support such as local carers' groups, carers' workshops and relevant charities.*		(1), (19)
14.5	2	Family, friends or carers are offered individual time with staff members to discuss concerns, family history and their own needs.		(1), (10), (19)
14.6	2	The service offers specific support to people with children, siblings or other dependants, for example meeting with these individuals, offering appropriate written information, support groups or supporting the service user to communicate with their children, siblings or dependants about their mental health.		(10), (15)
14.7	1	Family, friends or carers are offered carer-focussed education and support programmes.		(2), (4), (13), (14)
14.8	2	Carers feel supported by staff members. *Guidance: This could be through the provision/sign-posting to carer support networks or groups. It could be through the provision of a designated staff member dedicated to carer support.*		(1), (19)
14.9	2	Family, friends and carers are given information and advice to support service users' independence, safety and wellbeing, and to consider the impact of psychosis on their functional abilities.		(18)
TREATING SERVICE USERS WITH COMPASSION, DIGNITY AND RESPECT				
15.1	1	Staff members treat service users and carers with compassion, dignity and respect. *Guidance: This includes respect of a person's age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.*	10.1	(1), (23)
15.2	1	Service users feel listened to and validated by staff members.	10.1	(1)
15.3	1	Service users do not feel stigmatised by staff members.		(1)

NHS England Access & Waiting Time standards [2]

No.	Type	Standard	CQC	References
15.4	1	All service users are offered the opportunity to see a staff member on their own without a family member, friend or carer present.		(20), (21)
15.5	1	The service can demonstrate that it promotes practice sensitive to the diversity of the service user. *Guidance: The diversity of each service user is taken into account during assessment, treatment and support. This includes ethnicity, culture, age, sex, gender reassignment, marital status, sexual orientation, pregnancy and maternity status, disability, religion/beliefs and social background.*		(4), (15)
15.6	1	Staff members are knowledgeable about, and sensitive to, the mental health needs of service users from minority or hard-to-reach groups. This may include: • Black, Asian and minority ethnic groups; • Asylum seekers or refugees; • Lesbian, gay, bisexual or transgender people; • Travellers.		(1)
PROVISION OF INFORMATION TO SERVICE USERS AND FAMILY, FRIENDS AND CARERS				
16.1	1	The service uses interpreters who are sufficiently knowledgeable and skilled to provide a full and accurate translation. The service user's relatives are not used in this role unless there are exceptional circumstances. *Guidance: Exceptional circumstances might include crisis situations where it is not possible to get an interpreter at short notice.*	10.1	(1), (5)
16.2	1	When talking to service users, family, friends and carers, health professionals communicate clearly, avoiding the use of jargon.	10.1	(1), (6), (16)
16.3	1	Service users are asked if they and their family, friends and carers wish to have copies of letters about their health and treatment.		(1)
16.4	1	Information for service users and carers is written simply and clearly, and can be provided in languages other than English (ensuring cultural relevance if necessary). It is available in easy-to-use formats for people with sight/hearing/cognitive difficulties or learning disabilities. Audio, video, symbolic and pictorial materials, communication passports and signers are used as necessary.	10.1 9.3g	(1), (6), (16)

NHS England Access & Waiting Time standards [2]

No.	Type	Standard	CQC	References
16.5	1	The service has access to materials (written information and assessment tools) in a variety of formats to meet the needs of service users and their family, friends and carers. *Guidance: Consider needs associated with various ages, diagnoses, language, literacy, learning disability, sensory impairment, etc.*		(15), (21)
At the time of the assessment, the service routinely provides service users and their family, friends and carers with a variety of written information appropriate to their needs including the following:				
16.6a	2	A description of the service and the range of interventions available, including emphasis on service user choice. *Guidance: This includes contact details, a website address, other local sources of support, the culture of the service including recovery aspects, and interactions with other mental health teams.*		(4), (5), (15), (16)
16.6b	1	How to access emergency support, including out of hours.		(4), (5), (10), (15)
16.6c	2	Managing their health and wellbeing. *Guidance: This may include reference to '5 Ways to Wellbeing'.*		(4), (15)
16.6d	2	Information to help them understand psychosis and treatment options. *Guidance: Consider needs associated with age, capacity, culture.*		(4), (7), (16)
SERVICE USER CONFIDENTIALITY				
17.1	1	Confidentiality and its limits are explained to the service user, family, friends and carers at the initial assessment, both verbally and in writing. *Guidance: This includes transfer of service user identifiable information by electronic means. This includes sharing information outside of the clinical team and confidentiality in relation to third party information (for carers).*		(1), (4), (16), (21)
17.2	1	Service users' preferences for sharing information with their carer are established, respected and reviewed throughout their care.		(1)

NHS England Access & Waiting Time standards [2]

No.	Type	Standard	CQC	References
17.3	1	All service user information is kept in accordance with current legislation. *Guidance: This includes transfer of service user identifiable information by electronic means. Staff members ensure that no confidential data is visible beyond the team by locking cabinets and offices, using swipe cards and having password protected computer access.*	17.2c	(1)
17.4	1	The service has confidentiality policies which are regularly monitored and reviewed, and upheld at all times when exchanging information. *Guidance: Policies include the provision of information release forms and advance statement protocols and forms.*		(15), (19), (21)
SERVICE ENVIRONMENT				
18.1	2	The service regularly works in a variety of low stigma settings appropriate to the needs and wishes of service users. *Guidance: This may include, but is not limited to, service users' homes, GP practices, schools, community services, etc.*		(5), (21)
18.2	1	Clinical rooms are private and conversations cannot be easily over-heard.	15.1c 10.2a	(1)
18.3	1	The environment complies with current legislation on disabled access. *Guidance: Relevant assistive technology equipment, such as hoists and handrails, are provided to meet individual needs and to maximise independence.*	15.1c 10.2a	(1)
18.4	1	Staff members follow a lone working policy and feel safe when conducting home visits.	18.1	(1)
18.5	1	An audit of environmental risk is conducted annually and a risk management strategy is agreed.	12.2d 17.2a	(1)
18.6	1	Furniture is arranged so that doors, in rooms where consultations take place, are not obstructed.	12.2d	(1)
18.7	1	There is an alarm system in place (e.g. panic buttons) and this is easily accessible.	12.2d 15.1b	(1)
18.8	1	Staff members follow an agreed response to alarm calls.	15.1b	(1)

NHS England Access & Waiting Time standards [2]

No.	Type	Standard	CQC	References
18.9	1	All rooms are kept clean. *Guidance: All staff members are encouraged to help with this.*	15.1a	(1)
18.10	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/treatment, service user records, clinical outcome and service performance measurements.	15.1c	
18.11	3	The team is able to access mobile IT resources to enable them to make contemporaneous records.	15.1c	
18.12	1	Emergency medical resuscitation equipment, as required by Trust/organisation guidelines, is available immediately (available for use within the first minutes of a cardiorespiratory arrest) and is maintained and checked weekly, and after each use.	15.1f	(1)
18.13	2	Staff members have access to a dedicated staff room.	15.1c	(1)
18.14	2	The clinic environment is comfortable, clean and warm, appropriate for service users, and areas of privacy are available in the waiting area.		(15)
LEADERSHIP AND CULTURE				
19.1	2	Staff members can access leadership and management training appropriate to their role and speciality.		(1)
19.2	2	Team managers and senior managers promote and support positive risk-taking to encourage service user recovery and personal development. They ensure staff members have appropriate supervision and MDT support to enable this.		(1)
19.3	1	Staff members feel able to challenge decisions and to raise any concerns they may have about standards of care. They are aware of the processes to follow when raising concerns.	9.3d 20.1	(1)
TEAMWORKING				
20.1	2	Staff members work well together, acknowledging and appreciating each other's efforts, contributions and compromises.		(1)

NHS England Access & Waiting Time standards [2]

No.	Type	Standard	CQC	References
STAFFING LEVELS AND SKILL MIX				
21.1	1	The service has an adequate skill mix to provide a range of psychological, pharmacological and social interventions.	18.1	(4), (15)
The service has dedicated sessional time from:				
21.2a	2	A service lead;		(15)
21.2b	2	Registered Mental Health Nurse(s);		(5), (15)
21.2c	2	Social Worker(s);		(5), (15)
21.2d	2	Occupational Therapist(s);		(5), (15)
21.2e	2	Clinical Psychologist(s);		(5), (15)
21.2f	2	Psychologist(s) with Child and Adolescent Mental Health Service (CAMHS) experience and knowledge;		(5)
21.2g	2	Support Worker(s); *Guidance: An unqualified professional, e.g. healthcare assistant, occupational therapy assistant, psychology assistant etc.*		(5), (15)
21.2h	3	Vocational Specialist(s);		(2), (3)
21.2i	2	Consultant Adult Psychiatrist(s);		(5), (15)
21.2j	2	Consultant Child and Adolescent Psychiatrist(s);		(5)
21.2k	3	Independent Prescriber(s);		(15)
21.2l	3	Pharmacist(s);		(15)
21.2m	2	Employment Adviser(s);		(15)
21.2n	3	Family Therapist(s); *Guidance: A specific family therapist independent to workers delivering family interventions.*		(15)
21.2o	2	Psychological Therapist(s).		

NHS England Access & Waiting Time standards [2]

The team has adequate access to:				
21.3a	2	Peer Support Worker(s); *Guidance: An individual with relevant lived experience who is employed to support service users and/or family, friends or carers.*		(15)
21.3b	2	Approved Mental Health Professional(s) (AMHPs);		(15)
21.3c	3	Welfare and Benefits Advisor(s);		(15)
21.3d	2	Administrative assistance to meet the needs of the service.		(5), (15)
21.4	1	The service has a mechanism for responding to low staffing levels, including: • A method for the team to report concerns about staffing levels; • Access to additional staff members; • An agreed contingency plan, such as the minor and temporary reduction of non-essential services.	18.1	(1)
21.5	1	When a staff member is on annual leave or off sick, the team puts a plan in place to provide adequate cover for the service users who are allocated to that staff member.		(1)
21.6	1	Full-time care coordinators have a caseload of no more than 15 (reduced pro-rata for part-time staff).		(5), (10), (11)
21.7	1	The service has access to prescribing advice during working hours from a consultant psychiatrist, independent prescriber or specialist pharmacist.		(15)
21.8	2	The service has a nominated medicines management lead.		(15)
STAFF RECRUITMENT AND INDUCTION				
22.1	2	Service user or carer representatives are involved in the interview process for recruiting staff members. *Guidance: This could include co-producing interview questions or sitting on the interview panel.*		(1), (17)

NHS England Access & Waiting Time standards [2]

22.2	1	New staff members, including bank staff, receive an induction based on an agreed list of core competencies. *Guidance: This includes arrangements for shadowing colleagues on the team; jointly working with a more experienced colleague; being observed and receiving enhanced supervision until core competencies have been assessed as met.*	18.2a	(1)
22.3	2	All new staff members are allocated an appropriate person to supervise their transition into the service.		(1),
22.4	2	All new staff receive an induction and access to ongoing training which includes the principles of early intervention in psychosis services and their role in promoting empowerment, hope, recovery, self-management, wellbeing, family support, physical healthcare, safety and positive risk management.	18.2a	(5), (15), (16)
APPRAISAL, SUPERVISION AND SUPPORT				
23.1	1	All clinical staff members receive clinical supervision at least monthly, or as otherwise specified by their professional body. *Guidance: Supervision is profession-specific as per professional guidelines and is provided by someone with appropriate clinical experience and qualifications.*	18.2a	(1)
23.2	2	Staff members in training and newly qualified staff members are offered weekly supervision.	18.2a	(1)
23.3	2	All staff members receive line management supervision at least monthly.	18.2a	(1)
STAFF WELLBEING				
24.1	1	The service actively supports staff health and well-being. *Guidance: For example, providing access to support services, providing access to physical activity programmes, monitoring staff sickness and burnout, assessing and improving morale, monitoring turnover, reviewing feedback from exit reports and taking action where needed.*	17.2a	(1)
24.2	1	Staff members are able to take breaks during their shift that comply with the European Working Time Directive. *Guidance: They have the right to one uninterrupted 20-minute rest break during their working day, if they work more than 6 hours a day. Adequate cover is provided to ensure staff members can take their breaks.*		(1)

NHS England Access & Waiting Time standards [2]

24.3	2	Staff members are able to access reflective practice groups at least every 6 weeks where teams can meet together to think about team dynamics and develop their clinical practice.	18.2a	(1)
24.4	3	The team has received training in reflective practice and maintaining a psychologically informed environment.		(1)
24.5	2	There are systems in place to monitor individual caseloads of staff members.		(15)
STAFF TRAINING AND DEVELOPMENT				
25.1	Staff members receive training consistent with their role, which is recorded in their personal development plan and is refreshed in accordance with local guidelines. This training includes:			
25.1a	1	The use of legal frameworks, such as the Mental Health Act (or equivalent) and the Mental Capacity Act (or equivalent);	11.1	(1), (5), (7)
25.1b	1	Statutory and mandatory training. *Guidance: Includes equality and diversity, information governance, and basic life support.*		(1)
25.1c	1	Physical health assessment; *Guidance: This could include training in understanding physical health problems, understanding physical observations and when to refer the service user for specialist input.*		(1)
25.1d	1	Recognising and communicating with service users with special needs, e.g. cognitive impairment or learning disabilities;		(1)
25.1e	1	Risk assessment and risk management; *Guidance: This could include: Safeguarding vulnerable adults and children; Assessing and managing suicide risk and self-harm; Prevention and management of aggression and violence; Prevent training; Recognising and responding to the signs of abuse, exploitation or neglect.*		(1)
25.3f	2	Carer awareness, family inclusive practice and social systems, including carers' rights in relation to confidentiality;		(1), (16), (19)
25.3g	2	Training on the Individual Placement Support (IPS) approach;		(3)

NHS England Access & Waiting Time standards [2]

25.3h	1	Medication; *Guidance: This includes storage, administration, legal issues, encouraging concordance and awareness of side effects.*		(5), (15)
25.3i	2	Cultural sensitivity including those based on family background, cultural, subcultural and religious beliefs;		(4), (6), (16)
25.3j	2	Addressing personal beliefs regarding biological, social and family influences on the causes of psychosis;		(4), (16)
25.3k	2	Reflective practice and debriefing;		(15)
25.3l	2	Providing psychologically informed interventions as required by their role; *Guidance: This may include coping skills, normalising techniques, early warning signs, motivational interviewing techniques and relapse prevention.*		(3), (5)
25.3m	2	Engagement and developing high quality therapeutic relationships with service users and their families, friends and carers; *Guidance: This includes the principles of kindness and compassion, consideration of different ethnic and cultural backgrounds, and working with young people and their families.*		(4), (7), (16), (21)
25.3n	2	Case formulations;		(3)
25.3o	3	Delivering group interventions;		(15)
25.3p	2	Substance and alcohol misuse awareness and assessment;		(6)
25.3q	2	The individual needs of service users with bipolar affective disorder;		(3)
25.4	2	Service users, family, friends, carers and staff members are involved in devising and delivering training face-to-face.		(1)
25.5	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.	12.2g	(15)
25.6	2	Staff working with children and young people have received training in working with children and young people with all levels of emotional maturity, cognitive capacity and learning ability.		(7), (16)

NHS England Access & Waiting Time standards [2]

GENERAL MANAGEMENT				
26.1	1	The service is a stand-alone holistic multidisciplinary team. If the service is serving a sparsely populated rural area and a hub and spoke model is adopted, the service can provide evidence that it is able to overcome the risks associated with this model, and deliver the same benefits as the evidence based stand-alone model.		(2), (5), (10), (22), (23)
26.2	2	The service has an operational policy which covers the purpose and aims of the service, ways of working and defined catchment population.		(15)
CLINICAL OUTCOME MEASUREMENT				
27.1	1	Clinical outcome measurement data is collected at assessment, after 6 months, 12 months and then annually until discharge. *Guidance: DIALOG, HoNOS/HoNOSCA and QPR are utilised for all service users.*		(1), (2)
27.2	2	Staff members review service users' progress against service user-defined goals in collaboration with the service user at the start of treatment, during clinical review meetings and at discharge.	9.3d	(1)
27.3	2	The service's clinical outcome data are reviewed at least 6 monthly. The data are shared with commissioners, the team, service users and carers, and used to make improvements to the service.		(1)
AUDIT, SERVICE EVALUATION AND DEVELOPMENT				
28.1	2	The service has an active programme of research which includes opportunities for service users and their family, friends and carers to participate in local, national and international research, such as research promoted by the National Institute for Health Research (NIHR) or equivalent local bodies.		(3)
28.2	2	The service has a programme of clinical audit in line with national priorities. *Guidance: This includes ECG monitoring, prescribing practice, access to psychological interventions, integration of employment support and physical healthcare.*	17.2a	(1), (15)
28.3	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.	17.2a	(1)

NHS England Access & Waiting Time standards [2]

28.4	2	A review of local early intervention in psychosis service provision has taken place, including examination of population demographics.		(2)
28.5	2	An audit of the frequency of review of physical health indicators has been undertaken in the last year. *Guidance: This includes monitoring of weight, cardiovascular and metabolic indicators.*		(15)
28.6	3	An audit of the provision of carer education and support programmes has been undertaken in the last three years.		(15)
28.7	3	As assessment of the extent to which the service is recovery-focused has taken place, using an identified tool within the last two years. *Guidance: e.g. Scottish Recovery Indicator, Developing Recovery Enhancing Environments Measure (DREEM) or Implementing Recovery through Organisational Change (IMROC).*		(15), (23)
28.8	2	An audit of the frequency of care plan reviews has been undertaken in the last year.		(15)
28.9	2	An audit of adherence to the Mental Health Act (or equivalent) guidance has been undertaken in the last year.		(3)
28.10	2	Key performance outcome measures for the service include: • Discharge destination; • Occupation; • Suicide rates; • Inpatient admissions; • Use of the Mental Health Act (or equivalent).		(3), (10)
28.11	2	An audit and/or service evaluation on referrals to the service has been undertaken in the last two years. *Guidance: e.g. including demographics, ethnic and cultural issues, waiting times, as appropriate.*		
THE SERVICE LEARNS FROM INCIDENTS				
29.1	1	Systems are in place to enable staff members to quickly and effectively report incidents. Managers encourage staff members to do this.	12.2b 13.2	(1)

NHS England Access & Waiting Time standards (2)

29.2	1	Staff members share information about any serious untoward incidents involving a service user with the service user themselves and their family, friends or carers, in line with the Duty of Candour agreement.	12.2b 20.2a	(1)
29.3	1	Staff members, service users and their family, friends or carers who are affected by a serious incident are offered post incident support.	20.2b	(1)
29.4	1	Lessons learned from untoward incidents are shared with the team and the wider organisation. There is evidence that changes have been made as a result of sharing the lessons.	12.2b	(1)

NHS England Access & Waiting Time standards (2)

Definitions

First Episode Psychosis (FEP)

This relates to an individual experiencing clear symptoms of psychosis typically operationalised in terms of PANSS (Positive and Negative Syndrome Scale) as below:

- Experiencing 4 or above on the *hallucinations and delusions* section of the PANSS, with other items on the *positive* section of the scale scoring 5 or above in the context of a cluster of symptoms.
- The symptom must have lasted throughout the day for several days or several times a week, and not limited to a few brief moments.

The above symptoms must be present for a period of over seven days' duration over the last 12 months (or if less than this, then the improvement must be attributable to antipsychotic treatment).

At-Risk Mental States for psychosis (ARMS)

An at-risk mental state may include:

- an episode of psychosis lasting less than seven days, or
- a more extended period of attenuated (less severe) psychotic symptoms, or
- an extended period of very poor social functioning perhaps accompanied by unusual behaviour, for example, withdrawal from school or friends and family.

This relates to an individual who clearly does not have FEP or a suspected psychosis but has a significantly elevated risk of developing psychosis. Two subgroups specify state risk factors, defined by the presence of either transient psychotic symptoms, called brief limited intermittent psychotic symptoms, or attenuated (subclinical) psychotic symptoms. The other subgroup comprises trait plus state risk factors, operationally defined by the presence of diminished functioning plus either a first degree relative with a history of psychosis or a pre-existing schizotypal personality disorder. Symptom profiles are evaluated by the Comprehensive Assessment of At-Risk Mental States (CAARMS).

Specialist ARMS assessment

This should be carried out by a trained EIP specialist using a recognised assessment tool such as the Comprehensive Assessment of At-Risk Mental States (CAARMS), the Structured Interview for Prodromal Syndromes (SIPS) or the Scale of Prodromal Symptoms (SOPS). The clinician conducting the assessment should be either a Consultant Psychiatrist or Mental Health Professional who has received additional training on assessing at risk mental states.

Suspected Psychosis

This relates to an uncertainty which requires assessment. A referrer may refer on the basis of suspected psychosis and when assessed by a specialist EIP team they may be able to confirm that this is a case of FEP. However, it is also possible that the team requires a more longitudinal assessment in order to fully understand the complexities of someone's presentation i.e. they suspect it may be psychosis but the confirmatory evidence or complexity of the case prevents a definitive FEP diagnosis being applied. When this happens, the individual is typically placed on an extended assessment pathway for three to six months. Service users can be transferred to an FEP pathway, an ARMS pathway or discharged.

Cognitive Behavioural Therapy for Psychosis (CBTp)[1]

Cognitive behavioural therapy for psychosis is a discrete intervention which should be delivered by **a trained therapist** on a one-to-one basis over at least 16 planned sessions and follow a treatment manual so that:

- Service users can establish links between their thoughts, feelings or actions, and their current or past symptoms, and/or functioning;
- Re-evaluate their perceptions, beliefs or reasoning in relation to the target symptoms.

It could also involve:

- Service users monitoring their own thoughts, feelings or behaviour with respect to their symptoms or recurrence of symptoms;
- Promoting alternative ways of coping with the target symptoms;
- Reducing distress associated with target symptoms;
- Improving functioning.

Trained therapist for CBTp

Training is defined as:

- Postgraduate diploma level or equivalent generic CBT training (in the form of a CBT training programme or in the course of training as a clinical psychologist), plus additional specialised CBTp training.
- An HEE-approved training course.
- Early cohorts of practitioners involved in developing CBTp may have undertaken a different route to qualification. This might have involved:
    - Being a therapist in a CBTp trial with supervision from experts in the field;
    - Attending numerous CBTp conferences (post generic CBT training) with supervision from experts in the field;

[1] NICE Guidance (2014) Psychosis and Schizophrenia in adults (Recommendation 1.3.7.1)

- Training in generic Psychosocial Interventions (PSI), generic CBT alone or brief training courses in CBTp are not considered sufficient to deliver NICE recommended CBTp;
- The competences required to deliver CBTp are described in the "Competence Framework for Psychological Interventions for People with Psychosis and Bipolar Disorder". CBTp courses should follow curricula derived from this national competence framework.

Family Intervention[2]

Family intervention is a structured intervention for families, carers or people living with, or spending extended periods of time with, a person experiencing psychosis delivered by **a trained therapist.** The aim of this intervention is to support families to deal with their relative's problems more effectively, to reduce stress within families and to ultimately reduce the chance of a future relapse.

Family intervention should:

- Include the person with psychosis if practical;
- Be carried out for between three months and one year and include at least 10 planned sessions.

It should take account of:

- The whole family's preference for either single-family intervention or multi-family group intervention;
- The relationship between the family or carers and the person with psychosis.

It should also have a specific supportive, educational or treatment function and include negotiated problem solving or crisis management work.

Trained therapist for Family Intervention

Staff must have completed, or are currently attending, a training course in providing family interventions which is recognised by Health Education England (HEE). Staff who have completed a recognised training course have been assessed as having the competencies required to deliver family interventions. Competencies required to deliver family interventions are described in the "Competence Framework for Psychological Interventions for People with Psychosis and Bipolar Disorder". CBTp courses should follow curricula derived from this national competence framework.

Supported Employment Programmes

Supported employment programmes, of which Individual Placement and Support (IPS) is an example, are any approach to vocational rehabilitation that attempts to place service users in competitive employment immediately. Examples include:

[2] NICE Guidance (2014) Psychosis and Schizophrenia in adults (Recommendation 1.3.7.2)

Individual Placement and Support (IPS)	IPS is an evidence based Supported Employment Programme for people with severe mental illness. Service users are placed in paid, competitive employment immediately, receiving training and support on the job. For more information on how IPS should operate, please see Centre for Mental Health guidance.
Supported Employment Programme	Any approach which aims to place people in competitive employment immediately. A period of preparation may be included but this should last less than one month and not involve a work placement in a sheltered setting, transitional employment or training.
Work Placement Schemes	This may include a placement in a protected, sheltered setting (e.g. social firms), work experience programmes, volunteering, or transitional employment (e.g. paid, temporary jobs organised by the scheme) which aim to develop people's skills and confidence.
Back to work support	This may include programmes which provide practical support to people returning to work such as developing and agreeing reasonable adjustments or a phased return to work plan with people and their employer; support to people and their employer during fluctuations in their mental health; practical support and encouragement when people experience difficulties, and regular contact to help people find solutions to situations which may affect work performance.
Employment preparation programmes	An approach where people undergo a period of preparation before being encouraged to enter competitive employment. Preparation may include sheltered work placement and pre-vocational skills training.

Carer-focused education and support programmes

A carer-focused education and support programme should be offered as soon as possible. Such groups provide information, mutual support and open discussion to friends, family and carers through voluntary participation. The programme should be available as needed and offer a positive message about recovery.

Glossary

Advance statement	A set of written instructions drawn up when a person is well which describes how they would like to be cared for if they become unable to make a decision for themselves about their care.
Advocate	A person independent from health services who can help service users understand their assessment and rights, and who can help the views of the service user be heard by the service.
AMHP	Approved Mental Health Professionals. Staff trained in the use of the Mental Health Act.
ARMS	At-Risk Mental States. A term used to describe people who may be showing early, low level signs of psychosis.
Art/Creative Therapy	A form of psychotherapy that uses art media (e.g. paints) to help people express, understand and address emotional difficulties.
Assertive Outreach Model	A way of providing giving care to people with severe mental illness outside of hospital who may have complex needs, disabilities or who have not been able to work with traditional community mental health teams.
CAMHS	Child and Adolescent Mental Health Services. Services for children and young people, normally up to the age of 18, who need help with emotional or behavioural problems.
Capacity Assessment	An assessment of a person's ability to understand and use information to make a decision and then tell others their decision.
Care Coordinator	A named person who is given as the main point of contact and support for a person who has a need for ongoing care.
Care plan	A plan agreed between a person and their health professional to help them manage their day to day problems.
Care Programme Approach (CPA)	A way of coordinating care for people with mental health problems and/or a range of different needs.
Carer	A person who looks after someone with mental health problems. In this document, it usually refers to an informal carer (e.g. a family member or friend).
Carers Assessment	An assessment that looks at how caring affects a carer's life, including for example physical, mental and emotional needs, the support they may need and whether they are able or willing to carry on caring[3].

[3] Carers UK (2015). Assessments and the Care Act.

CBTp	Cognitive Behavioural Therapy for Psychosis. A type of psychotherapy which aims to help people make links between their thoughts and behaviour, and help them manage their psychosis.
Childrens' services	Teams that provide support to vulnerable children, young people and their families, and young carers.
Clinical Supervision	A professional relationship between a staff member and their supervisor. A clinical supervisor's key duties are: • Monitoring employees' work with service users; • Maintaining ethical and professional standards in clinical practice.
Commissioners	People (or groups of people) who are responsible for buying services for their local population.
Co-production	Service users and providers of services work together as equal partners in decision making, designing, commissioning and developing services.
Crisis	An episode of mental illness which overwhelms a person's ability to cope, and may be severe enough to need care in hospital or the help of a special crisis service.
Crisis and relapse prevention plan	A written document drawn up by a person when they are well, usually with their care coordinator. It includes signs they are becoming unwell, what they can do to help themselves if they think they are becoming unwell, who to contact and when, and what has been helpful or unhelpful in the past.
Crisis house	A non-hospital residential home for people having an episode of severe mental ill health. Stays are short term and provide a break for carers.
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 (4 hours 10 minutes).
Dependants	Children or adults who depend on a person (i.e. the service user) for everyday care.
Depot medication	A type of medicine, given by injection. The medicine is slowly released into the body over a number of weeks[4].
DIALOG	A questionnaire rated by the service user which asks about their quality of life, care needs and satisfaction with their treatment.
Dual diagnosis	Experiencing both mental illness and problematic drug and/or alcohol use.

[4] Royal College of Psychiatrists (2014). Depot Medication

ECG	Electrocardiogram. A test which checks the electrical activity of a person's heart to look for abnormal heart rhythms and investigate chest pain.
Education providers	Registered services providing education and learning (e.g. schools, higher education colleges, universities, training organisations).
Evidence based treatments	Any treatment (medicine, psychological or social) that high-quality research has shown to work for a particular problem and/or is recommended by NICE (see below).
Family Intervention	A therapy which includes carers and family members who are close to a person with psychosis which provides support and understanding to help them manage their loved ones illness.
Formulation	An explanation of a person's difficulties which is rooted in theory and informs the person's treatment plan.
Gillick competence	A term referring to the ability of a child under the age of 16 to consent to his/her own medical care without the need for parental consent.
GP	General Practitioner or 'family doctor'.
Crisis resolution/home treatment team	Some teams call themselves 'crisis resolution', others call themselves 'home treatment', and some are both. These teams treat people with a severe mental health problem outside of hospital (e.g. in their own homes or in a suitable residential facility)
HoNOS/HoNOSCA	Health of the Nation Outcome Scales. A measure of the health and social functioning of people with mental illness. HoNOSCA is a version of the scale which is designed specifically for use with children and adolescents
Individual Placement and Support (IPS)	A type of supported employment programme which helps people gain and keep a job.
Line management supervision	Supervision relating to the job description or the workplace. A line management supervisor's key duties are: • Prioritising workloads; • Monitoring work and work performance; • Sharing information relevant to work; • Clarifying task boundaries; • Identifying training and development needs.
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.

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[5].
Mental Health Act	A law under which people can be admitted to, or kept in hospital, or treated against their wishes, if this is in the best interests of, or for the safety of, themselves or others.
Mental Health Services Dataset	A set of data which contains information about people in contact with mental health, learning disabilities or autistic spectrum services.
Multi-disciplinary Team (MDT)	A team made up of different kinds of health professionals who have specialised skills and expertise.
NICE	National Institute for Health and Care Excellence. Organisation which publishes guidance for health services in England and Wales.
Occupational Therapy	A way of supporting people who find everyday tasks and activities challenging with the aim of helping them recover or gain independence.
Operational Policy	A policy document which outlines the role and aims of the service.
Positive risk taking	A way of working which accepts that risks cannot be avoided but can be minimised and prepared for, and encourages people to take greater control of their lives.
Postpartum psychosis	A term to describe a group of mental illnesses that can occur soon after birth and have psychotic symptoms.
Prevent Training	Training to support staff to understand and recognise radicalisation in people and help them provide support and guidance to people who are vulnerable to radicalisation.
Primary care	Usually the first point of call for health problems. Includes general practitioners, dentists, community pharmacists etc.
Psychosis	If you have psychosis, you might see or hear things, or hold unusual beliefs that other people do not. Typical symptoms of psychosis include hallucinations and delusions[6].
QPR	Process of Recovery Questionnaire. A questionnaire which asks people recovering from psychosis about aspects of their recovery which are meaningful to them.
Recovery plan	A document, designed with a person who has mental health difficulties, stating everyday activities they can do to keep well, and triggers and warning signs that they are becoming unwell.

[5] Mental Health Foundation (2015). The Mental Capacity Act
[6] Rethink Mental Health (2015). Psychosis – what is psychosis?

Reflective Practice	The ability for people to be able to reflect on their own actions and the actions of others to engage in continuous learning and development.
Risk Assessment	A systematic way of looking at the potential risks that may be associated with a particular activity or situation.
Safeguarding	Protecting people's health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect[7].
Signpost	To tell a person how to access a related service.
Statutory Duty of Candour	Legislation to ensure that services are open and transparent with people who use services about their care and treatment, including when it goes wrong.
Substance misuse	Can include the excessive or illegal use of alcohol or drugs.
Supported Employment Programmes	An approach that attempts to place people with mental health difficulties in competitive employment immediately. Individual Placement and Support is a type of supported employment[8].
Therapeutic environment	A place which attends to psychological, emotional and social factors in creating a space that maximises the potential for healing, development and growth.
Therapeutic relationship	The helping relationship between a profession and service user.
Triage	To screen information about a person referred to a service to see whether they are appropriate for that service.
Watchful waiting	A way of monitoring a person's symptoms to see whether they get better or worse, before providing treatment.
Working age adult services	A mental health service (e.g. community mental health team) which works with adults aged 18-65.
Youth agencies	Organisations who work with young people to believe in themselves and develop skills for later life.
Youth offending team	A team who work with young people that get into trouble with the law, are arrested or convicted of a crime, and help them stay away from crime.

[7] Care Quality Commission (CQC) (2015). Safeguarding People
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