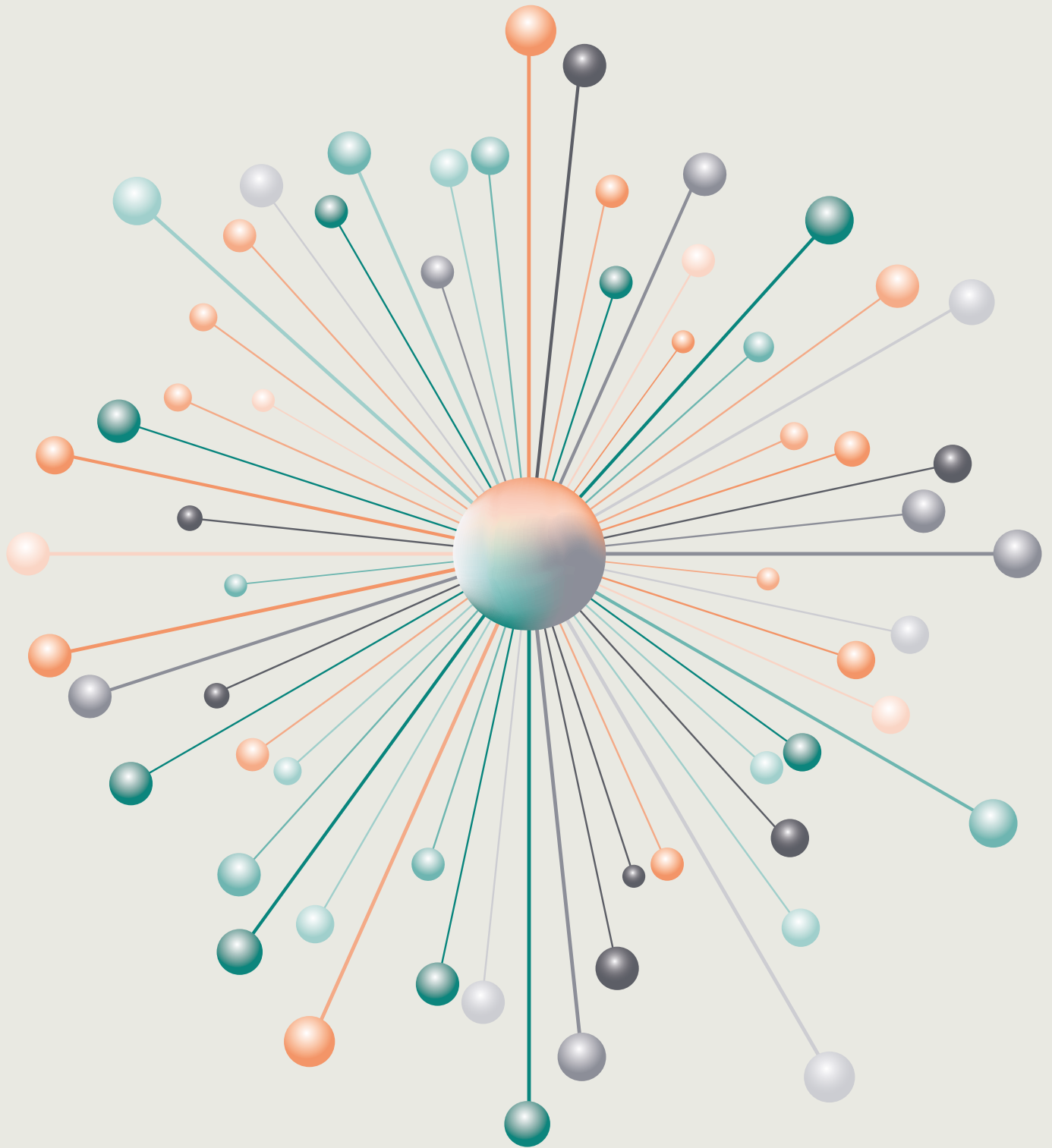


The Community Mental Health Framework for Adults and Older Adults: Support, Care and Treatment



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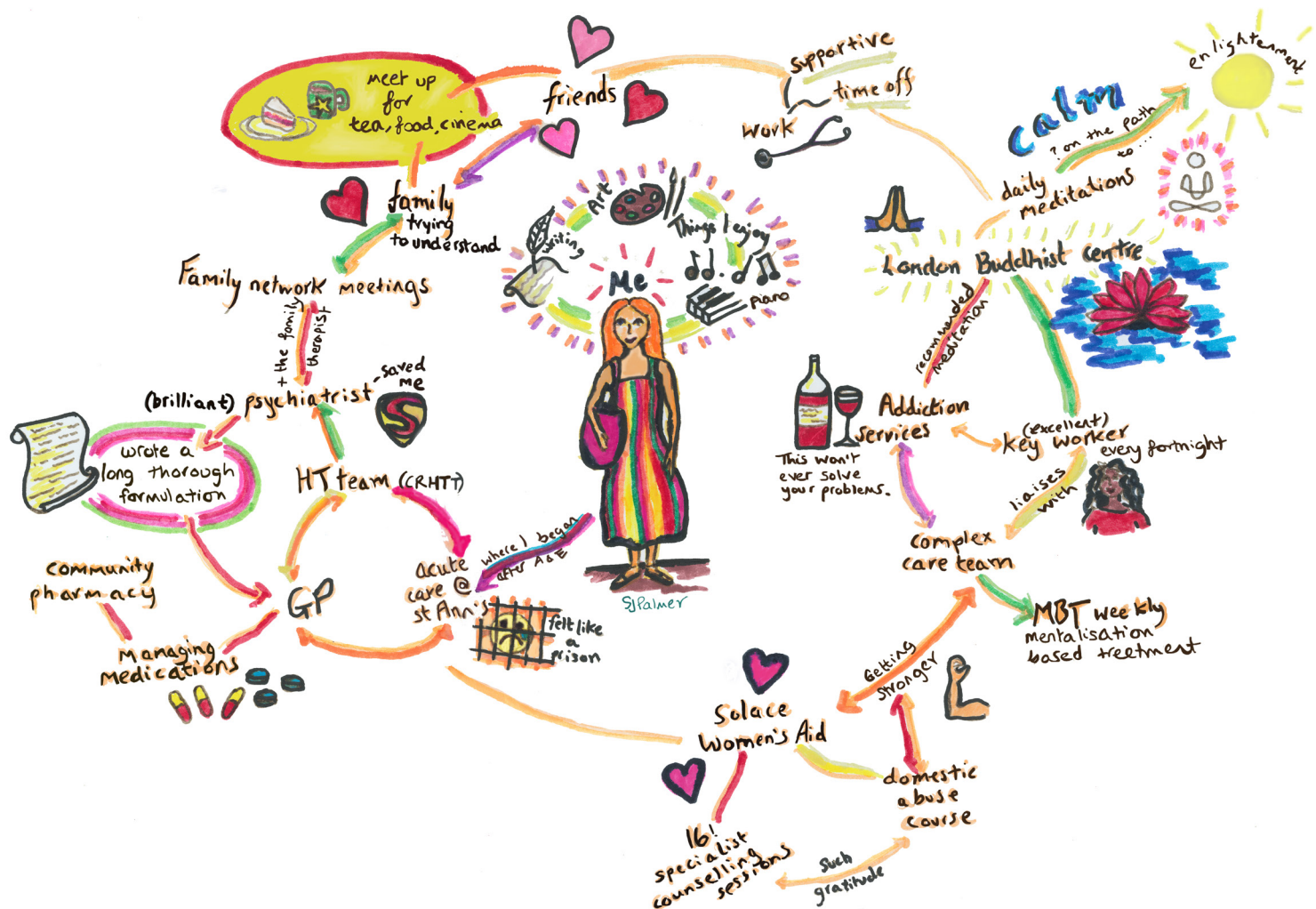


Illustration of the importance of a community network. See [Appendix 1](#) for Sarah's story.

The illustration represents my journey through the mental health system, and mainly highlights the benefits not only of the system but also of the wider access throughout the community, and voluntary and community sector, to services that have benefited me so much. The illustration also represents the interconnectedness that exists between all of these services, which sometimes may be overlooked when trying to understand the complexity of one's journey through severe and complex mental illness. Even in less severe mental illness, someone's journey may still require the links between multiple community assets and mental health services.

The illustration helps to demonstrate how a multitude of services can work together, while placing the individual at the centre of the system of support and acknowledging the person as a unique individual with positive attributes and interests, thus avoiding loss of identity within the process of accessing mental health services and community assets.

Sarah Jane Palmer, national adviser and expert by experience

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Cite as:

National Collaborating Centre for Mental Health. The Framework for Community Mental Health for Adults and Older Adults: Support, Care and Treatment. Part 1. London: National Collaborating Centre for Mental Health; 2021.

Illustrations for [Figure 2](#) by Julia Hayes, 2018.

Preface

The framework introduced in this guide represents a new approach to situating and providing place-based integrated support, care and treatment in the community for people with mental health problems whatever their level of need. Adoption of this framework will enable more and higher-quality care to be provided at a local ('neighbourhood') community level by making better use of resources including community assets. More targeted, intensive and longer-term input for people with more complex needs would be provided at the wider community level.

The framework offers a structure for doing this by dissolving the barriers that currently exist between (1) mental health and physical health, (2) health, social care, voluntary and community social enterprise (VCSE) organisations and local communities, and (3) primary and secondary care, to deliver integrated, personalised, place-based and well-coordinated care for adults and older adults.^a

Instead, there will be a 'whole system' of mental health care, which will ensure timely access to support, care and treatment. People with mental health problems will be enabled to access mental health care when and where they need it and be able to move through the system easily. They will be able to manage their problems or move towards individualised recovery on their own terms, surrounded by their families, carers and social networks, and supported in their local community. They will also be able to contribute to and be participants in the communities that sustain them, to whatever extent is comfortable to them.

Central to this will be a 'core community mental health service'. This will bring together and enhance the mental health care, support and treatment provided in primary care with that provided by secondary care community mental health teams, and in residential settings (including supported housing and care homes).

In addition, a key component of this vision of more efficient and effective mental health care is setting out a method for coordination of care that replaces the Care Programme Approach.

Stigma and inequalities in access to mental health care, for adults and older adults, and for whole communities, need to be addressed and reduced. Access to mental health support, care and treatment should be based on a person's needs, and where and which services are best placed to meet them. The framework will help local systems address inequalities in mental health care.

In developing this framework, we recognise the innovations and advances in service delivery in the recent past, for example in primary and specialist care and crisis teams (over 50 positive practice examples to support the implementation of the framework can be found in the [appendices](#)). However, there is evidence that the functional model is no longer fit for purpose and a different approach is required. This framework builds on the valuable work undertaken by colleagues and repurposes it for a future that requires integrated mental health care.

The perfect mental health service exists – it just isn't all in one place.

Tony Russell,
founder of Positive
Practice in Mental
Health

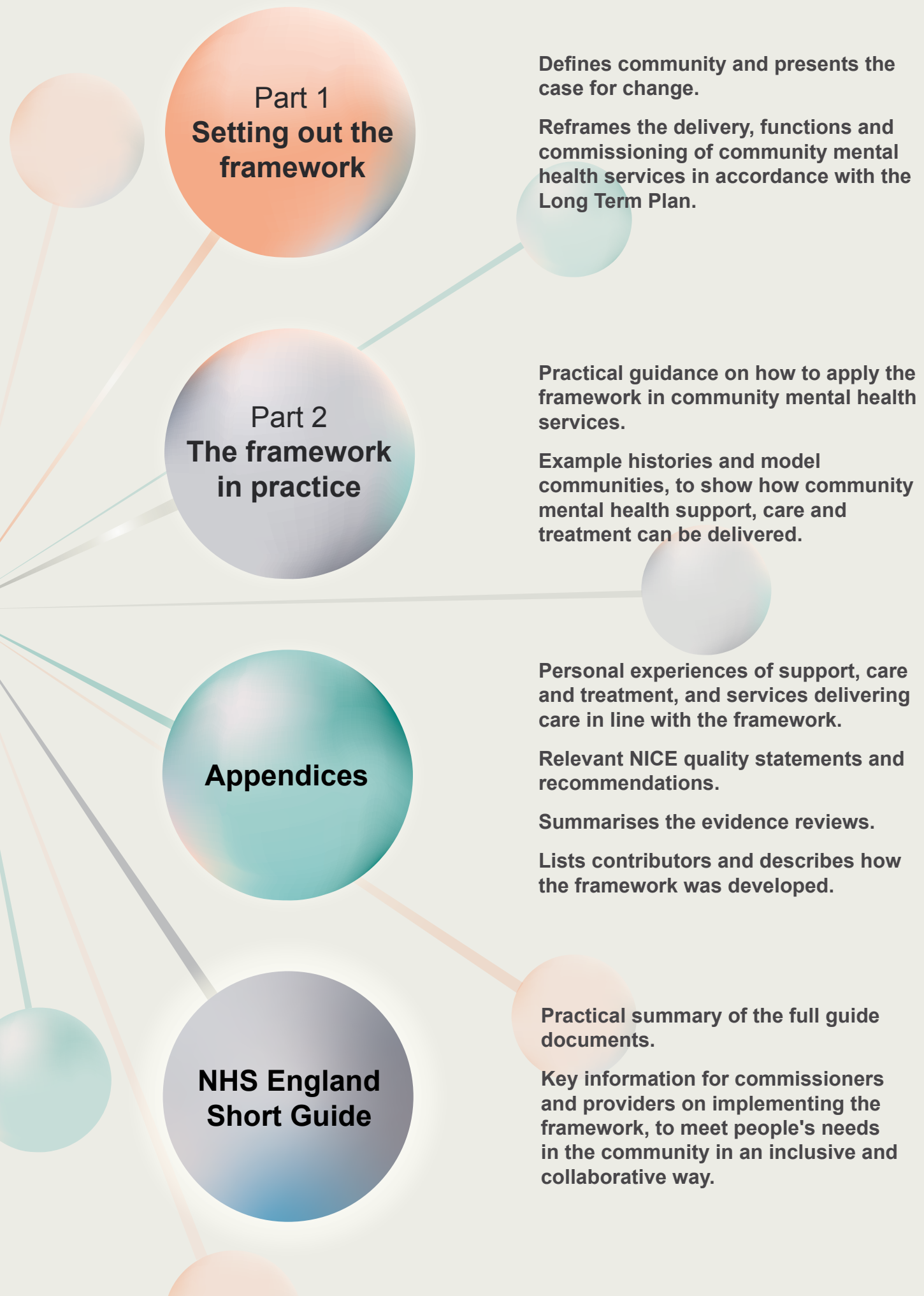
Note about the framework documents

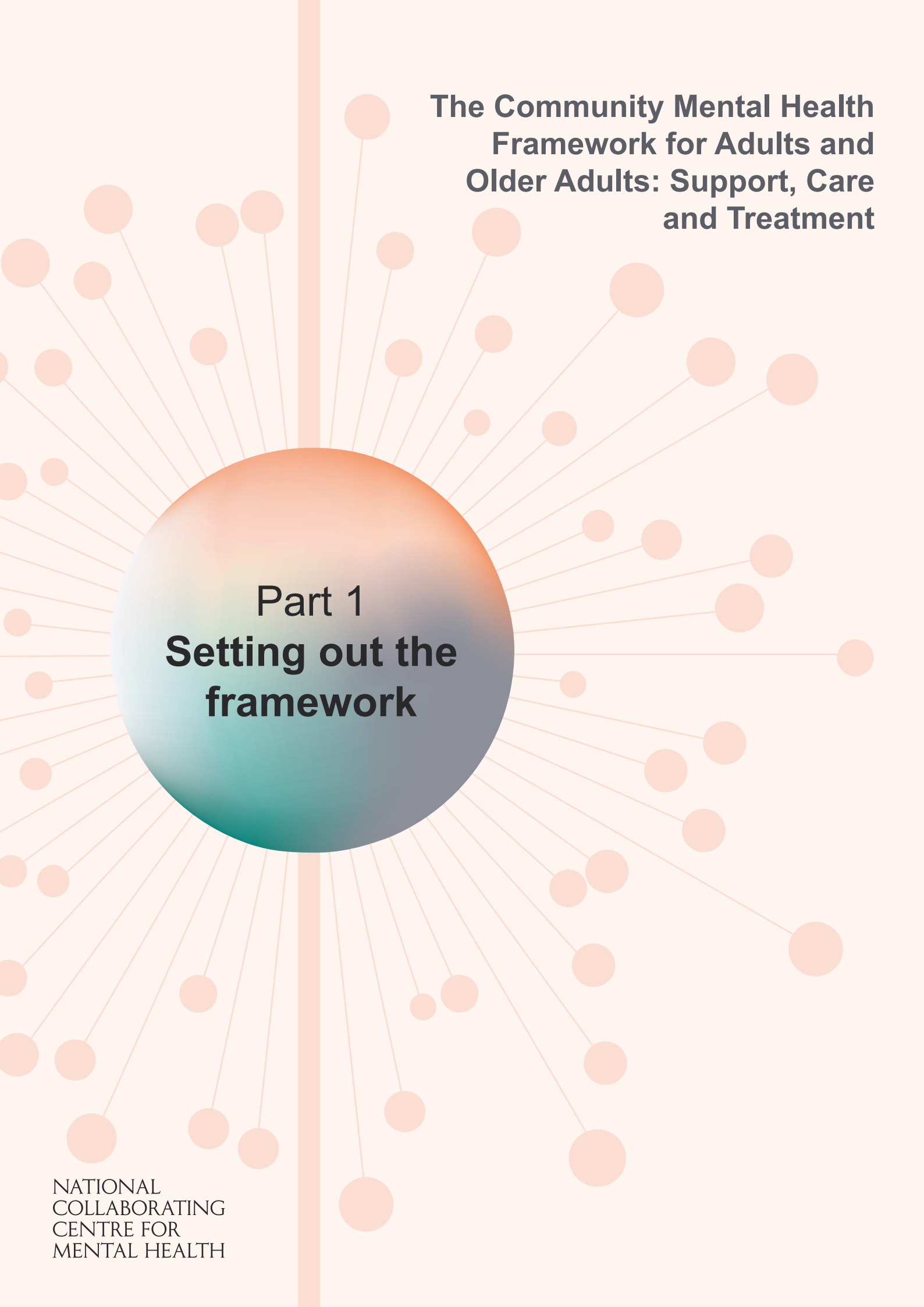
The three framework documents were developed and prepared up to 2019. The short guide (a practical summary of the documents) was published by NHS England that year.

Prior to publication, the three documents were updated to include developments that have taken place since then, including the impact of and responses to the COVID-19 pandemic.

^a Please note that this framework covers adults including older adults with functional mental health problems, who may have coexisting cognitive issues, or dementia, as well as other coexisting health issues such as frailty or substance use. There is a separate [pathway for dementia care](#).

Overview of the framework documents





The Community Mental Health Framework for Adults and Older Adults: Support, Care and Treatment

Part 1 Setting out the framework

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1. What people want and need from community mental health services

The following statements have been central to the development of the framework. Written and developed by people with lived experience of mental health care in the community, including family members and [carers](#), they reflect what people want and need, and what they should be able to access, from mental health services. The statements emphasise that change is needed across the whole system, so that people can get the help they need and be able to access care given with kindness and compassion, by people with the skills and resources to deliver high-quality, safe and effective services. How the framework can be used to support these statements in everyday practice was also considered during their development, and recommendations for actions that can be taken to do this for each statement can be found throughout Part 1 and [Part 2](#).

Experience and equality

I want the service to get to know me as a person; the things I like, the things I need, and the difficulties I've had. I deserve to be seen as a whole person.

I want to be supported to enjoy and do the things I want to do.

I expect that people who are supporting me will be honest and open with me.

Understanding my needs (assessment)

I want an assessment to be about understanding me, my needs, and where I'm coming from, so I don't have to repeat myself if I don't need to.

Getting help and support

Services can talk to me to figure out the best way to contact me or work with me. I might prefer to email someone or text, instead of talking face to face or on the phone.

I want support to look after my health, before I have a problem, or if I feel that things start to get worse.

I want a say in what my options are; I want to be able to choose when, where and how I get the support I need, and to be supported in my choices.

I want to get the right help or support for my situation when I need it.

I want services to be upfront with me and tell me how long it will take to get help. I want support while I am waiting for an appointment, so I'm not left waiting and getting worse.

Psychosocial education and information

I want information about a service and what it does.

I want someone to help me understand my mental health and how things can affect me in the future.

As a parent, family member, carer, or friend, I want to receive the right level of information about mental health and ways I can support my loved one.

Connecting to the community

I want support to build a life for myself in my community, to be a part of my community, without it being linked to mental health.

I want to know what is in my community, and be able to do something without needing a referral.

Care planning

My care plan will never be written without me. It will reflect my needs and how they can change over time.

I want access to my care plan, so I can share it with anyone important to me or with other services.

I want enough time to talk about my care plan: what I need and what I want. I want to know what the next steps are.

I want to choose who is involved in my care plan.

As a parent, carer, family member or friend, I want to be a part of, and have access to, the care plan for my loved one, and be involved in care review or family network meetings (with agreement).

Advocacy

I want access to advocacy support when I can't do these things for myself, so I can get the right support for me.

I need to be able to raise concerns about my care, without worrying about what will happen.

Safety

I have the right to feel and be safe. I want to trust that services will provide the right care if I ever feel vulnerable, and will make sure I'm safe.

Joint/collaborative working between agencies

I expect that the people involved in my care will listen to me, talk to me and to each other, and work together. I don't want to repeat myself if I don't have to.

Staff

I need my first point of contact with any service to be warm, welcoming, respectful, compassionate and friendly.

Parents, carers, families, friends, support network

As a parent, carer, family member or friend, I want to be listened to and taken seriously, with my relationship, knowledge, skills and experience with my loved one taken into account.

We will be informed of sources of support in the community available for parents, carers, families, friends and support networks.

Co-produced service planning, development and evaluation

If I want to, I would like to be given the chance to help services provide better care to other people.

Continuity of care

If I have to move to another service, or another area, I need the right support to do this.

I want to see the same person if possible, someone who can help me get the support I need, and who will check in on me if I need it.



Throughout this document and [Part 2](#), you will find these boxes containing these **statements about what people want and need from mental health services, why it is important to include each statement and practical recommendations for how using the framework can make this happen in everyday practice** to improve the care that people receive.



These recommendations were developed alongside the statements, and there are explanations for why it is important to include the statements here.

2. Introduction

Mental health problems, whatever their origin, severity or complexity, have an impact on an individual's personal and social worlds. Equally, these personal and social worlds can contribute to the development, maintenance and improvement or exacerbation of their problems. The communities in which people live are therefore central to the understanding, care and treatment of people's mental health problems.¹ This has been recognised since the very beginnings of mental health care and treatment.

Relationship building, social support, employment and education are not only what a healthy community can provide but have also long been seen as effective components of good mental health care. The amount of support people might get from a community varies, as does the ability to utilise what a community has to offer. A key aspect of effective mental health care is ensuring that communities can maximise the support they provide to people who need it.

People with mental health problems want to live a good life, and it is the job of mental health services to help them do that.

Isaac Samuels, Person with Lived Experience

2.1 What we mean by community

Community traditionally means the geographical space in which people live, and this is the community in which the framework operates. People also form their own communities based around ethnicity, gender, sexual orientation, socioeconomic status, occupation or interests, which can be important sources of support. Increasingly, people develop bonds online and their communication may take place only in the virtual/digital domain. Whether community is a geographical location, or a group in which people find or place themselves, it provides a context for people's lives.

COVID-19 has prompted an even greater need to think about what community means because of the reduced face-to-face contact during the pandemic. This lack of regular, direct face-to-face contact may be considered as more 'normal' for people who experience social isolation and marginalisation, including people living with severe mental health problems. The importance of digital communities and networks, and other ways to stay connected, is now more apparent than ever.

2.1.1 Bringing health and social care systems together

Delivering effective mental health support, care and treatment to meet the wider range of mental health needs in the community can only be achieved if all parts of the health and social care system, including VCSE organisations, work together. Without this collaborative approach, resources are wasted and outcomes are poorer.

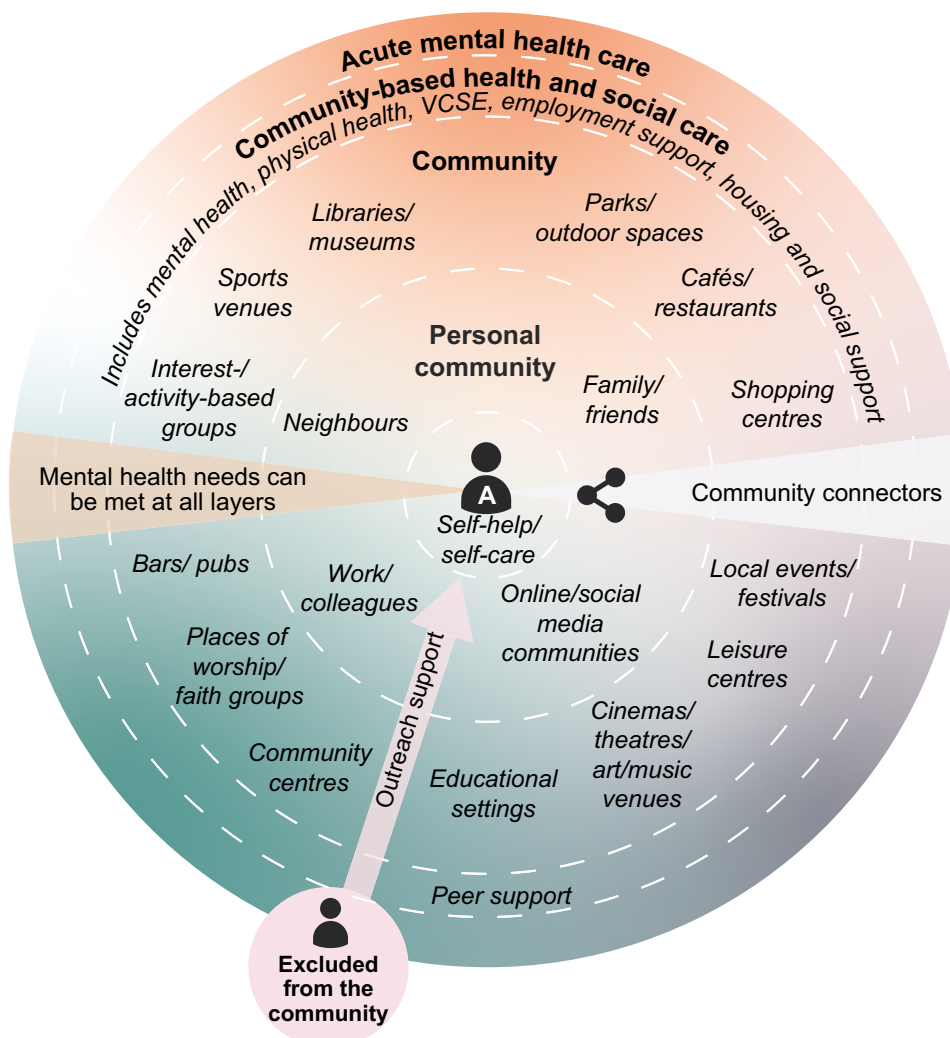
In this framework, integrated care for people of all ages does not refer to moving towards ageless services. Instead, it involves bringing all the services and agencies that support people with varying mental health needs much closer together. This will involve integrated working with services that have particular skills to care for people with specific needs, and between different professionals, some of whom already possess or could acquire these skills. Throughout this, people using the services need to be kept at the centre of service provision, with services tailoring their work and support around the individual's possibly changing needs.

2.1.2 Connections between people, their community and services

[Figure 1](#) shows a person's links to a typical community. It shows what services might be available to them, what they might need to help them stay well, and what primary, community and [specialist](#) services can be accessed if they become unwell.

Integrating care at the point of delivery and supporting shared decision-making will require effective connections and alliances across community, mental health, primary and social care, public health and VCSE organisations.

Figure 1: A representation of a person (A) who has a good connection with their community, showing their proximity to different parts of the community



Establishing and maintaining links with specialist care pathways that may provide interventions at a larger population level will ensure that specialist expertise (for example, community services for people with severe and enduring mental health problems or inpatient care) is available and readily accessible when needed. This means that the organisation of care will need to take place through sustainability and transformation plans ([STPs](#)) and integrated care systems ([ICSs](#)), working in partnership with Local Authority Health and Wellbeing Boards that oversee local health and care developments, and using Primary Care Networks (PCNs) as geographical 'building blocks'.

This approach can also help to reduce the increasing reliance on hospitals and crisis services and deliver better support in the community through the availability of a wider system of support that will be able to provide a timelier response and support the person to access care that best meets their needs. This will lead to better outcomes in terms of mental health and wellbeing for the individual and the population, and a more efficient use of resources.

Effective community mental health care should support people to achieve their potential and live the best life they can.

Sridevi Kalidindi, Consultant Psychiatrist

2.2 The case for change

2.2.1 Background

Developments in the provision of mental health care in community settings over the last 20 years are set out in [The Five Year Forward View for Mental Health](#).² The current structure and operational processes of CMHTs^b have evolved over some time to take a central role in the delivery of mental health services. More recently, a range of other services have been developed. These include teams for primary care, early intervention, assessment, crisis and home treatment, and assertive outreach. These teams evolved in response to the National Service Framework or local demand, but this has resulted in some fragmentation of services, discontinuity of care and a tendency to weaken links with local communities. There is currently a wide variety of local reconfiguration and innovation, and, in some places, stagnation. The level of integration varies between teams in health, social, primary and mental health care, while specialist teams are often created based on diagnosis or [care cluster](#). Throughout the delivery of care, there is a lack of consistency in the involvement of VCSE organisations. Recent legislation such as the [Care Act 2014](#)³ and the [Health and Social Care Act 2012](#)⁴ has tended to exacerbate fragmentation rather than support integration, despite the Care Act creating a statutory duty for agencies to work together.

^b In this guide, community mental health teams (CMHTs) serve a local population. Community mental health services may include more than one CMHT across an area.

2.2.2 Barriers and variation in care

People can find it difficult to access services because of inefficient systems and the development of multiple services with referral criteria that are too narrow and exclusive. Some people cannot always make an appointment with the same GP, which can impact on their continuity of care. Assessment and triage services have been developed by secondary care services to manage referrals more efficiently. But often these have not had the desired effect and have sometimes made processes more complex and fragmented, increasing the possibility of people falling into gaps between services. Across the community mental health system, waiting times are variable and often long (outside of early intervention in psychosis services), services lack resources^{5,6} and there are restrictions resulting from commissioning arrangements. The NHS Long Term Plan seeks to address all these deficiencies. In addition, social care assessments can be difficult to access, as can personalised support and housing, advocacy, welfare advice and employment support.

At times, decisions about care can be overly focused on self-harm risk assessment and the use of risk assessment tools, despite risk assessment tools having poor predictive value of risk and therefore poor ability to predict allocation to interventions.^{7,8} This means that although care is becoming increasingly targeted it may not always be targeted in the right way.

If initial support is limited or lacking, it is likely that people will later require more intensive support if their health deteriorates. It is also likely that this will have contributed to the growing pressures on inpatient care, where occupancy levels are at their highest, use of the [Mental Health Act 1983](#)⁹ ([amended 2007](#))¹⁰ has significantly increased in the last 8 to 10 years,¹¹ and people in many parts of the country are being routinely admitted to inpatient beds outside of their home area. The decline in community and social care support is as much a cause of these pressures as the historic lack of adequate investment in NHS community mental health services.

When people's care moves between teams, over 20% of them do not make it to the new team.¹² Complicated referral and [transitions](#) processes or lack of the most appropriate support in one place to address multiple needs may contribute to this high figure.

Transitions are a significant issue for young people moving into adult mental health services – a proportion of whom are lost in the transition from children and young people's services to adult services, then may present to adult services later down the line with more complex needs – and people moving from general adult services to those for older people. People whose care is transferred from drug and alcohol misuse services to a community mental health service or primary care can also experience discontinuities in their care.

A number of services have recognised these problems and there are encouraging developments around the country that demonstrate that care can be both more responsive and less fragmented, and that make the most appropriate use of specialist mental health services (see [Appendix 2](#) for examples of positive practice in this area). This framework will enable community mental health providers to explicitly address these concerns.

These factors put pressure on primary care services, as people with legitimate care needs are excluded from mental health teams because they do not fit rigid service specifications or meet often arbitrary thresholds.

[I just want] to be treated like a human being; my experience with mental health services was dehumanising. I want someone to sit down with me and get to know me as a person, not my mental health condition.

A service user

2.3 Scope and aims of the new framework

This framework is for providers and commissioners working in the health and social care system, including VCSE organisations. It sets out how the vision for a new place-based community mental health model can be realised, by outlining a framework for mental health support, care and treatment for adults aged 18 and over, including older adults, within a community network (see [Section 3](#)). It is also relevant to adult services that accept young people aged 16 or 17. Specific guidance on transitions (see [Section 6.2](#)) and working with children and young people should be read alongside this. This work builds on and supports the NHS aims for improving mental health, as outlined in [Implementing the Five Year Forward View for Mental Health](#),¹³ the [Five Year Forward View for Mental Health One Year On](#)¹⁴ and The NHS Long Term Plan.¹⁵







The framework will be applicable to people irrespective of their diagnosis. This includes but is not limited to those with:

- coexisting frailty (likely in older adults)
- coexisting neurodevelopmental conditions
- eating disorders
- severe manifestations of common mental health problems, such as anxiety or depression, that are not treatable within IAPT services operating in line with the national [IAPT Manual](#)
- [complex mental health difficulties leading to a diagnosis of personality disorder](#)
- co-occurring drug or alcohol-use disorder, and other addiction problems, including gambling problems
- severe mental illnesses such as psychosis or bipolar disorder.

NHS England's focus of NHS Long Term Plan investment in community mental health care is adults and older adults with severe mental health problems, as defined on page 26 of the [NHS Mental Health Implementation Plan 2019/20 – 2023/24](#).

2.3.1 The six aims of the framework

The framework promotes an approach in which people with mental health problems will be enabled as active participants in making positive changes, rather than as passive recipients of disjointed, inconsistent and episodic care. Delivering good mental health support, care and treatment in the community is underpinned by the following six aims:

-  Promote mental and physical health, and prevent ill health.
-  Treat mental health problems effectively, using evidence-based psychological and/or pharmacological approaches that maximise benefits, minimise the likelihood of inflicting harm and use a collaborative approach that:
 - builds on strengths and supports choice
 - is underpinned by a single care plan accessible to all involved in the person's care.
-  Improve quality of life, including supporting individuals to contribute to and participate in their communities as fully as possible, connect with meaningful activities, and create or fulfil hopes and aspirations in line with their individual wishes.
-  Maximise continuity of care and ensure no 'cliff-edge' of lost care and support by moving away from a system based on referrals, arbitrary thresholds, unsupported transitions and discharge to little or no support. Instead, move towards a flexible system that proactively responds to ongoing care needs.
-  Work collaboratively across statutory and non-statutory commissioners and providers within a local health and care system to address health inequalities and social determinants of mental ill health.
-  Build a model of care based on inclusivity, particularly for people with coexisting needs, with the highest levels of complexity and who experience marginalisation.

Mental health care in our communities is vital for thriving and cohesive neighbourhoods, where the quality of life for every individual counts. To cater for the needs of diverse citizens, they need to be actively involved in commissioning decisions and service design that responds to their needs. Then, all parties have a genuine chance to get the nature of the support right, and provided at the right time. The community framework robustly assists this process.

Jacqui Dyer, Black Thrive

2.3.2 Recommendations and specialist pathways

The framework also sets out recommendations that reflect current evidence and existing guidance by the National Institute for Health and Care Excellence (NICE; see [Appendix 3](#) for NICE recommendations and relevant guidance), to support providers and commissioners across the system to develop and implement the framework.

This framework will link with existing specialist pathways, such as [perinatal mental health](#), [liaison mental health](#), [early intervention in psychosis](#) and the [Improving Access to Psychological Therapies \(IAPT\) programme for people with long-term physical health conditions and medically unexplained symptoms](#), as well as outlining where rehabilitation functions can be usefully supported and implemented. This framework will also link with existing models of asset-based communities used in social care and to principles of personalisation.

3. Foundations of an effective framework for community mental health care

3.1 The impact of the community on mental health

Healthy communities are underpinned by better mental and physical health.^{14,15} However, not all aspects of community life are available to all adults and older adults. Social isolation, unemployment, financial problems, housing problems, exposure to crime or violence, prejudice, socioeconomic deprivation and domestic issues can all have a negative impact on a person's mental (and physical) health. For a person to have the best possible health outcomes, they should be helped to minimise any inequalities that they may experience. This can be done through community support and engagement.

3.2 Making the most of community assets

The extent to which a person can have their mental health needs met within the community is enhanced by effective care and treatment. Similarly, the effectiveness of care and treatment can be enhanced if the person is helped to make use of community resources, with the focus of interventions moving beyond the individual or family level and into the community. These assets of the wider community, and the contribution of community organisations and networks to improving people's health and wellbeing, may have been somewhat neglected in recent years.

Building and sustaining social networks is a key way in which the best can be made of community resources, including supporting people to access community-based social, educational or employment services, or engaging in leisure activities. Building capacity in communities and supporting people to use community assets is therefore central to the effective delivery of mental health care, and a fundamental component of the framework introduced in this guide.

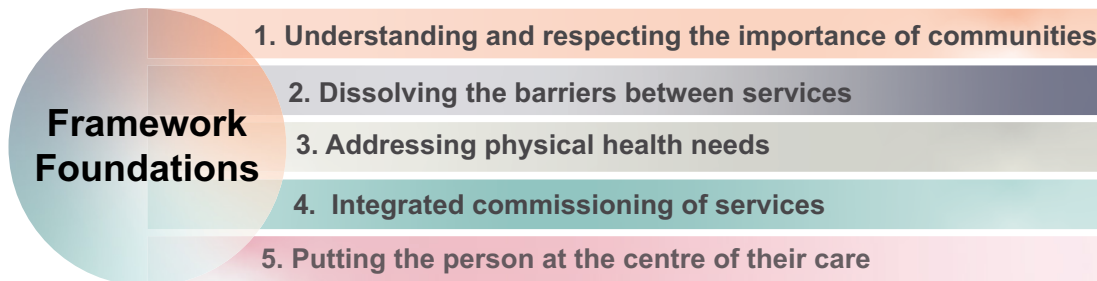
Resources on the benefits of community working



Public Health England and NHS England have published [A Guide to Community-Centred Approaches for Health and Wellbeing](#),¹⁸ and Power to Change have published [Treating Mental Health in the Community: A Policy Review](#),¹⁹ which both describe why community working is beneficial to health outcomes. Social Care Institute for Excellence (SCIE) have also published resources on [developing asset-based places](#).

3.3 Foundations of mental health support, care and treatment

The foundations of mental health support, care and treatment are:



1. **Understanding and respecting the importance of communities.** Recognise how characteristics of communities and the availability of resources can affect mental health. This includes quality of housing, employment, family and personal contacts, leisure and cultural activities, technological solutions and other community resources such as green spaces. Work together with the community to ensure that care can be provided locally, and that support can be received in several settings for multiple aspects of a person's life.
2. **Dissolving the barriers** between (1) primary and secondary care, (2) mental health and physical health, and (3) health and social care, **to deliver integrated, personalised, place-based and well-coordinated care.**^c Integration will allow for the responsibility of care to be shared, and ensure effective and collaborative working and continuity of care. People will then be able to get information, advice, support and care easily, and services can begin to break down referral barriers through greater communication.
3. **Addressing physical health needs.** People with mental health problems have a higher incidence of physical health problems, resulting in reduced lifespan. In addition, there are many people with physical health problems who have unrecognised mental health needs, and many who live with multiple physical and mental health problems, particularly for older people. Ensuring that a person's mental and physical health needs are assessed and addressed will lead to a reduction in avoidable morbidity and premature mortality.
4. **Integrated commissioning of services, between the NHS and local authorities.** Clinical commissioning groups (CCGs) and local authorities should work together to commission services to meet local needs. This is a key recommendation of the NHS Long Term Plan and the [Independent Review of the Mental Health Act](#). Joined up care can be provided if organisations come together to commission services.

^c Those who are receiving care in drug and alcohol misuse services provided by the local authority will not be excluded from this statement. There needs to be effective communication between the drug and alcohol misuse service, the person's GP and their mental health service. See point 4 on integrated commissioning.

The Local Government Association and NHS Clinical Commissioners have developed [Integrated Commissioning for Better Outcomes: A Commissioning Framework](#), which provides guidance on how to achieve integrated commissioning to benefit the health and wellbeing outcomes of local people.²⁰

One example of where commissioning could be joined up is in substance misuse services. These are commissioned by local authorities rather than the NHS and are an example of where changes in commissioning structures have led to fragmentation between services.

Drug and alcohol services



Public Health England provides [Quality governance guidance for local authority commissioners of alcohol and drug services](#), and guidance for commissioners and service providers delivering [Better care for people with co-occurring mental health and alcohol/drug-use conditions](#).

5. **Putting the person at the centre of their care. Delivering person-centred care** and ensuring that people can access support, care and treatment in a timely manner will prevent them from falling through gaps in services and being 'bounced around' or excluded, and will enable people to re-access services for as long as they require, which may be ongoing. [The Person-Centred Training and Curriculum Scoping Group](#) at the Royal College of Psychiatrists have detailed the value of person-centred care and how it can be embedded into care.²¹ To deliver person-centred care, the staff involved in a person's care should communicate clearly with each other to ensure that no identified needs are being missed, as well as preventing the person from having to tell their story multiple times. The NHS Long Term Plan promises more personalised care and support across the health and care system. NHS England has published [Universal Personalised Care: Implementing the Comprehensive Model](#), the delivery plan for personalised care until 2023/24.²²

Person-centred care



Person-centred care is flexible care based on the need of the person rather than the service. People are: treated with dignity, compassion and respect; offered coordinated and personalised support, care or treatment; and supported to recognise and develop their strengths and abilities, to enable them to live as independent and fulfilling a life as possible.

'I want the service to get to know me as a person; the things I like, the things I need and the difficulties I've had. I deserve to be seen as a whole person.'



This is because...

- Sometimes services don't listen. They write things about the person without their knowledge and make judgements based on case notes instead of getting to know the person
- Mental health diagnoses can overshadow physical health needs
- Social needs can have a large impact on a person's life



How using the framework can make this happen:

- Services that listen to people, treat them with respect and not judge them based on how they look or what their file says
- Physical and mental health needs considered together at all points of care, with concerns about physical health taken seriously
- Commissioned services that deliver integrated mental and physical health care, that also work with social care

'I want support to look after my health, before I have a problem, or if I feel that things start to get worse.'



This is because...

- People want services to be more proactive in providing help and support, such as helping them to stay well and look after their physical and mental health before they develop a problem



How using the framework can make this happen:

- Services that are proactive in supporting people to look after their physical health, and to prevent people's physical health problems from developing or declining

'I want to see the same person if possible, someone who can help me get the support I need, and who will check in on me if I need it.'



This is because...

- Seeing the same doctor and the same support person can be helpful
- People can find seeing different or unexpected people can be distressing, especially when they don't know the person
- People can find it difficult to build trust when they see lots of different people and have to repeat themselves each time
- Some services require people to be proactive in self-referring and accessing help, while not everyone has the capacity or resources to do this on their own
- Some services don't take ownership of a person's care, despite this being their responsibility
- People have said that receiving reminders can feel like someone remembers you, like someone cares



How using the framework can make this happen:

- Services to focus on providing consistency and continuity of care, working to ensure that people are seen by the same professional throughout their care (where possible)
- Communication across services and professionals with the people using the services
- Letting people know ahead of time if the professional they usually see will be unavailable, and for there to be a plan when this happens
- Providing a care coordinator/care navigator/community connector for a person, provided by VCSE if needed
- A main agency or organisation that takes responsibility for a person's care and for meeting their mental health needs
- Physical support to attend groups or appointments for those who need it
- Services to send follow-up information (including leaflets and further resources) to people

3.4 Advancing mental health equality in the community

Everyone has the right to be treated with respect and dignity, without discrimination. They have the right to access community-based mental health and social care, and all available help. However, some groups continue to experience inequalities in accessing mental health care in the community. Communities can be a positive influence on equality, but they can also perpetuate inequality if, for example, there is restricted access to resources in the community and if stigma is not addressed.

When improving mental health care, there can be no quality without equality.

Jacqui Dyer MBE, Black Thrive

To tackle inequalities, mental health services should respond to the specific needs of the people in the community. Regarding access, reasonable adjustments should be made for people who need services, such as those with disabilities or complex needs. Staff should have the skills and competences to support and care for people with different needs, though it may also be appropriate for some people to receive care from specialist services. Care should always be provided in a location that can most appropriately support the person's needs.

Identifying and tackling inequalities, and working to advance equality, are explored in the [Advancing Mental Health Equality](#) resource (2019), developed by the National Collaborating Centre for Mental Health (NCCMH) and NHS England. The resource was produced to support system leaders, commissioners and service providers in their continuing advancement of equality in mental health care across this framework, and other pathways and frameworks.

The role of local health systems in inequalities, in light of the COVID-19 pandemic and Black Lives Matter movement, has been examined in NHS England and NHS Improvement's [Advancing Mental Health Equalities Strategy](#) (2020).

See Table 3 in [Part 2](#) of this framework guidance for solutions to challenges around advancing equality for commissioners and services.



Section 7.8 in [Part 2](#) lists various publications and resources that can be used when tackling mental health inequalities in the commissioning of mental health services.

Equalities top tips

The scales symbol can be found throughout this framework, highlighting our tips for advancing equality in mental health care.



3.5 Benefits of the framework

Implementation of the framework will lead to the following benefits:



Integrated place-based working will mean existing resources can be used more effectively, allowing resource allocation to other parts of the system (including freeing up time to deliver evidence-based care such as psychological therapies) and providing greater opportunity for prevention and early intervention. There will be less administration and bureaucracy because within an integrated system there will be no referrals, which should result in more time to provide good quality care.



Improved integration of services (mental health, physical health, social care and VCSE at the point of delivery) will facilitate people's access to care and support for all their needs, and prevent fragmentation of their care.



The primary care workforce will be better supported to care for people with mental health problems, increasing their skills and knowledge. Fewer primary care appointments will be needed by people seeking mental health support, and there will be fewer frequent attenders with unmet mental health needs.



People's quality of life will be improved by the development of their personal skills, and the building of resources and assets available that help them stay well in the community and connect with a range of meaningful activities (see [Figure 1](#)).



People will have access to the support, care and treatment that meets their needs within their communities and across all organisations and sectors. This will prevent exacerbation of symptoms or situations because of being less able to access timely and appropriate care.

NHS access standards



In line with the [Clinically-led Review of NHS Access Standards](#), 4-week waiting times for adult and older adult community mental health teams are being tested with selected local areas as part of wider testing of these new models.

'I want to get the right help or support for my situation when I need it.'



This is because...

- Having available support and options explained is important, including how to access a service
- Sometimes people have complicated situations, or responsibilities that need to be considered
- Some people are fearful or anxious over telling people about their responsibilities and worry about the consequences
- People want support that fits their needs without being judged
- People want to be able to talk to someone on the weekend, late at night, or whenever they need it most, as they often need support outside of working hours and sometimes can't wait until the next appointment



How using the framework can make this happen:

- Services that consider the range of people's needs and provide flexible support (such as for young carers and people with other caring responsibilities, people with complicated family situations, family or childcare arrangements)
- Services that can provide support for parents, families, carers, friends and support networks
- Services that provide clear information (such as on a website) and communicate clearly about who to contact, where to go and provide help to access it, including self-referrals and how to get help via other means (such as online or by phone)
- Statutory services that connect with, utilise and provide information about other voluntary, community and social enterprise sector services (including those which provide out-of-hours care and have clear links with crisis services and outreach support)
- Including support options for parents, carers and families who might need support after hours

3.6 Evaluating the framework

Throughout the implementation and delivery of this framework, providers and commissioners should evaluate the changes and assess the impact of the framework on the overall quality of care.

Section 4.1.1 of [Part 2](#) on implementing the framework, and [Appendix 3.1](#), on quality measures, provide more information on how to carry out the testing and measuring.

4. Delivering mental health support, care and treatment in the community

4.1 Community-based support, care and treatment

Mental health support, care and treatment should be place-based – rooted in communities, and designed with and for the people in those communities. Most community mental health care can be provided for local populations of about 30,000 to 50,000 (the same size as the natural communities served by [PCNs](#)), depending on natural geographies and communities (not including acute and specialist inpatient care). These local communities will make up wider communities of around 250,000-500,000^d people, which will be the base for the provision of specialist mental health services for people with more complex needs (for example, first episode psychosis services). Community resources, including housing, debt advice, employment services and other community assets can and should make a significant contribution to providing support to people with mental health needs in the community.

See Table 3 in [Part 2](#) of this framework guidance for solutions to challenges met by people who use services, for (1) commissioners and (2) for mental health trusts.



4.1.1 What community support, care and treatment should do

Community-based mental health support, care and treatment should be effective and efficient in its:

- prevention of mental health problems and early intervention
- recognition and assessment of mental health problems
- provision of treatment, including social, psychological and pharmacological
- support and management of physical health problems
- ability to work with and support families, carers and social networks
- links to housing and specialist supported housing services, including housing for older adults
- support for attaining and maintaining employment or education
- use of other community assets and resources (see [Section 5](#)), including VCSE organisations, online resources and personal contacts.

This section describes how an integrated community mental health service that unites primary and secondary care can make the best use of community assets and match services with need, using fictional examples of people with different levels of complexity. First, we set out what we mean by complexity. Please note that the examples were written before the COVID-19 pandemic.

See Table 3 in [Part 2](#) of this framework guidance for solutions to challenges around VCSE organisations, for commissioners.



^d These numbers are merely indicative, and the footprint may be greater depending on the nature of the service and local need.

‘I want someone to help me understand my mental health and how things can affect me in the future.’



This is because...

- Sometimes people don't receive clear information about how mental health and physical health interact and can affect each other



How using the framework can make this happen:

- Providing psychoeducation on mental health to everyone, including the impact of physical health and vice versa
- Providing the person, their family or carer with clear and accessible information in a range of formats about possible diagnoses and what they mean

‘As a parent, carer, family member or friend, I want to be listened to and taken seriously, with my relationship, knowledge, skills and experience with my loved one taken into account.’



This is because...

- It needs to be acknowledged that there are many terms for ‘carer’, and many ways of addressing people in this role
- It needs to be acknowledged whether the close person wants to be the carer, and to what extent they wish to be involved in the care, support and treatment



How using the framework can make this happen:

- Confirm how people in carer roles prefer to be referred to (that is, as carer or other), and that they are able to take on the caring responsibilities in the first place
- Check the level of involvement that is wanted (the person and/or their family member)
- Carers/families should feel able to voice their concerns and have these heard

4.1.2 Complexity within this framework

This framework advocates a flexible structure for the delivery of services, accommodating people's changing needs over time. We use the term ‘complexity’ to capture the different requirements for services that people with mental health problems may have, ranging from ‘less complex’ to ‘complex’ and to ‘more complex’. We also use the term to inform the development, structure and delivery of services required to meet problems of differing complexity.

The terms ‘less complex’, ‘complex’ and ‘more complex’ are not intended to be fixed categories or long-term labels – people may move between levels of complexity as their needs change. We have also avoided the use of terms such as ‘severe mental illness’, not because we think they are unhelpful (they have an essential role in guiding the choice of pharmacological and psychological interventions) but because they do not give a clear indication of complexity.

Diagnosis alone does not always give a clear indication of complexity. For example, a person with a psychotic disorder may function very well and need limited help and support in managing

their condition, whereas a person with chronic and severe depression and diabetes may have more complex needs that require the support of a specialist multidisciplinary mental health team.

4.1.3 Less complex and complex needs

For a significant number of people with **less complex needs**, these will be met by time-limited, brief interventions often involving one practitioner. These could be, for example, a brief consultation with a GP, involvement in a community support group or treatment in the IAPT programme.

Many people with **complex needs**, including those with psychosis, bipolar disorder, severe depression, complex post-traumatic stress disorder or people with complex mental health difficulties who are diagnosed with a personality disorder, can be well cared for in the community, with the support of an integrated mental health service in which care is shared with primary care staff and community mental health staff. Such staff would be based in the community service that also provides care for less complex needs. As well as the direct provision of care, it would also involve care coordination for some people with complex needs.

4.1.4 More complex needs

For those with more complex needs, a specialist multidisciplinary team will be required, which will involve the staff mentioned above, as well as further input from specialist mental health staff. This team can function in a wider geographical area than services for those with less complex needs (see Section 3 of [Part 2](#) for model communities that demonstrate these functions).

4.1.5 Illustrating complexity of need within the framework

In [Figure 2](#) over the next three pages, we have devised histories for eight people living in different parts of England to illustrate mental health needs that range from less complex (Ashik, Louise and Dave) to complex (Diane, Kyle and Carol), to those with more complex needs requiring specialist care (Mei-Lin and Frank). We refer to these people throughout this guide to show how the framework can be used to organise support, care and treatment to address similar needs.

Factors influencing complexity



Complexity is cumulative and influenced by the following factors:²³

- 1** nature, duration and severity of mental health problems (including comorbidity and neurodevelopmental disorders)
- 2** co-occurring drug and alcohol-use disorders
- 3** problems associated with ageing, such as frailty
- 4** nature, duration and severity of coexisting physical health problems
- 5** availability and quality of personal and social support and networks
- 6** associated functional impairment
- 7** effectiveness of current or past treatment and support
- 8** services' ability to engage with people and be accessible.

Figure 2: Example histories of eight people with different complexities

Less complex needs



Louise, 18



Busy university town
Local population = 77,000
Wider population = 148,000

Louise is a white British woman living in university accommodation, having recently moved away from home to study. She was mugged and assaulted 10 months ago. Louise was diagnosed with post-traumatic stress disorder and had a course of psychological treatment with a therapist (Ivor) in her home town over 200 miles away. This appeared to be effective and she started going to a ceramics class and a self-defence class with her friends and girlfriend at the time. They thought it might help to rebuild her confidence. She enjoyed this; however, since moving to a new city she is anxious about socialising. Louise has had minor hearing problems since the assault, for which she is seeing a GP in her university town. She has also talked a little about her anxiety and low mood. She feels isolated because she is nervous about going out, especially at night, so she does not socialise with university friends much and feels like a burden to her friends at home. She has not told her father about her low mood so as not to worry him. He is a widowed, single parent with three young children living at home.

Born in Bangladesh, Ashik moved to the UK with his family aged 2. He was diagnosed with bipolar disorder 11 years ago, for which he takes medication, and is managing this well with support from specialist mental health services. Ashik works in the financial sector and was recently promoted, which has increased his workload. This is contributing to chronic and ongoing anxiety. Ashik sometimes manages his anxiety by drinking too much and sometimes taking cocaine. Ashik has an understanding partner and two primary school-age children, whom he rarely sees on weekdays due to work. Ashik is happiest when he can spend time with his family at weekends. While he has a good relationship with his parents, Ashik has struggled to explain his current problems to them and worries that, as devout Muslims, they might disown him if they found out about his drinking and drug use. Ashik also worries that his parents will not understand his mental health problems. While he has a supportive GP, Ashik recognises that he needs some more help for his problems but does not know who else to talk to.



Ashik, 32



Small, diverse neighbourhood
in a densely populated region
of a major city.
Local population = 16,000
Wider population = 323,000



Dave, 43



Small, rural village, relatively
disconnected from larger towns.
Local population = 4,500
Wider population = 77,000

Dave is a white British male who lives in a rural community. He has been working for the local council for 12 years. Dave's 15-year marriage broke down 4 months ago and he and his ex-wife are currently trying to sell their home and divide their assets. While Dave does not want his colleagues at work to think anything is wrong or that he might not be capable of doing his job, they have noticed he seems quieter, more tired and less sociable. Dave's father is also worried about him, but feels there is not much he can do to help because he lives far away. Dave occasionally goes to a running club after work to keep up routine, but he does not socialise much with friends from the club anymore and does not always respond to their messages. Dave recently found out that his ex-wife is seeing another man, and this has made him feel helpless and a failure. Recently, Dave has started walking alone over a motorway bridge and has at times contemplated suicide. He does not feel he can talk to his friends about his feelings and is unsure his GP will understand.

Complex needs



Diane, 82

Small, rural village, relatively disconnected from larger towns.
Local population = 4,500
Wider population = 77,000

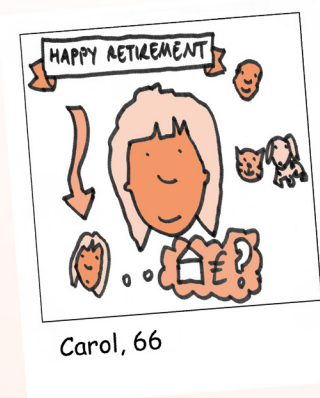
Diane is a widow whose physically abusive husband died 8 years ago. She has four children and nine grandchildren, almost all of whom live nearby and have close relationships with her. Usually very independent, Diane's physical health has worsened over the last few years, with a recent diagnosis of chronic pulmonary obstructive disease. She had a mental health crisis aged 20 and was diagnosed with bipolar disorder and spent many years in and out of hospital, often detained under the Mental Health Act. Fluctuations in mood affect her relationship with her family, as she will either isolate herself or telephone them non-stop. She has had negative experiences as an inpatient and is wary of mental health services. She was prescribed lithium but stopped taking this by mistake during a hospital admission for her emphysema and, as a result, deteriorated. She is currently well, but is starting to forget things. Diane enjoys spending time with her family and friends and she has a dog, but she struggles to walk him as frequently as she used to.

Kyle is the son of a white British mother and a black Caribbean father. His parents separated when he was 5 and his relationship with his father is strained. He has a long history of depression coupled with periods of heavy drinking, this has worsened recently following the death of a childhood friend through a gang-related attack. He fears talking about his friend's death to professionals because he worries they might wrongly assume he is also in a gang. He lives at home and supports his family financially. His mother spends a lot of time caring for his grandmother, who also lives in the family home and is very unwell. Kyle has lots of close male friends with whom he plays football, but he does not feel comfortable sharing his feelings with them. He is a sales assistant, and has become uncharacteristically snappy with colleagues and customers. He has a colleague he is close to and would like to ask out but worries he would be a burden to her. He has tried using medication for his depression, but it did not help and it's not clear if he followed the prescription.



Kyle, 28

Large semi-rural town on the outskirts of a major city.
Local population = 48,000
Wider population = 206,000



Carol, 66

Very densely populated district in a deprived part of a major city.
Local population = 37,150
Wider population = 155,000

Carol is a British woman who recently retired from her cleaning job. She has lived in the same council estate for almost 40 years and receives housing benefit. Her son, whom she raised alone, is 37 and lives on the other side of town. Their relationship is turbulent and she spent a long time supporting him with his difficulties with mental health and drug use, and with his financial difficulties in early adulthood. Carol has long-term anxiety which appears to be related to financial insecurity and housing issues. She receives pension credits, but is constantly worried about money because she has high vet bills. Since retiring, Carol feels she is of no use to anyone, struggles to get out of bed in the morning and is anxious about leaving the house. She has recently gained weight, which has contributed to her low mood. Due to severe asthma, she is unable to exercise frequently. After a bad experience, she has come to mistrust GPs and does not see hers often. She has four siblings but she is not close to any of them and she does not have any close friends. She spends a lot of time at home reading and feels very isolated.

More complex needs



Mei-Lin, 37



Small district in a central part of a large, densely populated city.
Local population = 15,000
Wider population = 98,000

Mei-Lin is a married British Chinese woman with two children under the age of 5. As a child, her parents, having to work, would leave her with a neighbour, who abused her physically and sexually. She was afraid to tell her parents and did not disclose the abuse until she was much older. She is constantly worried about leaving her own children with other people and this causes intense arguments with her husband. She has been admitted to both general and psychiatric hospitals following periods of self-harm. Her parents encourage her to take part in traditional Chinese exercises and take traditional medicine. Her Chinese husband cares about her but does not understand her unstable mood, and believes that only western people experience mental health problems. She has become convinced he wants to leave her, despite him never showing signs of this. She feels alone and empty and that nobody understands her. She was previously referred to a CMHT but has not engaged with any treatment offered. Recently, she appears more depressed.

Frank is a white British male with schizoaffective disorder. He also drinks alcohol and uses cannabis at times. His first episode of psychosis was following smoking cannabis aged 19 years old, when working in a garden centre. Frank has had several psychiatric hospital admissions due to the severity of his illness - he has tried to harm himself in the past and is vulnerable to being exploited financially, when unwell. As Frank's symptoms haven't responded to first and second-line antipsychotic medication, he is on clozapine, which means he must have blood tests and physical health checks once a month. Before being on clozapine, Frank was unwell for a long time. His symptoms, risks and difficulty with managing his daily activities, meant that he was unable to leave the hospital ward and needed a longer stay on an inpatient rehabilitation ward. Before being admitted he had been living with his mother in her home. However his mother is now elderly and frail and unable to support Frank.



Frank, 51



Small coastal village, with good transport links to larger towns nearby.
Local population = 5,600
Wider population = 181,000

4.2 Organisation of mental health support, care and treatment across the local and wider community

The composition and needs of communities differ considerably across the country, depending on the level of deprivation, the availability of resources and other factors. [Figure 3](#) illustrates how wider communities (about 250,000 people) can encompass (in this example) five local communities (typically with a population of 50,000) and how, for each, a range of needs can be met within them.

Each local community should have the resources and assets to support and care for people with less complex needs (such as those of Ashik, Louise and Dave) and complex needs (see Diane, Kyle and Carol). Services to care for people with more complex needs (see Frank and Mei-Lin) are likely to be provided at a larger population level (described here as at a 'wider community' level, also known as 'place' level).

4.2.1 Services in local communities

The majority of support, care and treatment should be provided at a local community level. It should be built around existing GP practices, neighbourhoods and community hubs – elements that make up the new PCNs. This will be a 'core community mental health service', bringing together what is currently provided in primary care for people with less complex as well as complex needs, with that which is currently provided by secondary care community mental health teams and community social work teams.

See Section 2 of [Part 2](#) for further detail about the structure of community mental health provision.



See Table 3 in [Part 2](#) for solutions to challenges for people who work in primary care.

Figure 3: Organisation of community services



Local community = a population of about **50,000** people

Wider community = several local communities, to a total population of **250,000+** people

Services for **less complex** and **complex needs** at a local community level

Specialist services for **more complex needs** are delivered to the wider community population

* Local communities 1–5 represent population sizes and complexity of needs, not geographical location.

Public health-provided services are out of scope.

Needs met by the community
Less complex needs
Complex needs
More complex needs



To effectively address the needs of people with a range of mental health needs, there should be functions located in communities, and delivered from within the framework's place-based and integrated model, that promote better outcomes for the individual and provide or have access to the following:

- advocacy services
- assessment, advice and consultation for mental health problems
- community assets (for example, libraries, leisure and social activities, and faith groups)
- coordination and delivery of care
- effective support, care and treatment for co-occurring drug and alcohol-use disorders
- employment, education and training services
- evidence-based interventions for mental health problems, including psychological and pharmacological treatments, and NICE-recommended psychological therapies for people with severe mental illnesses^e
- help and advice on finances (including benefits)
- high-quality, co-produced, [personalised care and support planning](#)
- housing and social care services
- physical health care
- services enabling access to mental health information and online resources
- specific support groups (such as older adult groups, hearing voices groups, or problem-specific support groups such as for diabetes or depression)
- support that takes into account frailty, mobility issues and sensory impairments, and helps people live independently.

See Table 3 in [Part 2](#) for solutions to challenges around social care, for commissioners and services.



4.2.2 Services to the wider community

Mental health services for the wider community will have the expertise and capacity to deliver care to people who have more complex needs. These services could include inpatient care, specialist residential care or dedicated community eating disorder services. They should also include intensive and assertive support, long-term care and support for those who may be at risk of exclusion from their community, including people leaving the criminal justice system, rough sleepers, socially excluded people, those with very disabling psychotic disorders or those with [complex mental health difficulties associated with a diagnosis of 'personality disorder'](#).

^e NHS England and NHS Improvement have established a national and regional programme to increase access to psychological therapies for people with psychosis, bipolar disorder and complex mental health difficulties associated with a diagnosis of 'personality disorder'. This includes supporting the establishment of regional and local clinical leadership and, in partnership with Health Education England, major new investment in training courses for staff working in community mental health services.

'I want access to advocacy support when I can't do these things for myself, so I can get the right support for me.'



This is because...

- Some people need support for their voice to be heard



How using the framework can make this happen:

- Work with people to help empower them, and to be a central part of the decision-making process around their care
- People are given clear information on advocacy services, and are supported to access an independent advocate if required. As a minimum, independent advocacy must be offered as described in the Care Act 2014, Mental Capacity Act 2005 and Mental Health Act 2007, and the section on advocacy in [Modernising the Mental Health Act](#)

'I want information about a service and what it does.'



This is because...

- Sometimes roles and services aren't explained clearly – a person might be told to go to an appointment without it being explained why
- People want to be told about services not only verbally but also to be sent written information, by post or email



How using the framework can make this happen:

- Services that provide clear, accessible information about what they offer in a range of formats
- Services that explain what support, care and treatment they provide, the responsibilities of different professional roles and how they work with people
- Better communication with people about what is happening in their support, care or treatment and who they are seeing
- Provide information about what other services can do if the service doesn't or can't meet all the person's needs

4.3 Matching services to need

[Figure 4](#) shows the levels of need that might be met for people in one local community, depending on complexity of need and the types of services that might meet those needs. We expect that a single community-based integrated service could help and support most people with less complex and complex problems, even if some elements of that service are organised on a broader base than the local community (for example, employment services, services for people with eating disorders or some psychological treatment services). Services for people with more complex problems, including inpatient services and specialist community teams would need to be organised at a wider community level. People should be able to have their needs met by the service that is best suited to do so, with as little disruption to their lives or their links to their community as possible.

Some examples of how services can meet needs are set out in [Figure 5](#), which looks at Frank, Diane and Dave and outlines the support, care and treatment that they could benefit from, and the services that can deliver this.

4.3.1 Older adults

Older adults may have differing types of needs and therefore may require support in different ways to meet these needs. Services providing care need to meet the person's complexity of need, taking into account any impact from the person's age and whether specialist older adult expertise is required. This expertise might exist within the core community mental health team, or specialist older adult support might be sought from another service.

Some needs that might require greater and different input to adults of working age include, but are not limited to:

- bereavement
- changing cognitive function
- complex prescribing
- frailty
- loneliness and isolation
- long-term health conditions
- multiple morbidities.

As demographics change, it is the responsibility of all agencies who can provide support, care and treatment within the community to be more proactive in being aware of these needs and ensuring that they can be met. The Royal College of Psychiatrists' report [Suffering in Silence: Age Inequality in Older People's Mental Health Care](#) highlights some of the areas for improvement in older adult care and provides recommendations for improvement.

Figure 4: Example functions of mental health support, care and treatment that can be delivered within a local community

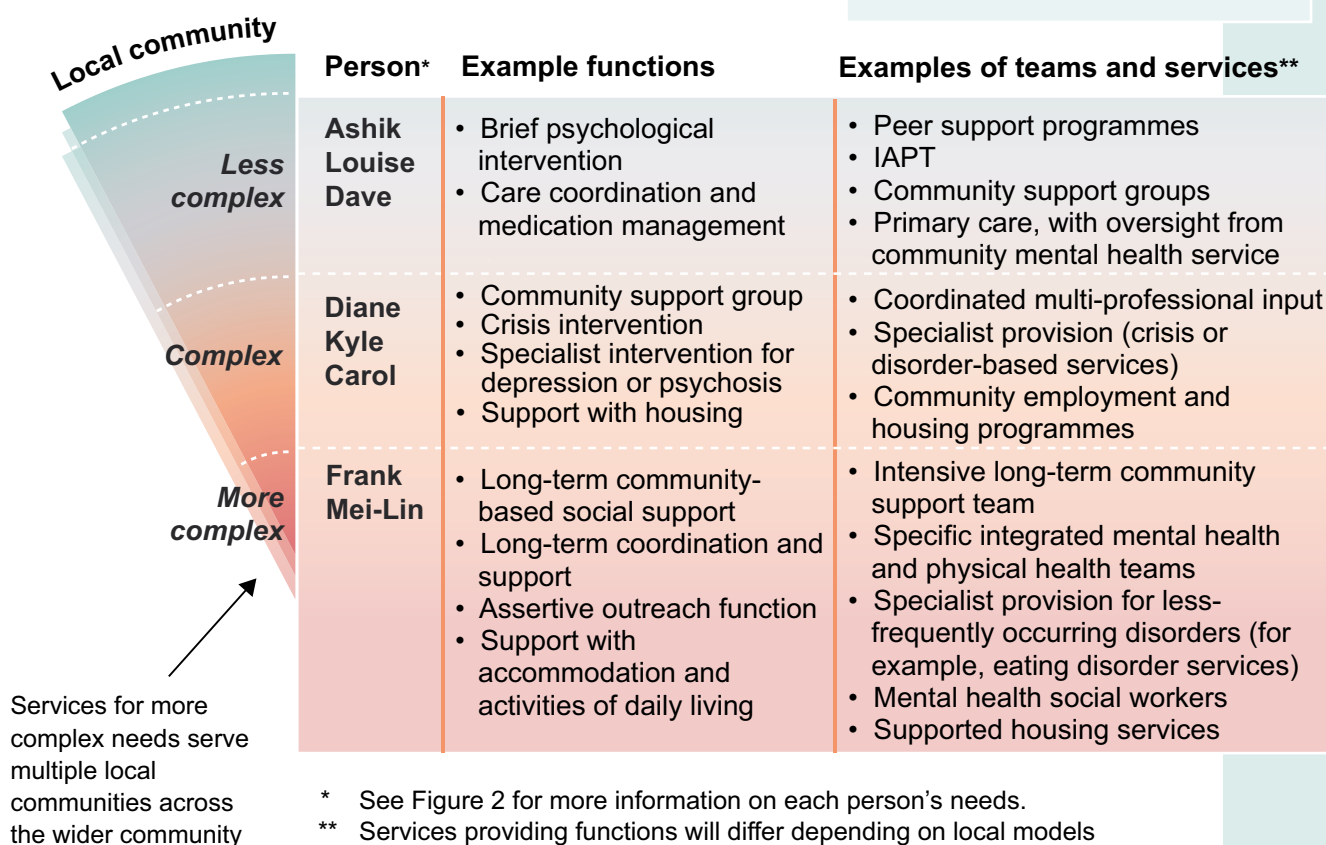


Figure 5: How three levels of mental health needs can be supported using the framework

	Examples of functions required to meet needs	Examples of services that could provide functions
Dave	Providing support in the community through new connections and interests. Helping Dave to rebuild his life within the community.	Community assets/groups
	Helping Dave to find any new groups to engage with that might be able to provide additional support in the community. This might include new activity groups or targeted support groups.	Community connector
	Support, care and treatment for mental health problems, which may include medication or further assessment and ongoing mental health support by the mental health team. Management and advice around sleeping problems and other related symptoms.	GP with input from core community mental health service
Diane	Diane could link in with a local community asset that could offer support for dog walking.	Community assets
	Investigating and following up with any memory problems and supporting Diane and her family with these.	Specialist memory service
	Care for chronic obstructive pulmonary disease.	Specialist chronic obstructive pulmonary disease team
	Support, care and treatment for ongoing bipolar disorder symptoms, including psychological therapy and medication management, including linking in with any physical health services that Diane is seeing.	Core community mental health service and pharmacist
Frank	Helping Frank to live a full life within the community, supported by the people in his community who might share similar personal interests or values.	Peer support group run by VCS Exercise group for people with mental health needs
	Encouraging and enabling Frank to access services, including mental health services, physical health care, and activity groups in the community.	Community connector with experience and competence to work with people with SMI
	Management and care of type 2 diabetes and other physical health concerns, as well as support for mental health needs and encouraging attendance to mental health services.	GP with input from mental health team
	Supporting Frank with his daily living and routine. This may also provide assurance and relief to Frank's family.	Supported housing services with support from mental health social workers
	Treatment for ongoing and persisting symptoms of schizoaffective disorder and medications management.	Specialist mental health service

4.4 Integrated working

Place-based systems of local mental health care should be built around PCNs and existing community hubs. Rooted in the community, care should come together using an integrated approach to mental health and physical health care, health and social care and primary and secondary care.

Integrated working relies on relationships being built between professionals and across services, both locally and in the wider community, through a collaborative approach to delivering care. Services that focus on improving communication with others, sharing knowledge and learning, and supporting people in a collaborative way, will be able to provide more effective care.

On the next page there are two examples where integrated working has proved to be successful for the community who receive care. For further information on the Peterborough Exemplar (formerly known as Primary Service for Mental Health [PRISM]) and Westminster services, and for additional positive practice examples, see [Appendix 2](#).

4.5 Community assets

Community assets include activities, groups, services or organisations open to the community. They can be grouped into four domains (some might be relevant to more than one service):

- **Health and social care services:** GP community services, GP surgeries, mental health services, day services, respite services, recovery colleges, social care services, hospitals and services that support people with their health.
- **Local facilities and services:** education, work places, libraries, social clubs, parks, community transport, cultural organisations, support groups – for example, peer support groups, activity groups, sports clubs, parent and toddler groups.
- **Personal interests:** creative groups (in person or online), worship or spiritual groups, sports clubs or special interest groups (including therapeutic leisure activities), leisure activities specific to people with mental health problems and other user-led leisure groups.
- **Personal relationships:** family, carers, friends, neighbours and the person's care team.

Positive practice in integrated working

Peterborough Exemplar (formerly known as PRISM), Cambridgeshire and Peterborough NHS Foundation Trust:



PRISM was an integrated planned care service providing specialist mental health support to GP surgeries for adults up to the age of 65, and the model was extended into the Peterborough Exemplar through 2019/21. PRISM acted as an intermediate service between primary and secondary care, where a person can receive further support for their mental health needs while remaining under the overall care of their GP and receiving this care at their GP surgery. This was achieved through integration between specialist mental health, physical health, social care, and recovery and peer support workers. The Peterborough Exemplar created multiple new senior liaison clinical roles, to better integrate the mental health pathways across care and sectors, with a local mental health team. They increased the access to and options for mental health support while linking with the wider Peterborough community.

Westminster Older Adults Integrated Community Mental Health and Home Treatment Team:

A multidisciplinary team providing specialised needs-based care for older adults. They are integrated with the Home Treatment Team to ensure transitions to – and from – crisis care are timely and seamless. This also avoids repeat assessment, ensures continuity of care and avoids duplication of work. They also have good links with other local community agencies

'I expect that the people involved in my care will listen to me, talk to me and to each other, and work together. I don't want to repeat myself if I don't have to.'



This is because...

- People have described experiences of services that don't communicate with each other, which leads to fragmented care
- People don't want to repeat their story unnecessarily
- People don't want to be passed from service to service unnecessarily



How using the framework can make this happen:

- Services and professionals should share information (as appropriate) and commissioners should ensure compatibility of IT systems across services; ensure data sharing is in line with General Data Protection Regulation
- Shared care agreements
- Services to consider the viewpoints of other professionals that work with the person, such as advocates, staff from a VCSE organisation or support workers
- Clear communication across services
- Services/professionals are held accountable to their responsibilities for the mental health of people in their care

4.5.1 Engaging with community assets

Community assets can play a role in promoting health and maintaining wellness within the community, so may also provide a preventive function as well providing support. [Figure 6](#) illustrates each of the eight fictional people within their local community, and their different levels of connection to the assets available to them. The complexity of each person's needs does not necessarily determine whether a person will engage with the resources in their community. For example, it might be assumed that a person with more complex needs will make less use of what is available to them in their community than people with less complex needs. However, although Frank and Mei-Lin have more complex needs, they make more use of assets than Carol and Kyle whose needs are less complex.

Despite making use of some of the resources available to them in their community, Frank and Mei-Lin are likely to require ongoing support from health and social care services due to the complexity of their needs. However, they can still make use of resources in their community and services should help them to do this.

I feel like a lot of community assets are “hidden” and consequently they get shut down because people don’t use them. We kind of assume that the community assets are only the ones that are related to mental health, which is not true because it’s about engaging a person in activities just as a person, not the ill person.

Person with lived experience

‘I want support to build a life for myself in my community, to be a part of my community, without it being linked to mental health.’



This is because...

- People want to be able to access services and resources in the community that are not only related to mental health
- People who do not have a community can need extra support to create one around themselves, so they don't have to rely only on mental health services



How using the framework can make this happen:

- Commissioners to re-allocate resources, to ensure that an adequate number and range of assets are available in local communities
- Clear options provided for the person, including peer support
- Supporting people to access resources/assets in their community, depending on their interests and the level of support needed

‘I want to know what is in my community, and be able to do something without needing a referral.’



This is because...

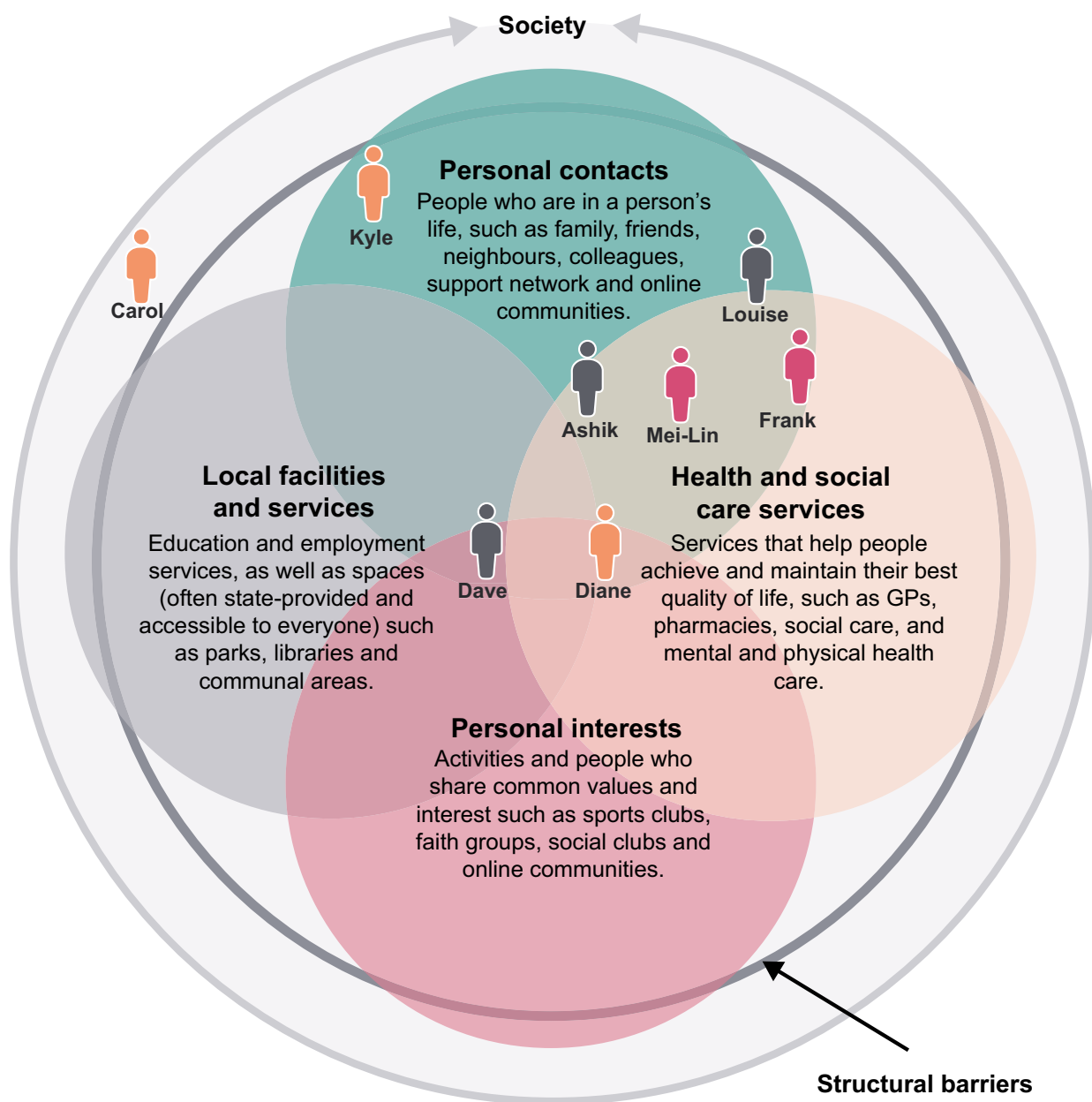
- Some areas have very few resources or groups, or some groups are held at times or places that are not appropriate or accessible to some people
- Some groups will only accept a referral, which some people are unable to get
- People have experienced not being able to attend a group or activity, which may be a result of the organisation not feeling they can provide the right support



How using the framework can make this happen:

- A comprehensive map or directory of community assets and resources that is clear and publicised, and that has an emphasis on resources that are not linked to mental health
- Services across the system to have open and inclusive access for everyone

Figure 6: The resources and assets of a community, and how different people might be connected with them



4.5.2 Difficulty accessing community assets

Sometimes a person can find themselves unable to access any community assets, as demonstrated by Carol. She has very little connection with her family and other personal contacts, seeks little help from health and social care services, and is very isolated in her day-to-day life. Therefore, she finds herself outside of all available assets and may find it difficult to establish connection with them.

The effects of the COVID-19 pandemic highlighted the impact of isolation and digital exclusion, with many people experiencing isolation and it being amplified for others. People who live alone, are on very low incomes, are in supported housing, are older adults, or have been diagnosed with severe, complex psychosis, were particularly affected.

Beyond COVID-19, a person might be unable to access assets within their community because of geographical distance from them (for example, people living in rural or isolated areas with poor transport links), if they have difficulties leaving the house or if they have recently been released from prison. Homelessness or financial problems can make it difficult to access facilities and services, and to maintain personal relationships.

Other examples of difficulties with access include language barriers, services not adapting to meet a person's needs and any disabilities, stigma or self-stigma, or social exclusion (for example, refugees and migrants). Age, socioeconomic status, housing situation and other lifestyle factors can also make access difficult. These structural barriers that are outside of the person's control can significantly contribute to a person's lack of connection with their communities; these barriers are represented by a thick border in [Figure 6](#).

4.5.3 Facilitating connection to community assets

Everyone involved in a person's care has a potential role to play in facilitating their connection with community resources and supporting them to develop connections using their own resources and strengths. Signposting can help, as can support from a [community connector](#) (see [Section 5.3](#)).

Some [areas in the North West of England](#) have managed to integrate the provision of many different types of assets, to provide seamless support across the community.

During the COVID-19 pandemic, some local areas started using Personal Health Budgets to give people with mental health problems access to technology, for example tablets or smartphones, so they could attend remote appointments with their CMHT.

The Local Government Association have published [Being Mindful of Mental Health – The Role of Local Government in Mental Health and Wellbeing](#),²⁴ which outlines how local authorities can contribute to the mental wellbeing of communities and support to develop community assets.



4.6 Reducing variation in availability of community assets

Some communities are not asset rich, whereas others have assets available but have difficulty engaging people. If community assets are lacking, providers should work with local CCGs, STPs/ICSs and local authorities to consider commissioning to close this gap or identify resources that facilitate access to existing services (for example, considering financial aid for transport).

See Table 4 in [Part 2](#) for additional recommendations around joint CCG and local authority responsibilities for community asset development.

Availability of online resources, such as information directories and online communities, should be factored in. Local authorities and CCGs should ensure that assets are available to meet the needs of the local population, and all services should work together to promote engagement with these resources.

‘We will be informed of sources of support in the community available for parents, carers, families, friends and support networks.’



This is because...

- Parents, carers, families, friends and support networks also need support
- People don't always know what support they can access and what support they are entitled to



How using the framework can make this happen:

- All people with caring responsibilities will be signposted to support, including carers' assessments under the Care Act
- The wellbeing of parents, carers, family members or friends who support a person with a mental health problem needs to be considered
- Services provide an appropriate level of support for their mental health, so they can help care for someone else
- Support provided to prevent caring relationships breaking down

5. Improving engagement with community assets

This section sets out ways to improve engagement with community assets, which involves ensuring the availability of 'community connectors'. Enabling a person to engage with community assets will help them to:

- grow their personal community and strengthen the networks around them
- learn and develop skills or interests
- contribute directly to improving their own local community by working with community groups, re-investing learned skills or developing their own community groups.

Many people with mental health problems might need encouragement to engage with the resources, assets and amenities in their communities. Connecting people with their local communities runs through every level of this framework, regardless of complexity of need.

5.1 Social prescribing

[Social prescribing](#) is being adopted in many primary care settings in England. It involves referral or community connection to sources of support in the community that contribute to a person's health and wellbeing. Social prescribing helps people access sources of support other than mental health services. It empowers them to increase their personal networks by engaging with local resources. It can help a person build relationships, learn or develop skills or interests and have a local source of ongoing support.

5.2 The community connector role

For people who experience inequalities in access to support, care and treatment, the community connector can facilitate access to the assets and resources that meet their individual needs, thus contributing to a reduction in health inequality. People should be actively supported to access all the services that are relevant to them. This includes identifying resources, facilitating introductions to services and supporting ongoing engagement (which includes supporting access back into mental health services with ease and flexibility if the person requires long-term but less frequent care).

In some circumstances, the care coordinator might also have the role of the community connector, especially if the person has more complex needs.

See also the recent NHS England and NHS Improvement publication, [Advancing Mental Health Equalities Strategy](#).

Community connector

is the role otherwise known as a 'social prescribing link worker', 'wellbeing advisor' or 'care navigator'. When creating these roles, decisions about the most suitable terminology are for local determination.



Social prescribing

Social prescribing connects people to community groups and services, through 'link workers' who:

take referrals from local agencies
can dedicate time to the person

co-produce a plan to meet the person's wellbeing needs, based on what is important to them

Although the term 'community connection' is used within this guidance, the core purpose of social prescribing and community connection is the same – to ensure that a person can access the range of resources that are available to them in their communities to keep them well.



5.2.1 Functions of the community connector^f

Community connecting is critical, requires skills and should exist across all services that utilise the framework. A specific 'community connector' role might need to be created, or the functions of that role could be carried out by, for example, peer support workers, recovery coaches or care coordinators. However, all professionals and non-professionals should be able and supported to carry out some degree of community connection.

Community connectors will work closely with the whole spectrum of community mental health services. The key functions of this role are to:

- Assess a person's ability to engage with certain community activities, including their availability to attend new activities, if adjustments are needed or if additional support is required. Ability to engage can change and fluctuate over time.
- Assess a person's motivation to engage with activities and how the activity fits with achieving their goals.
- Be familiar with the local resources and assets available in the community. Find out about new resources and keep track of those that are no longer operational. This might be done by using a local **community assets map** (also see Section 4.3 of [Part 2](#)).
- Communicate with the person regularly, adapting support to align with their preferred contact methods. Face-to-face meetings are recommended, with appropriate infection prevention and control measures in place if necessary, including those that have proliferated during the COVID-19 pandemic. Be responsive to their choice of location.
- Encourage and enable people to get involved in the facilitation of existing assets or establishing new assets.
- Encourage people to become holders of their own information particularly of their care and safety plans.
- Explore how to meet the person's needs in a collaborative relationship.

Community assets maps



These are databases that list available resources and assets in local or wider communities, with a health and wellbeing focus or more general activities. Community assets maps are typically held on the internet, can be maintained and kept up to date easily, and are to be used by anyone in the community. By having an easily accessible list of resources, people can see what is available in their area that can benefit their wellbeing and help them connect with groups in their community.

'I want to be supported to enjoy and do the things I want to do.'



This is because...

- People's personal interests can often be overlooked. Sometimes people need to be asked about what they are interested in or what activities they like to do
- People don't always know what support they can access and what support they are entitled to



How using the framework can make this happen:

- Care coordinators or community connectors working with people to identify, set and work towards meaningful goals, including any activities in the community they would like to be involved in

^f This responsibility is described in terms of a role within this framework. While it can be located in a person/role, it is also important to note that it is the wider responsibility of all who support a person with their mental health.

- Familiarise people with relevant pathways into care.
- Have knowledge about mental health problems and related problems, and the skills to work with people who experience them with understanding and compassion.
- Have some knowledge about housing, benefits and employment support, advocacy and interpreters. Know where the person can get specialist advice.
- Identify any inequalities in access to health and social care resources and community assets. Be aware of community-wide access inequalities and work collaboratively with all agencies to address them.
- Link in with local community care teams and attend multidisciplinary meetings to facilitate information sharing.
- Provide [community advocacy](#) on behalf of the person.
- Support the person to link with other professionals and services, and liaise with relevant agencies when needed.

Vary the support provided, based on needs. Be flexible in assertiveness, enabling increased meaningful and independent engagement

Community connection should:



- be available to anyone who requires support for their mental health needs
- be developed with the local community and those who require support
- connect people with agencies, activities, groups and services beyond health and social care
- have tailored levels of support and signposting or facilitation of access
- help the person access resources that meet their needs and interests
- integrate knowledge and good practice between services and organisations.

5.2.2 Positive practice in community connection

The Pod in Coventry has been recognised for its successful use of the community connection function. More information about The Pod and other services that deliver effective community connection can be found in [Appendix 2](#).

Positive practice in community connection

The Pod, Coventry:

A local authority-commissioned social enterprise in Coventry that supports people in their mental health recovery journey through social brokerage. A full brokerage service is available for a person who has a severe or enduring mental health problem, through a referral from the local CMHT. A development worker [equivalent to a community connector] is allocated to help the person, and their care coordinator, to meet personalised goals that could help them to remain well in the community. The Pod also operate events with their wider collective of local businesses and activists, which can help anyone to have a stronger relationship with their community. The Pod maintains an innovative approach to recovery planning, where knowledge of community assets is spread primarily through word of mouth.



6. Functions of community mental health services in the framework

This section outlines certain functions of community mental health services and how they will fit into the new framework. There is further information in Section 4.5.1 of [Part 2](#) about care coordination and care planning, which make up a key component of the framework.

6.1 Support, care and treatment

6.1.1 Engagement

The nature and quality of engagement with a person, especially at their first contact with services, can determine how they go on to engage with the service. Building connections through collaboration and shared decision-making are essential to ensure that support, care and treatment fit with the person's needs, strengths, values and preferences. When people are unwell, they can find it difficult to engage – and services' approaches and responses may cause or compound this. They are then less likely to seek help, and some may require more assertive strategies to support engagement, particularly those who have difficulty accessing sources of support or leaving their house. People may require staff to consider flexibility of location and appointment times, and support to navigate the system. See the positive practice example of [The Life Rooms](#).

The first moments of interaction between a service provider and a person seeking care [...] can start a journey to recovery and a satisfying life – or [they] can leave a person unsure or even hopeless about their future and unwilling to go back a second time.

The same is true about interactions with others in the community; a person who has been told that people with mental illness are scary, weak or unable to care for themselves may not seek help or may avoid telling others the full extent of what they are experiencing.

[National Alliance on Mental Illness](#),
July 2016

6.1.2 Assessment and formulation

Assessment can be a continual process that is integral to care delivery, directly relating to the wellbeing aims of the person. Assessments should be inclusive, lead to the shared development of a personalised care plan when needed, and have input from the person's [support network](#) and other professionals where appropriate. The '3 conversations' model is a good example of an initial conversation and assessment, which may begin with questions such as, 'How can I help?'. A care plan should outline the most appropriate course of action to meet their needs, including if and how a person would like to engage with their community.

Positive practice in engagement

[The Life Rooms](#), Mersey Care NHS Foundation Trust:

A vibrant social enterprise located in three sites across the Mersey area, with a focus on wellbeing, learning and recovery. The sites include a meeting space, café, library and IT (information technology) suite alongside the range of services that it provides. The services are all co-produced, social care-focused and accessible to anyone within the community, regardless of having a mental health need or not. They hold recovery college classes, welfare and employment advice, literacy and IT skills training, and much more. One-to-one appointments can be booked with a pathways adviser to talk about which local services and activities could best meet their needs, and how to accessing them with help to do so given as needed. Due to COVID-19, The Life Rooms started to deliver learning and social prescribing services via telephone and online video conferencing. The Life Rooms developed an online learning platform, which can be accessed at any time.



'I need my first point of contact with any service to be warm, welcoming, respectful, compassionate and friendly.'



This is because...

- People sometimes don't feel welcome by receptionists or other staff
- People with mental health problems want to feel treated the same as any other person



How using the framework can make this happen:

- Attitudinal shift by professionals
- Commissioning based on values that makes sure all services (such as primary care, VCSE, general medical and secondary care services) are informed about mental health
- Training for staff across the system so they have an awareness and understanding of mental health
- Basic understanding of mental health for professionals that people may come into contact with, including community or PCN clinical pharmacists, GPs, receptionists and physical health staff
- Ensure that staff have the right skills and competences

'I want services to be upfront with me and tell me how long it will take to get help. I want support while I am waiting for an appointment, so I'm not left waiting and getting worse.'



This is because...

- Not knowing when an appointment will be, or being left without support while waiting for an appointment, can have a negative impact on experience and wellbeing



How using the framework can make this happen:

- Services that provide people with information and support while waiting for an appointment (including online resources or community support options)
- Commissioners that set clear local access and waiting time standards, in keeping with national standards, and adequately commission services to meet them
- Commissioners that take robust action if providers aren't meeting access and waiting time standards
- Staff that have the necessary training and knowledge around referral pathways across services and access and waiting time standards

The assessment should enable the person to easily access the full range of services that are available to meet their needs, as well any additional support and care they are entitled to. This might include care and support planning under the Care Act, entitlement to [Section 117](#) aftercare and [personal health budgets](#).

Any assessment should be reviewed throughout the delivery of support, care and treatment, to ensure the care plan remains up to date and appropriate to the person's needs, and to determine if the care provided needs to change or end.

Screening tools may be used before an assessment, but they should only ever be used as a guide, prompt or means to allow the person to express their experience if they are having difficulties articulating it.

See [Appendix 4](#) for summaries of the evidence reviews conducted on assessment.

Delivering effective and efficient assessments

All assessments in community mental health services should be delivered with a matched framework where the structure and function of the assessment should vary according to personal need and service function. The structure does not require people to 'progress' through the system, although this may happen for some people, but rather to ensure that assessments are matched as far as possible to need, so that unnecessary assessments are avoided. The output of all assessments should be clearly communicated to all those involved in the assessment with a shared formulation of the presenting problems, including what maintains the problems and what can resolve them, and an agreed care plan where needed. See the evidence reviews summary in [Appendix 4](#) for detail on the development of formulations and care plans.

6.1.3 The four components of assessment

Broadly, assessment has four key components:

1. An **initial brief assessment** to determine if there is a mental health need to be met.
 - a. It may take place in a primary care or community setting, or the person may present to or be referred by other health/social care/community services.
 - b. It would focus on gaining an understanding of the immediate problems and any associated safety issues.
 - c. It can be undertaken by a person with appropriate training in a wide range of community settings (possibly over a digital platform).
 - d. The outcome (which should be shared with the person, and the people involved in their care including their friends, family or carer as appropriate), and could include:
 - advice and no further action
 - referral to or advice to engage with a particular health, social or community intervention
 - a comprehensive or specialist assessment.
2. A **comprehensive assessment** to clarify how an identified mental health need might be met.
 - a. It may take place in a primary care or community setting, or the person may be stepped up from an initial brief assessment, or they may present to/be referred by other health/social care/community services.
 - b. It would focus on gaining an understanding of the past and present mental health problems, a person's current functioning and mental state, relevant personal and social factors, and any associated safety issues.
 - c. It can be undertaken by a person with appropriate training in a wide range of community settings.

3 conversations model



The [3 conversations model](#) centres

assessment and care planning around a person's strengths and the assets available to them in their community. There are three distinct conversations that can be had to ensure that the assessment and care planning process is person-centred and personalised.

Listen to the person in the initial contact – connect with them and identify their needs. Help them to connect with other personal connections or community resources

What can we do in a crisis? – helping the person to identify what their own level of risk is and what they might need to do to stay safe when they are in crisis

Long-term outcomes and planning – asking the person to identify what their hopes and goals are for the future and what resources can be utilised to support these.

- d. The outcome (which should be shared with the person, and the people involved in their care including their friends, family or carer as appropriate), could include:
 - advice and no further action
 - the development of a formulation and care plan
 - referral to, or advice to engage with a particular health, social or community intervention
 - further, more detailed assessment (see point 3 below).
3. A **specialist assessment** to determine the need for a specialist intervention/service^g or make recommendations for care and treatment in existing services.
- a. It usually takes place in a specialist care setting or is carried out by specialist staff. It may be stepped up from an initial brief assessment, or be conducted on referral from a range of health/social care/community services.
 - b. It shares many components with a comprehensive assessment, but has additional elements that are particular to the specialised nature of the service.
 - c. It will be undertaken by a person with specialist training.
 - d. The outcome of the assessment should be shared with the person (and the people involved in their care including their friends, family or carer as appropriate) and could include:
 - advice and no further action
 - the development of a formulation and care plan linked to:
 - referral to, or the delivery of care within the specialist service
 - advice on the care and treatment of the person within existing community services.

^g This could include specialist neurodevelopmental, forensic, eating disorder or personality disorder services, or intensive community rehabilitation.

4. An **urgent or emergency assessment** to assess the need for care and treatment where there is an immediate safety issue which could involve risk of harm to the person or others.
 - a. It takes place in a specialist care setting or from specialist staff, or may be stepped up from an initial brief assessment, or be referred by a range of health/social care/community services including police and emergency services.
 - b. It shares many components with a comprehensive assessment, but would have additional elements focused on risk assessment and management.
 - c. It will be undertaken by a person with specialist training.
 - d. The outcome (which should be shared with the person and the people involved in their care including their friends, family or carer as appropriate), could include:
 - advice and no further action
 - the development of a formulation and care plan linked to:
 - the development of a formulation and a safety plan
 - referral to particular health, social or community services, including inpatient care.

To assess risk and safety within any type of assessment, a number of risk assessment tools exist but evidence indicates that they are not effective for predicting risk or determining treatment allocation so should not be used for this.^{7,25} It is suggested that a **safety plan** should be developed with the person, involving their family, carers, friends, support network, or other professionals, in accordance with the person's wishes.

‘I want an assessment to be about understanding me, my needs and where I’m coming from, so I don’t have to repeat myself if I don’t need to.’



This is because...

- Repeating information and assessments can be frustrating and traumatic for people
- People can have negative experiences of assessments, so being supported in the right way and being given the right information can make a big difference



How using the framework can make this happen:

- Commissioners and providers have a responsibility to ensure a timely, thorough and appropriate assessment, while providing timely access to services that will help a person achieve meaningful goals and that they have a thorough formulation and care plan where required
- Services that clearly explain what an assessment is for, how it is relevant, how it can help achieve a person’s goals and whether it considers the full range of needs
- Involving people in assessments, giving clear feedback about the outcomes and giving them opportunities to clarify any inaccuracies or misunderstandings

‘I expect that people who are supporting me will be honest and open with me.’



This is because...

- Honesty and building relationships with people are key to good support, care and treatment
- Being told certain things will happen, or that other services can help when they can’t; then being left with no care or support, and falling into the gap between services



How using the framework can make this happen:

- Commissioning based on values
- Services that are clear and direct about what they can and can’t do for a person
- Services that do not make promises or claims on behalf of another service
- Basic understanding of mental health for professionals that people may come into contact with, including pharmacists, GPs, receptionists and physical health staff
- Ensure that staff have the right skills and competences

‘I need to be able to raise concerns about my care, without worrying about what will happen.’



This is because...

- Needing to feel safe to voice concerns
- Knowing that concerns will be taken seriously



How using the framework can make this happen:

- The right people being involved in a person’s care and support, which means care will not be compromised if concerns are raised because people will continue to be supported in the right way
- People being involved in finding solutions
- Concerns taken seriously, with clear processes and actions for resolving them

6.1.4 Treatment and interventions

Interventions refer to a range of methods and practices used by professionals, support workers, families and carers or individuals themselves, to treat a mental health problem or maintain mental wellbeing. Interventions can be psychological, social, physical or pharmacological and people will need differing types of interventions, to different degrees, depending on their individual needs. Availability, delivery and location of interventions will vary depending on local population need and resource.

Evidence-based treatments and interventions

NICE guidelines provide comprehensive and evidence-based recommendations on how healthcare, social care and public health professionals should best care for, support and treat people with mental health problems.

The provision of NICE-recommended psychological therapies in community mental health services is critical in ensuring that adults and older adults with severe mental illnesses can access evidence-based care in a timely manner, to give them the best chance to get better and to stay well.

A summary of relevant recommendations and quality statements from NICE guidelines and quality standards is in [Appendix 3](#).

‘I want a say in what my options are; I want to be able to choose when, where and how I get the support I need, and to be supported in my choices.’



This is because...

- Language can be used to make it seem like the person has a choice, but people can be made to feel that they have to agree with certain support options, appointment times or appointment frequencies – this is not genuine shared decision-making
- Sometimes people are only given one option for how to access support and are not told why (such as only being able to speak to someone over the phone, but not being told why they can't talk to someone face to face)
- People are sometimes not listened to if they express a preference to see a professional based on particular characteristics (such as gender, cultural background, community)



How using the framework can make this happen:

- Services that provide people with genuine choices and options around appointment times and frequency (including online booking options, with standardised electronic reminders as well as reminders by letter)
- People receive clear information about their choices, including information about their legal rights
- Commissioners that develop resources and support in the community so people can stay in their local area to get help
- Providers that involve people in decision-making about their care, clearly informing people of decisions when they cannot be directly involved, with clear explanations about how and why the decision was reached
- Services that consider the additional support or flexibility that people might need to access help (such as for childcare, education, work commitments or transport)
- Giving people choice wherever possible about the professional they see

Advancing mental health equality: access to interventions



- Ensure people are kept regularly informed about what support is available in their local area.
- Identify what proportion of the local population should be receiving support and highlight any gaps.
- Engage with communities to understand the treatment access barriers in the local area.
- Work with communities, people who use services, families and carers to address treatment barriers and improve engagement and access.
- Ensure people are not excluded from accessing psychological support based on having co-occurring physical or mental health conditions (adopt a 'no wrong door' approach).
- Ensure that age- and developmentally appropriate interventions are available and accessible.
- Stabilise people's rights to social equality, such as housing, financial independence and welfare.

6.1.5 Community rehabilitation

People with more complex needs and long-term mental health problems may require additional support to live in the community and continue with their rehabilitation.

Rehabilitation involves supporting a person to move through a clinical pathway to greater independence, for example, from 24-hour residential care, to supported accommodation with 9–5 staff support, through to a council flat of one's own, with tailored support.

Community rehabilitation teams can work with commissioners and providers of housing to ensure that the rehabilitation provision meets local need. This optimises the management of the rehabilitation pathway and minimises the need to use out of area care, either within hospital or community residential placements.

6.2 Transitions between care services

Services need clear and effective links with specialist services and care pathways, and through necessary transitions between care settings.

Commissioners and providers should ensure there are clear processes for necessary transitions between services, to ensure that any risks or safety issues are managed. Community connectors or transition workers can facilitate smooth transitions and support the person over this period by helping the person access other resources for support. Providers, community connectors and the team involved in the person's care should consider offering sessions with the new care team or professional before the handover is complete.

Community rehabilitation services provide:



1. Residential teams, to support people with their daily living and ensure that they can gain the necessary skills and independence to maintain their wellbeing
2. Specialist community multidisciplinary teams, to optimise rehabilitation and recovery, help the person to live a meaningful life and work towards their goals, thereby increasing the likelihood of sustained community living and reducing the likelihood of hospital (re)admissions
3. Clinical expertise, to other teams when people in their care are not managing their health well in the community or have been inpatients for too long, and to advisory panels when decisions about funding and monitoring the effectiveness of placements take place.

During engagement work with the Department of Health's Voluntary Community and Social Enterprise Health and Wellbeing Alliance,^h some additional key principles were identified:

- The transition process and any reasons for transitions should be clearly explained to the person and their family and carers
- The new services should be involved in all transition planning meetings and be given the opportunity to get to know the person before the transition takes place
- Transitions should be gradual rather than immediate
- If a person is transitioning back into the community from an inpatient service, their housing needs should be considered by both teams before the transition takes place
- The transition process and the timeframe should be known and understood by the person, before and during the transition
- Clear information should be given about how the new team might differ from the discharging team
- The care plan should be reviewed by the person with the existing care team and new care team, to ensure that it is up to date and accurate
- During the transition, the person should have a clear line of communication with a named professional so that they can get support with any problems or queries that may arise
- The transition handover should be seamless, to prevent anyone from 'falling through the gaps'
- Transitions in care should be communicated to the person's GP, if they wish.

6.2.1 Safety plans during transitions

During transitions, the care team should ensure that a safety plan has been developed with the person and is up to date and accessible. This should also consider any safeguarding concerns and how to eliminate these during the transition process.

NHS England's mandatory national [Transition CQUIN Indicator for 2017/2019](#) for commissioners and providers focuses on transfers of care from children's and young people's mental health services.



'I have the right to feel and be safe. I want to trust that services will provide the right care if I ever feel vulnerable, and will make sure I'm safe.'



This is because...

- People can be more vulnerable when moving between services or if they are new to a service



How using the framework can make this happen:

- Services to make information available and known, so that people know what to do and who to contact if they don't feel safe
- Staff and managers within organisations to take responsibility for working with people to find acceptable solutions to safety issues, particularly those arising from insufficient resources, funding or workforce capacity

^h See [Appendix 5.1.5](#) for engagement group members.

6.2.2 Transitions in care for older adults

Care decision-making for people using older adult services should be based on which service will best meet their needs. General adult mental health services that provide care and support to older adults ('ageless services') need older adult expertise within the care teams such that the service can support the specific needs of older people, including frailty, multi-morbidity and comorbid physical health problems.

6.2.3 Transitions from out of area, acute and inpatient care settings

People transitioning back into the community from out of area placements, acute or inpatient hospital stays, forensic or secure settings or the criminal justice system may need specific support, as might younger people in higher education who have moved to a different area. Services will need to work with people to identify their needs and plan for such transitions.

For further guidance around transfers of care, commissioners and providers should refer to the [NICE guidance on service transition](#), and other national guidance.^{26–28}



7. Commissioning the framework

This section sets out some of the considerations that should be kept in mind when commissioning community mental health services in accordance with the framework set out in this guide. With the introduction of STPs, ICSs and accountable care partnerships having a significant impact on the commissioning process, it is recognised that the structure and form of commissioning are currently undergoing considerable change.

7.1 Guidance on the commissioning process

This framework does not provide advice on the commissioning process, which is covered in existing guidance from Public Health England²⁷ and the King's Fund,^{30,31} and in [Integrated Commissioning for Better Outcomes: a commissioning framework](#).¹⁸ However, the overall objectives of commissioning are in line with those set out in this guide and focused on the provision of effective, integrated community mental health care.

This will include the planning, organisation and development of services that best meet the needs of local populations. Although this guidance does not specify how local commissioning is configured, the framework is likely to be best delivered through integrated commissioning arrangements, where health and local authority commissioners work together to deliver the ambitions set out here.

7.2 Effective service planning

To be effective, the planning and organisation of services will need to be informed by an assessment of the needs of local and wider communities. To achieve this comprehensively, service planning must consider the capacity of the local community so that they can support people with a broad range of mental health problems effectively. This involves moving beyond the traditional boundaries of mental health service commissioning. Consideration needs to be given to factors such as available housing, community resources, employment opportunities and the support available for gaining and maintaining employment. Last but not least, access to and the availability of physical health services for people with mental health problems needs to be taken into account.

7.3 Building outcomes into the system

Effective commissioning should not only focus on the needs of the community but also on the outcomes that the services intend to attain. This is probably best achieved by building into the new system, outcomes for community mental health services that are meaningful for people with mental health problems, their families, carers and friends, those responsible for providing mental health services and those responsible for commissioning them. Outcomes seen as meaningful at all these levels are more likely to be accepted and acted on by all stakeholders. This requires not only agreement on what these outcomes are but also the means (principally, integrated electronic record systems) to collect and analyse outcomes. Then, prompt and meaningful feedback can be provided at the individual, team and service levels to inform both on progression through care and its outcome.

7.4 Co-production in commissioning

Throughout this guide a key objective has been to set out, as far as the evidence allows, a set of principles, functions and structures that can help to create an effective community mental health service. Perhaps the greatest challenge for commissioning mental health services is to ensure that the key stakeholders in the process – people with mental health problems, their families and carers, general practitioners, and other primary care staff (including those working in physical health care) and staff from secondary care mental health services – have a clear understanding of the overall aims and objectives of an integrated community mental health service. They should have a key role in developing and shaping the service, which is collaborative in nature, and all participants should feel that they have had a significant say in its production. Public Health England also have resources from the [Prevention Concordat for Better Mental Health](#), which can be used to help bring multiple agencies together locally to implement the framework.³²

7.5 Integrating community mental health services

Key to the effective development of services is establishing an integrated community mental health service in which current primary and secondary care, social care, public health and housing services come together in a single model to improve care. This model will make better and more effective use of current resources, reduce time spent on assessment and making and receiving referrals, reduce the number of repeat assessments and simplify and streamline pathways into care, facilitate effective multidisciplinary working, and ensure that the community can contribute to supporting people to live fulfilling lives and staying well.

Helpful resource

See the NCCMH publication [Working Well Together: Evidence and Tools to Enable Co-production in Mental Health Commissioning](#)



Advancing mental health equality: Co-production

Ensuring co-production occurs with a representative and diverse population can be challenging, especially when working with communities who may be most vulnerable to experiencing inequalities. One way of ensuring meaningful input is to work closely with local community groups and services that have experience of working with people who are at risk of mental health inequalities.



Helpful resource

SCIE have published a number of [resources](#) that can help local areas evaluate their progress towards achieving integrated care.



As detailed in [Section 2](#), current systems often do not operate effectively. Referrals between services, even for people with less complex problems, currently outnumber direct referrals into the service from GPs. Most referrals to CMHTs come from other community or inpatient teams, social care, self-referral or a range of other sources. The transaction costs involved in this, and the consequent disengagement by people who may require mental health support, are considerable.

In an effective service, referral letters and assessment clinics will be replaced by members of the service talking to each other. Implementing this model of care will mean that case identification will lead to prompt access to care and that individuals who are the first point of contact, for example GPs and those working in other community services, can have prompt access to advice and support on management when needed.

8. Abbreviations and glossary

Abbreviations

Abbreviation	Full term
CCG	Clinical commissioning group
CMHT	Community mental health team
CQUIN	Commissioning for Quality and Innovation
ICS	Integrated care system
NCCMH	National Collaborating Centre for Mental Health
NICE	National Institute for Health and Care Excellence
PCN	Primary Care Network
PRISM	Primary Service for Mental Health
SCIE	Social Care Institute for Excellence
STP	Sustainability and Transformation Partnership
VCSE	Voluntary, community and social enterprise

Glossary

Term	Definition
Carer	Any person who cares for a partner, family member, friend or other person in need of support and assistance with activities of daily living. Carers may be paid or unpaid, and includes those who care for people with mental health problems, long-term physical health conditions and disabilities.
Community advocacy	All advocacy that is not a legal entitlement. Community advocacy can support people to cope with a range of situations that they may encounter in their daily life.
Community connection	An approach that enables a person to build their social capital by supporting them to make use of their community resources. Some staff may be trained to take overall responsibility for this role, but all staff should be able to provide some community connection. This process may be aided by the use of accessible, detailed and up-to-date directories or 'asset maps'.
Specialist	Mental health care that targets people with particular characteristics (such as women with babies) or mental health problems. Practitioners delivering specialist care have competences that require a high level of experience and qualification.
Support network	A person, group of people or organisation that provides emotional and/or practical support to someone in need. A support network can be made up of friends, family members, peers, volunteers, health and social care professionals or supportive online forums and social networking sites.
Transition	The planning process around and handling of transfers of care between care settings or location, including the initial planning, the transfer itself and the support provided throughout.

9. References

1. National Institute for Health and Care Excellence. Community Engagement: Improving Health and Wellbeing and Reducing Health Inequalities. London: National Institute for Health and Care Excellence; 2016.
2. Mental Health Taskforce. The Five Year Forward View for Mental Health. London: NHS England; 2016.
3. Her Majesty's Stationery Office. Care Act. London: The Stationery Office; 2014.
4. Her Majesty's Stationery Office. Health and Social Care Act. London: The Stationery Office; 2012.
5. NHS Benchmarking. NHS National Benchmarking Data 2016/2017. NHS Benchmarking; Unpublished.
6. Care Quality Commission. 2018 Community Mental Health Survey. Statistical Release. Newcastle upon Tyne: Care Quality Commission; 2018.
7. Steeg S, Quinlivan L, Nowland R, Carroll R, Casey D, Clements C, et al. Accuracy of risk scales for predicting repeat self-harm and suicide: a multicentre, population-level cohort study using routine clinical data. *BMC Psychiatry*. 2018;18:113.
8. Carter G, Milner A, McGill K, Pirkis J, Kapur N, Spittal MJ. Predicting suicidal behaviours using clinical instruments: systematic review and meta-analysis of positive predictive values for risk scales. *British Journal of Psychiatry*. 2017;210:387–95.
9. Her Majesty's Stationery Office. The Mental Health Act. London: The Stationery Office; 1983.
10. Her Majesty's Stationery Office. The Mental Health Act. London: The Stationery Office; 2007.
11. Independent Review of the Mental Health Act 1983. Modernising the Mental Health Act. Increasing Choice, Reducing Compulsion. Final Report of the Independent Review of the Mental Health Act 1983. London: Department of Health and Social Care; 2018.
12. Richards DA, Bower P, Pagel C, Weaver A, Utley M, Cape J, et al. Delivering stepped care: an analysis of implementation in routine practice. *Implementation Science: IS*. 2012;7. doi:10.1186/1748-5908-7-3.
13. NHS England. Implementing the Five Year Forward View for Mental Health. London: NHS England; 2016.
14. NHS England. Five Year Forward View for Mental Health: One Year On. London: NHS England; 2017.
15. NHS England. The NHS Long Term Plan. London: NHS England; 2019.
16. Chuang YC, Chuang KY, Yang TH. Social cohesion matters in health. *International Journal for Equity in Health*. 2013;12:87.
17. Gordeev VS, Egan M. Social cohesion, neighbourhood resilience, and health: evidence from New Deal for Communities programme. *The Lancet*. 2015;386:S39.
18. Public Health England, NHS England. A Guide to Community-Centred Approaches for Health and Wellbeing. London: Public Health England; 2015.
19. Power to Change. Treating Mental Health in the Community: A Policy Review. London: Power to Change; 2017.

20. Local Government Association, NHS Clinical Commissioners. Integrated Commissioning for Better Outcomes: A Commissioning Framework. London: Local Government Association; 2018.
21. Person-Centred Training and Curriculum (PCTC) Scoping Group, Special Committee on Professional Practice and Ethics. Person-Centred Care: Implications for Training in Psychiatry. London: Royal College of Psychiatrists; 2018.
22. NHS England. Universal Personalised Care: Implementing the Comprehensive Model. London: NHS England; 2019.
23. Shippee ND, Shah ND, May CR, Mair FS, Montori VM. Cumulative complexity: a functional, patient-centred model of patient complexity can improve research and practice. *Journal of Clinical Epidemiology*. 2012;65:1041–51.
24. 22 Local Government Association. Being Mindful of Mental Health: The Role of Local Government in Mental Health and Wellbeing. London: Local Government Association; 2017.
25. 23 McMillan D, Gilbody S, Beresford E, Neilly L. Can we predict suicide and non-fatal self-harm with the beck hopelessness scale? A meta-analysis. *Psychological Medicine*. 2007;37:769–78.
26. Local Government Association. Guidance on Managing Transfers of Care. London: Local Government Association; 2017.
27. NHS England. Model Specification for Transitions from Child and Adolescent Mental Health Services. UK: NHS England; 2015.
28. National Institute for Health Research. Understanding and Improving Transitions in Older People: A User and Carer Centred Approach. UK: National Institute for Health Research; 2012.
29. Public Health England, London School of Economics and Political Science. Mental Health Services: Cost-effective Commissioning. 2017.
30. Naylor C, Taggart H, Charles A. Mental Health and New Models of Care: Lessons from the Vanguard. London: The King's Fund and Royal College of Psychiatrists; 2017.
31. The King's Fund. Nine Principles for Success: Integrating Mental Health in New Models of Care. London: The King's Fund; 2017.
32. Public Health England. Prevention Concordat for Better Mental Health. London: Public Health England; 2017.