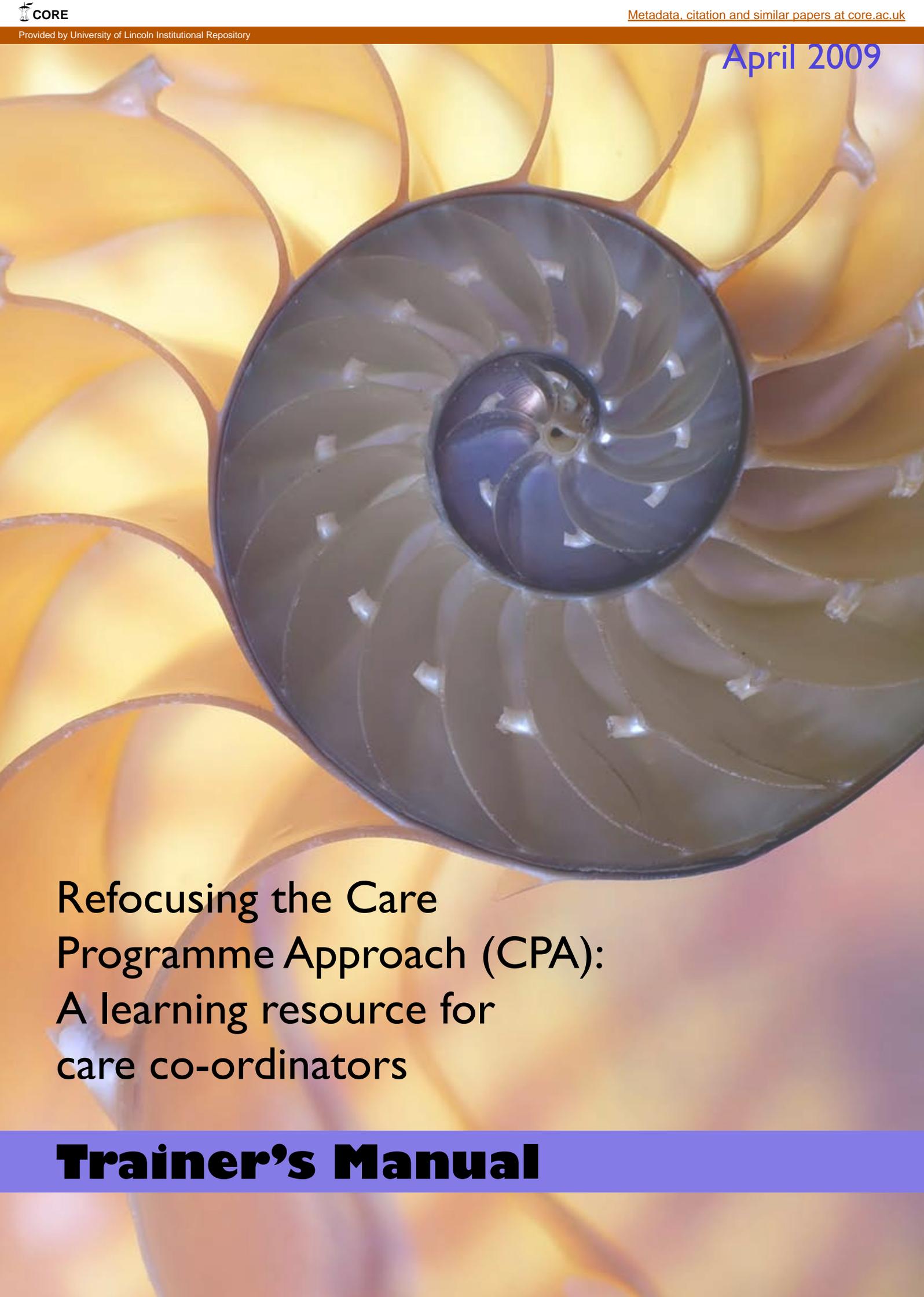


April 2009



Refocusing the Care
Programme Approach (CPA):
A learning resource for
care co-ordinators

Trainer's Manual



UNIVERSITY OF
LINCOLN



Mental Health Foundation



cpaa

Care Programme Approach Association



National Mental Health
Development Unit

Acknowledgements

This learning resource is the product of many different contributions from individuals and organisations. This includes service users, carers and mental health social care workers who contributed their narratives, or who took part in the piloting and evaluation of the resource, critical readers, the media and administrative staff, the steering group and the project group.

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Foreword

People's lives are complex. They can be in or out of work, alone or in a family, ill or well, or at risk. If the care they require is to reflect their needs, it too needs to be complex and well managed.

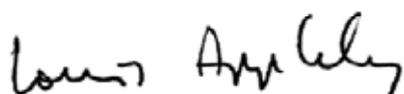
Refocusing the Care Programme Approach (CPA) updates guidance and highlights good practice in this important area. It emphasises a focus on delivering person-centred mental health care and the integration of risk management in the assessment, planning and review processes.

The refocused CPA provides an excellent framework to organise the delivery of fair, personalised, effective and safe mental health services. Care co-ordinators play a critical role in ensuring that this happens, often in complex systems. This learning resource will enhance their capacity to do this by preparing the workforce to apply the values and principles of positive, carefully co-ordinated practice to their work.

The learning resource will be helpful to existing and future care co-ordinators who work in mental health, irrespective of professional discipline and background. Indeed, maximum benefit will be gained by using the resource in multi-disciplinary and multi-agency learning contexts as these are likely to promote collaborative working and enhance a mutual understanding of roles and perspectives.

The resource is the product of collaboration, co-design and evaluation that involved service users, carers and mental health workers and includes narratives that reflect their respective experiences. This is congruent with the central message of refocusing the CPA which emphasises personalisation, partnership, inclusion and the integration of multi-perspectives.

I recommend this learning package to the mental health and social care workforce and am confident that it will make a difference to the practice of care co-ordination and, ultimately, to the quality of service provision.



Professor Louis Appleby
National Director of Mental Health

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Introduction to the care co-ordinator programme: Trainer's manual

Who is this manual for?

Changes to the Care Programme Approach for mental health in England were published in March 2008 following wide consultation¹. This learning resource is designed to support the existing workforce to adapt to these changes and to prepare future care co-ordinators to work with the refocused CPA.

This trainer's manual is a freely available learning resource for updating, training and supporting care co-ordinators with the new guidance. The care co-ordinator role may be taken on by a range of mental health and social care workers, most commonly nurses, doctors, occupational therapists or social workers. This list is not exhaustive and there will be situations where others take on the role and they too will benefit from the programme.

It is designed to be used in the face to face training of all disciplines and agencies that provide mental health services for adults of working age in the National Health Service, local authorities and the independent sector. It may also be appropriate for those who work in the voluntary sector. It is most useful when used in a multi-disciplinary, multi-agency learning context but may also be used with a group of mental health workers from the same discipline.

At this stage of its development the programme is aimed at those who are, or will be, care co-ordinators for **adults of working age** and the narratives and examples are from this group. Many aspects of learning apply equally to those who co-ordinate care for other sections of society such as older people, those with a learning disability, forensic contexts, children and adolescents (CAMHS), but there will be certain contextual and policy differences that are not included in these materials.

How to use this manual and DVD

The materials are divided into stand alone units of learning that may be worked through individually in short sessions or collectively in a block of learning. This will allow for local differences, taking into account demands on training time and other existing learning initiatives. For example, a mental health team could work through a single unit of learning at a time over a number of weeks. Alternatively, another local arrangement may be to structure a four day learning programme to complete the pathway in one go. There is also some flexibility built into each unit of learning with a choice of activities, according to the available time, training facilities and preference.

This flexibility will enable trainers to tailor their own programmes according to local provision and timeframes through the selection of specific units and learning activities.

¹ DH 2008 *Refocusing the Care Programme Approach: Policy and positive practice guidance*. London

Each unit of learning contains some or all of the following resources:

- Summary and outcomes
- PowerPoint presentations
- Readers/handouts
- Identified trigger points for the video clips
- Individual or group activities
- Relevant reading and links

Ideally, the training team should consist of at least two trainers, including a service user. Some of the activities require two trainers. Our experience is that trainer dialogue and support enhances the quality of learning as trainers who have used mental health services bring along an important alternative perspective.

Documentation

There is no standardised documentation for CPA. Indeed, each locality often has a number of different documentation systems according to context and speciality. Consequently this manual does not advocate or prescribe any specific documentation or forms. Where forms are included in the manual, they are examples only. If it is appropriate to incorporate local documentation in the units of learning, then go ahead e.g. in the assessment, risk and/or care planning units you may use local forms when conducting the activities.

The DVD

The DVD consists of a library of video clips of service users, carers and practitioners talking about their experiences and observations of mental health and services in relation to the CPA. This adds real value to the learning resource. The clips may be used as triggers for problem-based learning activities or to affirm or negate points of view. The trainer's manual indicates where these short narratives may be used to prompt discussion and learning that is relevant to the theme of each unit of learning. You may use as many or few of these as fits local need and circumstance. A catalogue of all the video clips indicates the theme, unit and duration of each narrative.

Copies of the DVD are available at no cost. Please order using the electronic form at <http://www.lincoln.ac.uk/ccawi/CPA.htm> or using the paper copy on Page 103, which should be returned to:

CPA DVD Request
CCAWI
University of Lincoln
3rd Floor, MHT Building
Brayford Pool
Lincoln
LN6 7TS

NOTE. We ask that one copy only is ordered for each training initiative i.e. the DVDs are not intended for distribution to individual course participants.

Trainee's manual

The trainee's manual is available as a pdf file at: <http://www.lincoln.ac.uk/ccawi/CPA.htm>. Please download and print as required for participants

Parallel process

During the piloting of this learning resource it frequently became apparent to trainers and participants that a parallel process exists between the learning and service provision environments. The emphasis on values in both contexts, the importance of partnership, the need to work on engagement, the benefits of accurate assessment and person centred planning, the utility of contingency plans and the requirement for continuous review and re-negotiation. This insight was useful in that it provided us with the opportunities to discuss explicitly these issues with renewed immediacy and make connections between positive practice and a fertile learning environment. We recommend that this opportunity is exploited when using the resource

Evaluation

A trainer's evaluation form is included in the resource (Appendix ii). The evaluations will be used to review and improve the learning resource. This feedback is crucial to this process. The participants' evaluation forms (Page 98) are intended to inform your trainer's evaluation so please encourage them to complete these and take the time to review and represent their responses in the trainer's evaluation.

Please complete the Trainer's evaluation and return by email to cpa@lincoln.ac.uk or by post to:

CPA Evaluations,
CCAWI,
3rd floor MHT Building
University of Lincoln,
Brayford Pool,
Lincoln LN6 7TS

Assessment in practice

An Assessment in Practice document is available at <http://www.lincoln.ac.uk/ccawi/CPA.htm>. The document outlines a work based assessment scheme to assess care co-ordinators' competences. It provides detailed guidance for care co-ordinators and their assessors. The assessment is designed to be completed in the six month period following this training and involves the collection and presentation of evidence to an identified assessor (from the local practice setting). The evidence may take different forms and is collated to demonstrate that the care co-ordinator has achieved the identified competences over the time period. For example, assessment documentation, care plans, notes of a review meeting, testimonies from service users and carers.

Accreditation

A module outline is available at the CCAWI website <http://www.lincoln.ac.uk/ccawi/CPA.htm>. This is included as an example of how the learning resource could be presented if seeking accreditation with a Higher Education Institution. Clearly each university has its own rules, procedures and templates and the examples would have to be modified to meet local requirements.



Permission

With the exception of the DVD, this resource is freely available to mental health and social care providers. Contents may be reproduced as required for the purpose of training (please acknowledge the source of any materials used).

PLEASE NOTE: the individuals who agreed to be filmed for this resource gave their written consent on the understanding that the DVD will ONLY be used for educational purposes within the context of the CPA project. Please manage this resource sensitively and ensure that it is only used by trainers for this purpose.

Disclaimer: the views expressed in the DVD and readers are those of the individuals who volunteered to contribute. They do not necessarily reflect the views of the Department of Health or designers of the learning resource.

The information and activities contained in this learning resource are intended to promote positive practice in care co-ordination using the refocused CPA. Neither the authors nor sponsors of this manual can accept any liability in respect of any claims for personal and or property damage or any financial losses sustained following incidents in health and social care provision.

Further copies of this trainer's manual are available at : <http://www.lincoln.ac.uk/ccawi/CPA.htm>

Enquiries

Enquiries regarding the learning resource should be directed to:

Anisa Mustafa at amustafa@lincoln.ac.uk

Trainer preparation

- **Familiarise yourselves with the learning resource:** the trainer and trainee manual; the DVD and catalogue; the handouts; the assessment document. Plan which units and activities you will include in the programme. This will depend on the time you have available
- **Recruitment and information:** liaise with appropriate others about attendance and how participants will be given information about the programme
- **Meet with your co-trainer(s)** sufficiently in advance to decide respective roles and responsibilities and plan the units. Plan in advance how you will use the resource, which activities, PowerPoint presentations, DVD narratives etc.? Some of the suggested exercises will require careful planning and allocation of specific trainer tasks. Ensure that you allow sufficient preparation time for this
- **Check the venue is suitable.** Think about size and resources for breaking out into groups. Find out domestic information so that you can pass on to participants: fire regulations, refreshments, toilets, telephones etc.
- **Equipment:** The DVD can be played on PCs, Apple Macs or DVD players (through a TV). If you are using a computer, you will need speakers (the in-built speakers will NOT be loud enough). The clips will run on Windows Media Player, Real Player, Nero or QuickTime.
- **Other equipment:** data projector, the DVD; flip chart, stand and markers; Blu-tak. Check what is provided at the venue.
- **Resources:** sufficient trainees' manuals for the group; assessment documentation. Local CPA documentation, as required.
- **Time management:** allow sufficient time to set up the room and prepare equipment prior to start time.

Introduction (1 hour)

Outline of session:

- To introduce the trainers and participants
- To engage as a learning group
- To agree ground rules for learning environment
- To outline the aim and content of the programme

Domestic information

- As per venue



Engagement/joining activity (20 mins)

Introduction in pairs (5 minutes each). Could use prompts such as:

Expectations of course..
How I got here.....
A goal I have in life.....
Experience of CPA.....

Feedback in group (restrict to name and one fact)



PowerPoint presentation Session 1: Introduction to the CPA programme

(presentation and handouts from PowerPoints on DVD)

Parallel processing

Encourage discussion, questions and negotiations on ground rules. Take opportunities to point out the importance of partnership, engagement, information sharing and co-production at the start of therapeutic and learning relationships.



Unit 1: Personalisation, values and the CPA

Summary

This Unit emphasises that the refocusing of the CPA is grounded in values and principles that are central to personalisation¹ and encapsulated in the 10 Essential Shared Capabilities², Human Rights in Healthcare³ and the 'Three Keys'⁴. These values underpin the process of CPA and inform all aspects of its day to day application. Without these, care will fail. Participants are prompted to consider challenges to values based care co-ordination and to examine how these may be addressed.

Choice' and 'personalisation' are now watchwords for NHS and social care and they underpin the refocused CPA. The review of the NHS in 2008 by Lord Darzi notes that *'personalising services means making services fit for everyone's needs, not just those of the people who make the loudest demands. When they need it, all patients want care that is personal to them. That includes those people traditionally less likely to seek help or who find themselves discriminated against in some way'*.

The CPA is at the heart of this personalisation focus. Personalisation of care provision starts with an examination of the core values which underpin CPA. It is no accident that the 'Refocusing CPA' document begins with a statement of values nor that this learning resource follows suit. This unit aims to promote greater consistency in how attention to values and principles are applied in CPA practice.

Learning Outcomes

By the end of this unit of study participants will:

- appreciate how national policy frames the role of the care co-ordinator in a refocused CPA
- articulate what 'values based practice' means and how it influences their roles as care co-ordinators
- identify challenges to values based practice and possible solutions to overcome them
- evaluate what 'personalisation' means to their practice as CPA care co-ordinators
- analyse how values affect decision making and how care co-ordinators can appreciate and negotiate difference of 'values'

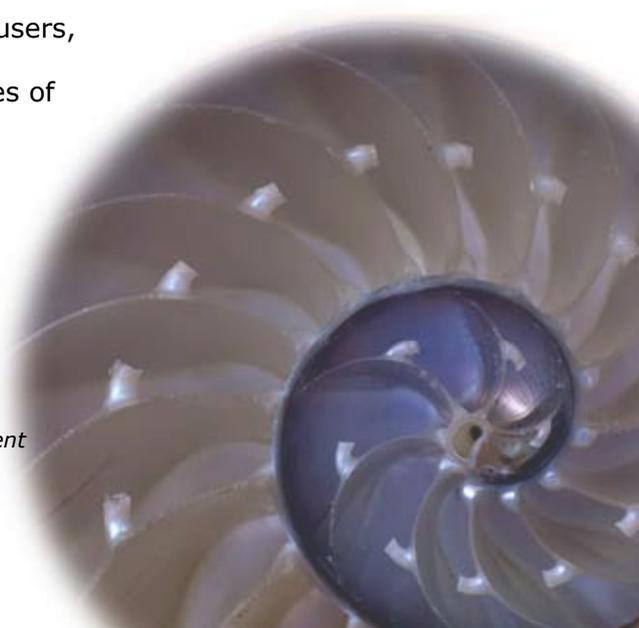
The unit will include triggers taken from narratives of service users, carers and practitioners. The triggers will be linked to group discussions and backed up by supportive reading and examples of evidence based and positive practice.

¹ DH 2008 *High quality for all. Next stage review final report.*

² DH (2004) *The Ten Essential Shared Capabilities - A framework for the whole mental health workforce NIMHE/Department of Health London*

³ DH (2007) *Human rights in healthcare - A framework for local action.*

⁴ CSIP / NIMHE 2008 *3 keys to a shared approach in mental health assessment*





PowerPoint Unit 1: Personalisation, values and the CPA

(presentation and handouts from PowerPoints on DVD)

Session 1 'Getting personal'

This unit will provide a context to the reasons why so much recent policy has an emphasis on values^(5,6,7,8). Key triggers include the prominence of consumerism and service user representation across the health and social care delivery spectrum^(9,10,11).

Unit 1 Activities



Activity 1.i Personal reflection point

Use handout Unit 1 H1 ('10 Essential Shared Capabilities' Page 20). This handout provides an overview of the descriptors behind the headings of the 10 ESC. They describe what high quality mental health care 'feels like' from a service user and carer perspective. Use these descriptors to begin a debate with participants on the ability of services and practitioners to achieve and manage these aspirations.

Consider any occasions in practice when these values may have been in direct conflict with each other. How was this tension resolved?

The 10 ESC headings

- Working in Partnership
- Practising Ethically
- Respecting Diversity
- Promoting Recovery
- Challenging Inequality
- Identifying People's Needs and Strengths
- Providing User Centred Care
- Making a Difference
- Promoting Safety & Positive Risk Taking
- Personal Development and Life-Long Learning

5 Department of Health (2006) CNO Review of Mental Health Nursing 'from values to action' Department of Health London

6 Department of Health (2004) The Ten Essential Shared Capabilities - A framework for the whole mental health workforce NIMHE/Department of Health London

7 Department of Health (2007) A Constitution for the NHS - Consultation Document. Department of Health London

8 Department of Health (2008) Reviewing the Care Programme Approach - Policy and Positive Practice Guidance. Department of Health London

9 Department of Health (2005) Our Health, Our Care, Our Say - a new direction for community services. Department of Health London

10 Department of Health (2008) Common Core Principles to Support Self Care: a guide to support implementation. Department of Health, Skills for Health, Skills for Care London

11 Carr, S & Dittrich, R. (2008) Personalisation: A Rough Guide (Adults' Services report No. 20). Social Care Institute for Excellence. London



1.ii Group activity (15 mins)

Instructions

- Watch the following three video extracts. Jot down your reaction to these narratives in relation to values based practice as you watch them
- Following each extract, discuss your individual reactions in groups
- Consider which of the 10 Essential Shared Capabilities are relevant to the extract
- Address the issues for you as CPA care co-ordinators and any implications for your practice?

Video Clips x 3 (DVD)

- Video Extract 1.A.ii Service user
- Video Extract 1.A.iii practitioner
- Video extract 1.C.i carer

Creating and Supporting Change

Your reflections on the values and behaviours from discussion and viewing the video extracts do not operate in isolation. This training programme supports the view that the CPA care co-ordinator is a key role in enhancing a personalised mental health service. In order to analyse this a little more we will consider the role of the care co-ordinator within a 'system' and 'process' of CPA.



1.iii Group Activity (25-30 mins)

Structures, Processes & Patterns (Behaviours)

Your role as a care co-ordinator takes place within an organisation and usually within a 'team'.

Structures: Significant attention has been placed in the past to attending to the structures that deliver health and social care. These structures (buildings and organisations) are in a constant state of change and reflect the dynamic nature of health and social care

- i) Give some brief thought to how your organisation has changed over the past number of years and how has your team changed in the way you manage CPA?

Processes: This refers to the way we do things, the sequence of events. In CPA, we may refer to the importance of a process driven approach to care planning through assessment, planning, implementation and review. The process will also refer to the communication processes with key partners in aiding the delivery of a multi-agency plan of care.

ii) Briefly think and discuss within a small group how the process of CPA care co-ordination has developed over the past few years. How do you go about the care planning process (assessment, planning, implementation and evaluation). What things have stayed the same and what things have changed? (There is no need to spend too much time on this aspect as we will return to these issues later in the training programme).

So far we have considered two elements of the system. The third part to review is your role as a care co-ordinator in attending and managing the way in which CPA is delivered and experienced by service users, carers and colleagues.

Patterns: These drive our thinking and behaviour and include an emphasis on such things as relationships, decision making, power, conflict management/resolution and how we learn. Failure to address patterns is likely to result in continuing issues in the process and structures¹².

iii) In groups discuss how your team and you, as a care co-ordinator deliver CPA. Pay particular attention to the values and behaviours you display in your approach to: partnership working, CPA meetings, managing conflicting views, how 'power' is displayed and managed in the CPA process.

Use your reflections on the 10 ESC to help in your analysis.

Recovery

The role of CPA care co-ordinator has a critical part to play in supporting a 'recovery' ethos in mental health care. Definitions of 'recovery' integrate a range of opinions including: recovery being the 'absence of symptoms'; social recovery; an ability to live as independently as possible even with symptoms of mental health difficulty and 'self recovery'; living well even within the context of long-term mental health difficulties¹³.

Whatever the definition, a recovery ethos promotes practice which supports a person to explore attitudes, goals, feelings, skills and roles. It promotes hope and meaning in people's lives. A recovery ethos to mental health practice applies to all participants concerned and so practitioners of mental health services will need to explore the issues above as much as the people they support.



1.iv Personal reflection point

Consider your role as a promoter of 'recovery' in the CPA process. What do having aspirational goals, developing new skills and reinforcing existing skills and roles mean for you and secondly, what they may mean for the people whose care you co-ordinate?

¹² Plsek, P. E. (2001) *Re-designing healthcare with insights from the science of complex adaptive systems (in) Crossing the Quality Chasm: A new health system for the 21st century.* National Academy Press. Washington DC.

¹³ SCIE (2008) *A Common Purpose: Recovery in Future Mental Health Services.* Joint Position Paper 08 [CSIP, Royal College of Psychiatrists and SCIE]



1.v Group activity (20 mins)

Instructions

- Watch the following three video extracts.
- Jot down your reaction to these narratives in relation to recovery as you watch them.
- Following each extract, discuss your individual reactions in groups
- Address the issues for you as CPA care co-ordinators and any implications for your practice?

👤 Video Extract 1.B.i service user '*Focus on meaningfulness and wellness*'

👤 Video Extract 1.B.ii carer '*hope*'

👤 Video Extract 1.B.iv service user '*strengths and fulfilment*'

Conclusion

Summarise the discussions and use this point to start work on the application of values throughout the rest of the course. Have you unearthed challenges in your review of 'values'? Do you share the same values and are these values expressed in the same way in the practice of care co-ordinators?

Values based practice relates to the understanding that we do not share the exact same values and that they are expressed in different ways in practice. A key theme of this unit is to help you understand how you engage in 'negotiation' in understanding distinctive positions and how you work towards accommodating solutions.

Parallel processing

We know that people learn effectively when they have mutual respect for each other, when others are prepared to listen to their point of view and experiences. The parallels with values based practice are clear. A learning culture that is grounded in values highlighted in this unit is likely to enhance the quality of learning that takes place.



Reader 1: Personalisation values and CPA

Looking at the evidence

It is easy to assume that services are always under threat and that they face any number of seemingly insurmountable challenges, but a more balanced view reveals that community mental health care is improving in many aspects:

A Picker Institute report flagged up mental health care as a special problem because patients were more critical of these services, but there are now encouraging signs of improvement in the services provided in the community:

- In 2007, 82% of mental health patients said they had definitely been treated with dignity and respect by psychiatrists, an improving trend, better than 2006 (81%), 2005 (80%) and 2004 (79%)
- There were similar improvements in mental health patients' views of treatment from community psychiatric nurses, up from 85% in 2005 to 86% in 2007
- 65% of mental health patients who had seen a psychiatrist in 2007 reported that they were definitely given enough time to discuss their condition and treatment, an improvement on 2006 (64%), 2005 (63%) and 2004 (60%)¹⁴

This evidence suggests that services are improving and often in difficult circumstances. Embracing the notion of continuous improvement, using feedback from service users and carers can help strengthen the development of high quality values based care and the centrality of service users in care planning¹⁵.

'The Standards We Expect' ¹⁶

This project explores the needs of service users receiving health and social care and highlights a number of the important standards for special consideration. Promoting these core standards for mental health is a key role of the care co-ordinator.

The standards are:

1. Choice and control

The report identifies the following in 'Choice and control':

- Being in charge of your life
- Being able to change your support if it does not work out for you
- Having support to make decisions
- Having the chance to learn about making decisions

¹⁴ Richards, N. & Coulter, A. (2008) *Is the NHS becoming more patient-centred? Trends from the national surveys of NHS patients in England 2002-07* Picker Institute. Oxford

¹⁵ Glynn, M & Beresford, P. with Bewley, C. Branfield, F, Butt, J., Croft, S., Pitt K.D., Fleming, J., Flynn, R., Patmore, C., Postle, K & Turner, M.. (2008) *Person-centred support - What service users and practitioners say.* Joseph Rowntree Foundation York.

¹⁶ www.standardsweexpect.org/index.cfm

2. Setting goals

Think about the people for whom you act as a care co-ordinator in relation to goal setting. How would you approach any difference of opinion about goal setting between service users, family & carers and you as a care co-ordinator?

For service users in the project, setting goals was about deciding what they want to do or change in their lives. This contrasted with views from some managers and staff that service users would get upset if goals did not work out. Service users thought this was an excuse that stopped them from trying to make changes happen.

This raises questions about power and control and reflects the challenge in 'personalisation'.

There may not be definitive answers about whose values are 'right' The key learning outcome should focus on the process of understanding what you share and how values are understood and negotiated.

Some may argue there are no such things as 'right' values, only what people believe¹⁷. The philosopher David Seedhouse challenges this contention;

'Believing everything is relative is erroneous. People see their world rationally and when you discuss your 'rational' view of the world with other people you begin to see how much you have in common. Taking this 'rational field' approach is not about seeing other people, cultures and the external as alien and unreachable. Rather it is about tolerance – more than anything it is about tolerance....' Pp 92-93

3. The importance of relationships

Respondents in the report thought that relationships between service users, staff and managers were very important. This is important in exploring the role of care co-ordinators and those that manage them. Relationships and networks that service users have are also of critical importance as an on-going source of support and protection against isolation. This issue of social isolation is a significant concern for those people with major mental illness¹⁸. It has been reported that practitioners' views of the limited potential of service users may be the biggest barrier to social inclusion¹⁹.

4. Information

How do you make accurate and helpful information available in your approach to care co-ordination? If information is provided by you as a care co-ordinator how helpful do you think it really is? In what ways could it be improved upon?

5. A positive approach

Retaining a positive approach in spite of any number of organisational and other challenges you face in your care co-ordinator role is no easy thing. However, for service users, the positive attitude of key health care personnel is critical in their day to day relationships.

¹⁷ Seedhouse, D. (2005) *Values Based Decision Making for the Caring Professions*. Wiley. London

¹⁸ Thornicroft, G. (2006) *Shunned: Discrimination against people with mental illness*. Oxford: Oxford University Press

¹⁹ Office of the Deputy Prime Minister 2004 *Mental health and social exclusion: Social exclusion report*.



Staff and service users said that a positive approach was really important. Being positive helps service users to feel more confident and good about themselves and so make better choices. It may be useful to consider the role that active supervision may have in supporting practitioners to fulfil their role in this regard.

6. Learning

The 'Recovery' ethos extols the virtues of service users (at a time when they feel able) developing action plans which support the continuation of learning. This may involve learning about how problems affect them or how they can cope most suitably with their mental health difficulties. There is also a place for more formal types of learning, engaging in evening/social classes as an aid to social integration and reduction in isolation. In many ways this issue was the catalyst for the development of the Support Time Recovery (STR) Workers²⁰ as a valuable resource to overcome isolation. Such workers have a prominent role in the delivery of the CPA process.

²⁰ DH 2003 *Mental Health Policy Implementation Guide; Support Time Recovery (STR) Workers* DH London



HANDOUT Unit 1 H1. The Ten Essential Shared Capabilities

1. Working in Partnership. Developing and maintaining constructive working relationships with service users, carers, families, colleagues, lay people and wider community networks. Working positively with any tensions created by conflicts of interest or aspiration that may arise between the partners in care.

2. Respecting Diversity. Working in partnership with service users, carers, families and colleagues to provide care and interventions that not only make a positive difference but also do so in ways that respect and value diversity including age, race, culture, disability, gender, spirituality and sexuality.

3. Practising Ethically. Recognising the rights and aspirations of service users and their families, acknowledging power differentials and minimising them whenever possible. Providing treatment and care that is accountable to service users and carers within the boundaries prescribed by national (professional), legal and local codes of ethical practice.

4. Challenging Inequality. Addressing the causes and consequences of stigma, discrimination, social inequality and exclusion on service users, carers and mental health services. Creating, developing or maintaining valued social roles for people in the communities they come from.

5. Promoting Recovery. Working in partnership to provide care and treatment that enables service users and carers to tackle mental health problems with hope and optimism and to work towards a valued lifestyle within and beyond the limits of any mental health problem.

6. Identifying People's Needs and Strengths. Working in partnership to gather information to agree health and social care needs in the context of the preferred lifestyle and aspirations of service users their families, carers and friends.

7. Providing Service User Centred Care. Negotiating achievable and meaningful goals; primarily from the perspective of service users and their families. Influencing and seeking the means to achieve these goals and clarifying the responsibilities of the people who will provide any help that is needed, including systematically evaluating outcomes and achievements.

8. Making a Difference. Facilitating access to and delivering the best quality, evidence-based, values-based health and social care interventions to meet the needs and aspirations of service users and their families and carers.

9. Promoting Safety and Positive Risk Taking. Empowering the person to decide the level of risk they are prepared to take with their health and safety. This includes working with the tension between promoting safety and positive risk taking, including assessing and dealing with possible risks for service users, carers, family members, and the wider public.

10. Personal Development and Learning. Keeping up-to-date with changes in practice and participating in life-long learning, personal and professional development for one's self and colleagues through supervision, appraisal and reflective practice.

Unit 2: Refocusing the CPA

Summary

This unit of study examines the rationale for a review of the CPA, highlights some of the inconsistencies and shortcomings in the way that it has been applied over the years, outlines the key changes in emphasis and assesses their possible impact on mental health services (risk management is viewed as integral to the CPA in this and all other units of study).

The CPA was introduced in England almost two decades ago as a framework to organise systematic, effective and consistent mental health care. Despite its longevity, the national consultation exercise in 2006¹ revealed a number of fundamental issues of concern such as lack of clarity and guidance, resource and training issues and a burdening bureaucracy. Elsewhere, over its lifespan, CPA implementation was criticised as failing or patchy^{2 3 4 5}. Areas of good practice were identified and highlighted but the lack of consistency across the country remained apparent.

This unit examines the key changes to CPA and encourages participants to consider implications for their practice. It prompts them to re-examine the fundamental principles of CPA as a framework for their practice and to 'let go' of some of the negative aspects that have sometimes been associated with CPA over the years.

Learning outcomes

By the end of this unit of study participants will be able to:

- Explain the rationale for refocusing the CPA at this time
- Identify policy initiatives that have influenced the review
- Summarise the key changes to the refocused CPA
- Apply the revised characteristics for one level of CPA
- Evaluate the implications for their practice

The unit will include triggers taken from narratives of service users, carers and practitioners. The triggers will be linked to group discussions and backed up by supportive reading and examples of evidence based and positive practice.

 **PowerPoint Unit 2: Refocusing the CPA**
(presentation and handouts from PowerPoints on DVD)

¹ Department of Health 2006 *Reviewing the care programme approach: A consultation document*

² The Audit Commission 1994 *Finding a place: A review of mental health services for adults*. London. HMSO

³ Department of Health 2005 *Building bridges: A guide to arrangements for interagency working for the care of severely mentally ill people*. London. The Stationary Office

⁴ Commission for Health Improvement 2003 *What CHI has found in mental health trusts*. Available from

<http://www.healthcarecommission.org.uk/assetRoot/04/00/00/51/04000051.pdf>

⁵ Bindman J, Beck A, Glover G, Thornicroft G, Knapp M, Leese et al 1999 *Evaluating mental health policy in England: Care Programme Approach and supervision registers*. *Br J of Psychiatry*; 175: 327-330

UNIT 2 Activities



Group Activity 2.i (45 mins)

Take a few minutes on your own to complete the following activity by indicating one of the following responses to each statement.

1. strongly agree 2. tentatively agree 3. tentatively disagree 4 strongly disagree

In my experience the Care programme Approach is:

		1	2	3	4
1	primarily a bureaucratic exercise in repetitive form filling				
2.	an effective framework for organising positive practice				
3	a gateway to mental health services				
4	a collaborative partnership that is service user centred and promotes choice				
5	an exercise that converts mental health workers into administrators				
6	an approach that is grounded in values				
7	primarily about managing risk and covering backs				
8	a process rather than an event				
9	mechanical and stifles creativity				
10	driven by the requirement to audit targets				
11	a process that puts needs of the service user ahead of needs of the service				
12	a shared approach that promotes sharing of information and joined up working				
13	a system for organising six/twelve monthly reviews				
14	an approach that involves families / carers				
15	a frustrating exercise in the shortcomings of IT systems				
16	a framework that promotes recovery				
17	an exercise that identifies responsibility without necessarily investing authority				
18	A dynamic process based on effective communication, information sharing and negotiation between partners				



Trainer's note

When completed, organise into groups of c. 6 and ask each group to try to come to a consensus on each of the statements. (no fights though, it is OK to disagree!). Then take feedback from groups and discuss issues involved and why CPA may be perceived that way. Also ask how they think service users and carers may have responded to the same activity.

This activity will reveal negative and positive perceptions of how CPA has worked previously. A balanced discussion will consider experiences of difficulties and positive practice and may prompt participants to rethink how CPA can be used more effectively.



Reader 2

Why refocus the CPA?

The need for a 'refocusing' of CPA suggests that practice is wide of the intended mark or that it has become distracted over the years from its original purpose. Despite supporting evidence, this is not the only reason for a review at this time. Society is changing and this is reflected in social and health policies over recent years. Practice is changing in line with a greater emphasis on personalisation, equality, social inclusion and safety.

Common failings have included:

- Service users and carers not knowing about CPA and not receiving copies of care plans
- Too few resources to deliver the care plans and variations in who receives CPA at enhanced level
- Poor risk management
- Important issues not being assessed and/or recorded such as financial circumstances or unmet needs
- Some teams and agencies not working together or sharing information
- Fractures in care at transition points such as hospitalisation or custodial sentencing

The consultation exercise (2006) and the subsequent DH report (2008) provide the guidance to address these issues and to make a real difference in the way that CPA is implemented across the country; a fresh and revitalised CPA that is fully integrated into practice and consistent with significant policy initiatives over the past few years; a CPA process that reflects core values of personalisation and recovery, is fair and socially inclusive, integrates best practice in risk management⁶ and is effective.

Perhaps it is inevitable that CPA gets caught up, to some extent, in local systems failures, politics and bureaucracy but there are examples where this does not happen. The point is that CPA is a framework or approach that is there to guide practice. As such, it is inherently neutral of these complications. The fact that historically it has sometimes become entangled with other system problems does not mean that it has to be like this.

⁶ Department of Health 2007 *Best practice in managing risk*. DH . London



The challenge is to look at CPA afresh, to suspend prior judgements and to think about how the approach can promote good practice and effective co-ordination of care. The essential structure of the CPA is logical, useful and politically neutral. It is difficult to argue against it as a simple structure that ensures care is systematic.

Changes to CPA and recommendations

1. Personalised mental health care

This is covered in Unit 1 but it is important to acknowledge that the refocusing of the CPA is grounded in an emphasis on values and principles that are linked to personalisation and encapsulated in the 10 Essential Shared Capabilities. These underpin the process of CPA and inform all aspects of its day to day application. Without these care will fail to deliver the desirable outcomes.

2. Refocusing the CPA

The term 'CPA' now describes the approach used in secondary mental health care to assess, plan, review and co-ordinate the range of treatment, care and support needs for people in contact with secondary mental health services who have complex characteristics as outlined in table 2.i.

These characteristics have been revised. The previous levels of standard and enhanced care are discontinued and there is a newly defined single level of CPA. The defined characteristics are designed to include individuals with complex or higher support needs. Those individuals who do not have these characteristics and do not require the higher level of support no longer come under the CPA, but are still eligible to receive secondary mental health services.

In this case people will have access to high quality, evidence based mental health services but their system will be less bureaucratic in terms of the amount of formal documentation required. They will have a lead professional, rather than a care co-ordinator, who has the responsibility for facilitating their care. This lead professional will be responsible for:

- conducting a full assessment (including risk)
- agreeing and recording a statement of care with the service user. This could be done in clinical notes or in a letter format and this documentation will constitute the care plan (a copy to be given to the service user and appropriate others)
- reviewing the individual's progress, including monitoring if CPA is required because of a change in circumstances
- liaising with carers and other agencies as appropriate
- maintaining records as required

Table 2.i Characteristics to consider when deciding if support of CPA needed

- Severe mental disorder (including personality disorder) with high degree of clinical complexity
- Current or potential risk(s), including:
 - Suicide, self harm, harm to others (including history of offending)
 - Relapse history requiring urgent response
 - Self neglect/non concordance with treatment plan
 - Vulnerable adult; adult/child protection e.g.
 - exploitation e.g. financial/sexual
 - financial difficulties related to mental illness
 - disinhibition
 - physical/emotional abuse
 - cognitive impairment
 - child protection issues
- Current or significant history of severe distress/instability or disengagement
- Presence of non-physical co-morbidity e.g. substance/alcohol/prescription drugs misuse, learning disability
- Multiple service provision from different agencies, including: housing, physical care, employment, criminal justice, voluntary agencies
- Currently/recently detained under Mental Health Act or referred to crisis/home treatment team
- Significant reliance on carer(s) or has own significant caring responsibilities
- Experiencing disadvantage or difficulty as a result of:
 - Parenting responsibilities
 - Physical health problems/disability
 - Unsettled accommodation/housing issues
 - Employment issues when mentally ill
 - Significant impairment of function due to mental illness
 - Ethnicity (e.g. immigration status; race/cultural issues; language difficulties; religious practices); sexuality and gender issues



Table 2.ii Service users on CPA	Other service users
An individual's characteristics:	
Complex needs; multi-agency; higher risk	More straightforward needs; one agency or no problems with access to other agencies/support; lower risk
What the service users should expect:	
<p>Support from CPA care co-ordinator (trained, part of job description, co-ordination support recognised as significant part of caseload)</p> <p>A comprehensive multi-disciplinary, multi-agency assessment covering the full range of needs and risks</p> <p>An assessment of social care needs against FACS eligibility criteria (plus Direct Payments)</p> <p>Comprehensive formal written care plan: including risk and safety/contingency/ crisis plan</p> <p>On-going review, formal multi-disciplinary, multi-agency review at least once a year but likely to be needed more regularly</p> <p>At review, consideration of on-going need for CPA support</p> <p>Increased need for advocacy support. Self-directed care, with some support if Necessary</p> <p>Carers identified and informed of rights to own assessment</p>	<p>Support from professional(s) as part of clinical/practitioner role. Lead professional identified. Service user self-directed care, with support</p> <p>A full assessment of need for clinical care and treatment, including risk assessment</p> <p>An assessment of social care needs against FACS eligibility criteria (plus direct payments)</p> <p>Clear understanding of how care and treatment will be carried out, by whom, and when (can be a clinician's letter)</p> <p>Ongoing review as required</p> <p>Ongoing consideration of need for move to (new) CPA if risk or circumstances change</p> <p>Carers identified and informed of rights of own assessment</p>

3. Assessment and Care Planning

These are covered in units 5,6 and 7 but the main recommendations from this section are:

- Everyone referred should receive an initial assessment of their mental health needs and where they should be met (sometimes known as screening or triage)
- A comprehensive health and social care assessment is undertaken including needs, strengths, goals, aspirations and choices
- Ensure that risk assessment/ management and crisis and contingency planning are integral to the assessment and care planning process (based on DH guidance – Best Practice in Managing Risk)⁷
- To develop one assessment and care plan that will follow the service user through a variety of settings and agencies
- Assessment and care planning should take into account the possibility for direct payments, individual budgets and statements of wishes and advance directives
- Assessments and care plans should have an outcome focus and should be explicitly agreed with service users and carers (a copy left with service user)
- Assessments and care planning should take account of the needs of individuals in respect of age, disability, gender, sexual orientation, race and ethnicity and religious beliefs
- Establishing whether an individual is a parent at the initial assessment is critical and should be routine, including potential risk of mental health on parenting
- Assessments and care planning should take into account the following: drug and alcohol misuse, physical health, housing and homelessness, employment, education and training, financial status, medication, need for advocacy, leisure, social functioning
- Carer's involvement should be identified at the service user's assessment and factored into care planning

The above should already be carried out in any comprehensive assessment and care planning. The guidance highlights common areas which assessments and planning should address. However, it is important that the assessment and planning process should aim to meet the service user's needs and choices, and not just focus on what professionals and services can offer.

4. Whole systems approach

This is covered in unit 8 but the key issues in the guidance focus on the provision of whole system approaches that promote and co-ordinate care and support across all aspects of the individual's life and circumstances. Examples that may help include:

- Integrated care pathways
- Improved information sharing between agencies
- Protocols and arrangements for working between different assessment and planning systems
- Improving local shared provider agreements
- Commissioning for a range of services to meet service users' and carers' needs
- Effective local strategic partnerships and Local Area Agreements to facilitate local planning across agencies

⁷ DH 2007 *Best practice in managing risk: Principles and evidence for best practice in the assessment and management of risk to self and others in Mental Health Services.* <http://www.nimhe.csip.org.uk/risk>

The other sections of the guidance relate to supporting the workforce and quality issues. They have implications for care co-ordinators but not as directly as above. The guidance also includes three annexes that relate specifically to other related assessments and planning frameworks such as Child and Adolescent Mental Health Services (CAMHS) and Older Adults



2.ii Reflections for discussion (15 mins)

- How has/will your practice change as a result of the refocused CPA?
- What impact has / will the changes have on a day to day basis?
- What do you need in place to work in this refocused way?



2.iii Group discussion (20 mins)

Instructions

- Watch the following three video extracts. Jot down your reaction to these narratives in relation to the refocused CPA as you watch them
- Following each extract, discuss your individual reactions in groups
- Address any issues for you as CPA care co-ordinators and any implications for your practice?

-  Video extract 2.A.i service user 'it's straightforward really'
-  Video extract 2.B.ii practitioner 'some concerns'
-  Video extract 2.B.ii service user 'what about those outside of the CPA?'



2. iv Group discussion (15 mins plus feedback)

The change to a single level of CPA was strongly opposed by service users and carer organisations in the consultation exercise.

- What do you think their concerns are?
- Do their fears have any legitimacy?
- How would you respond to a service user who expresses concerns over the service they will get if they do not meet the eligibility criteria for CPA.
- How would you explain to a concerned carer what is meant by 'complex needs'?
-



2.v Personal Reflection

Consider your current caseload. Use the criteria above (Table 2.i) to decide whether or not individuals meet the revised criteria for CPA. This could be set as homework task.



Trainer's note

Discussion on the importance of clear criteria because of the ambiguity of 'complexity' as an adjective within the context of individuals' needs. i.e. as human beings we are all complex.

Parallel processing

The concept of 'complexity' is not straightforward. We all have complex needs, whether service users or care co-ordinators; it is a feature of being alive. As care co-ordinators, the participants are unique individuals, each with a complex makeup and histories. Trainers do well to acknowledge individual differences and associated learning needs.



Unit 3: Role, authority & responsibilities of the care co-ordinator

Summary

The role of the care co-ordinator is central to the CPA but historically the role has not been clearly defined and has, consequently, been subject to diverse local interpretations and criteria. The absence of a universally agreed definition of care co-ordination has sometimes led to confusion and dissatisfaction with the role. Clarification is required to emphasise and define the role to reflect recent and ongoing health and social care reforms and initiatives.

This unit clarifies the role and responsibilities of a care co-ordinator following the review of the CPA. Participants will be encouraged to evaluate their own competence to carry out the functions of care co-ordination. The unit will also identify issues of authority and power that may impact on their capacity to do the work.

Care co-ordination has two critical functions:

1. Establishing and sustaining a professional relationship with the service user and significant others, based on regular contact.
2. Co-ordinating, monitoring and recording the assessment, planning, delivery and review of care, including risk.

These functions are examined along with the competences involved and principles for effective care co-ordination.

Learning outcomes

At the end of this unit of study participants will be able to:

- outline the critical functions and competences of the care co-ordinator
- reflect on their own practice in relation to the identified responsibilities and competences of care co-ordination
- discuss the significance of authority in respect of the role of care co-ordination
- identify potential complications that may compromise the role of care co-ordinator and construct possible strategies to manage them
- reflect on their strengths and areas for further development as a care co-ordinator

The unit will include triggers taken from narratives of service users, carers and practitioners. The triggers will be linked to group discussions and backed up by supportive reading and examples of evidence based and positive practice.





PowerPoint Unit 3: Role, responsibility and authority of care co-ordinator

(presentation and handouts from PowerPoints on DVD)



3.i. Group discussion: Who should be a care co-ordinator? (20 mins plus feedback)

Review and discuss in groups how care co-ordinators are allocated or chosen for specific individuals in your workplace. Use examples to explore this.

- What criteria are used to decide?
- How much choice does the service user really have?
- What happens if a service user expresses dissatisfaction with the care co-ordinator?
- How satisfactory is this system?
- How could it be improved?



Trainer's notes

Issues that can be explored in feedback include: service user choice; professional qualifications; specialist training; why not in pre-registration training; gender; ethnic background; capacity; based on who did the screening/initial assessment. Support Time Recovery (STR) workers? What about independent or voluntary sector workers, carers or service users co-ordinating their own care? Implications (local agreements required)? If not, why not? What happens if a service user is dissatisfied with the choice?

The following short video clip may prompt discussion on the limitations of choice:

- Video extract 3.A.i practitioner 'how much choice is viable?'



Reader 3.i

When deciding who should be the care co-ordinator, it is important to consider the service user's needs and wishes, balanced against staff availability and appropriateness. But it is critical that whoever the care co-ordinator is s/he has the authority to co-ordinate the assessment and delivery of the care plan, regardless of agency or origin. Inevitably the choice of care co-ordinator is sometimes compromised because of resource limitations but efforts should be made to take into account service users' wishes, particularly on the basis of gender or ethnicity. In other words, what is best for the service user as opposed to what is convenient for the service provider.

Within the spirit of the promotion of self management, it could be argued that the default position is that the service user is his/her own care co-ordinator, but it is acknowledged that this is not possible in most circumstances and, for the purpose of this learning unit, it is assumed that the care co-ordinator is a professional practitioner. Most often it is a nurse, social worker or occupational therapist in a community team. This does not exclude localised variations where others may take on this role. The decision making on who should be the care co-ordinator will involve consideration of:

- the service user's needs and choice
- the worker's knowledge and experience of the service user / family and context including race, culture and gender issues
- the worker's knowledge and network of relevant services and their respective roles
- the worker's knowledge, competence, skills, experience, training and qualifications
- the worker's likely level of input into the care of the service user
- the worker's capacity and current caseload
- the worker's level of authority
- the worker's access to resources

The care co-ordinator is a consistent point of contact but does not necessarily have to be the person who actually delivers the majority of an individual's care. In practice this will often be the case but it may be that the care is more appropriately delivered by other(s), for example when a specialist intervention is indicated. This flexibility in utilising workers' skills, irrespective of professional background, is articulated in *New Ways of Working in Mental Health*¹.

NOTE: Those who do not meet the revised characteristics for CPA will have a lead professional rather than a care co-ordinator. As the name suggests this will be the worker who takes the lead responsibility for the individual's care and treatment.

¹ DH 2007 *Mental Health: New ways of working for everyone. Developing and maintaining a capable and flexible workforce*

Role and responsibility of a care co-ordinator



3.ii Group activity: (45 mins including feedback)

This activity is designed to identify different perspectives and priorities. It is useful for participants to think how service users and carers may have contrasting views on the critical functions and priorities.

Form three groups:

- Group 1 put yourself in the 'shoes of service users'
- Group 2 put yourself in the 'shoes of carers'
- Group 3 care co-ordinators

For each group answer the following questions from your group's perspective.

- What are the critical functions of a care co-ordinator today?
- Rank them in order of importance
- Prepare a summary to feedback to the whole group



Trainer's notes

Categorise into themes. Try and reach a consensus on the most critical aspects of the role.



Reader 3.ii

Care co-ordination has two critical functions:

1. Establishing and sustaining a professional relationship with the service user and significant others, based on regular contact.
2. Co-ordinating and monitoring the assessment, planning, delivery and review of care, including risk.

When care co-ordinators function well everybody involved knows where they fit in and how their input complements those of others. Clarity, consistency and continuity of care are established and information reaches those who need to know.

Care co-ordination must be a recognised component of job descriptions as it constitutes a significant part of workload. The size and capacity of workload must take into account the considerable demands of the role. Good caseload management is crucial to maintaining effective practice. Local policy should include guidance on caseload management, access to clinical supervision sessions, an audit of caseloads and a protocol for managing caseloads that become excessive.

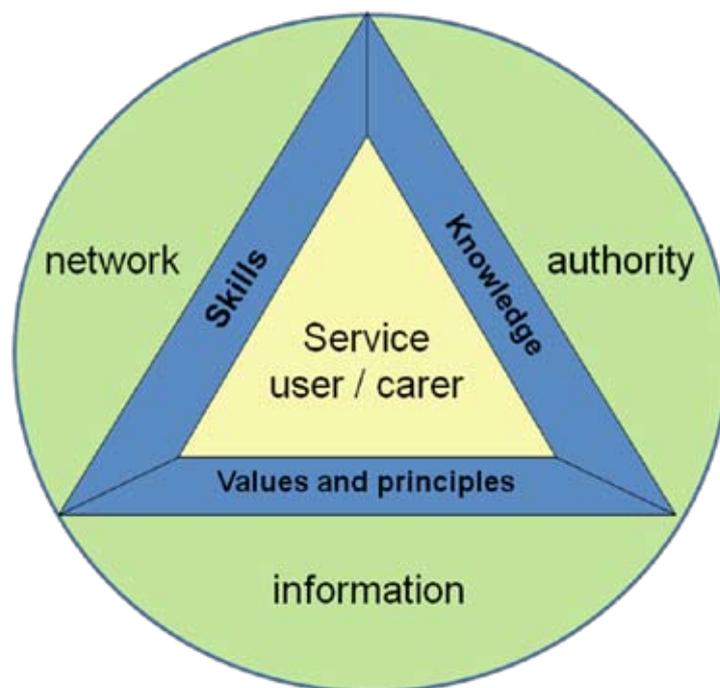


Fig 3.i Elements of effective care co-ordination

Fig 3.i illustrates that the service user and carer(s) lie at the centre of the activity of care co-ordination. The task is to engage and sustain a relationship that is based on partnership. This means encouraging active participation of the service user and, where appropriate, carer(s) to establish a shared understanding of the assessment, care planning and review of care. In this way decision making is transparent and, wherever possible, negotiated and agreed.

The base of the triangle indicates that values and principles underpin the activity of the care co-ordinator. These values and principles are covered in unit 1 and summarised in the 10 Essential

Shared Capabilities. The other two sides indicate that effective care co-ordination requires a set of skills and knowledge. These are covered in the identified competences for care co-ordinators (see appendix I).

Knowledge base for care co-ordinators²

- mental health law and other relevant government policy and legislation
- local policies and procedures
- tools for the assessment of health and social needs, including risk
- principles of care planning
- policies for discharge and transfer of care
- legislation and local policies concerning child protection
- respective roles of other health and social care staff
- equal opportunities
- principles and practice of CPA
- link between CPA and other care management systems
- knowledge of community services and the role of individual agencies
- adult protection procedures
- race, cultural and gender issues and legislation
- substance misuse and related issues
- personality disorders
- relevant professional codes of practice
- local knowledge e.g. housing, employment, training and education



Personal Reflection 3. iii

Identify any gaps in your knowledge from those listed above.
How can you gain this knowledge? (Could be done as homework task)



3. iv Group activity (15 mins)

Instructions

- Watch the following three video extracts. Jot down your reaction to these narratives in relation to the role of the care co-ordinator as you watch them
- Following each extract, discuss your individual reactions in groups
- Address any issues for you as CPA care co-ordinators and any implications for your practice?

-  Video extract 3.B.i service user 'the oil that makes the mechanism work'
-  Video extract 3.B.ii practitioner 'a consultant to the service user'
-  Video extract 3.B.ii carer 'are you my care co-ordinator?'

² Adapted from CPAA 2008 *The CPA and care standards handbook 3rd ed.* Chesterfield

Networks

Effective care co-ordinators develop strong networks with individuals, organisations and agencies. These relationships are important in the exchange of information, collective decision making and negotiation of responsibilities and tasks. These networks facilitate the communication process.

The authority of the care co-ordinator

Care co-ordination involves negotiation, delegation and requires authority. Best practice includes maximising the use of the respective skills, knowledge and experiences of team members to meet the needs of each service user. In this respect the care co-ordinator orchestrates the process. The degree to which the care co-ordinator is directly involved in the delivery of care will vary but the responsibility of overseeing the care package is always present.

Where the authority of the care co-ordinator is not acknowledged by the mental health team or other agencies, the task becomes difficult. Legitimate authority should come with the role but this is not always the case. At the very least the care co-ordinator must have the authority to:

- Monitor the care plan
- Evaluate the input of other members of the team
- Negotiate and co-ordinate the delivery of the care plan
- Access resources as appropriate
- Communicate concerns about care delivery
- Enable reviews to take place effectively

It is helpful if job descriptions and local guidance recognise the importance of the care co-ordinator's role and acknowledge the authority required to carry out their responsibilities effectively.

3.v Group discussion (20 mins)

Discuss in pairs:

- Was there a time when it felt like your authority as care co-ordinator was not recognised by others?
- How did this impact on your role and function?
- Did this impact on the service user? If so, in what ways?
- How would you manage this if it were to happen again?

(The feedback could focus on one or two examples and how care co-ordinators can gain, or be invested with, the required authority)



HANDOUT:

The CPA and Care Standards Handbook 3rd edition pp 16-17 (CPAA 2008)

- To ensure that a comprehensive, multi disciplinary and multi-agency assessment of the individual's health and social needs is carried out (including an assessment of risk to self and others and any specialist assessments that may be indicated)
- To co-ordinate the formulation, agreement and updating of a care plan, ensuring that all those involved understand their responsibilities and agree to undertake them and that the care plan is distributed to all those concerned, including the service user
- To arrange for someone to stand in if the care co-ordinator is away from work or to pass on the care co-ordinator role to an appropriate other person if no longer able to fulfil it
- To familiarise themselves with past and present records concerning the service user as appropriate (paper and electronic)
- To ensure that crisis and contingency plans are formulated, updated and circulated
- To ensure that the individual is equally involved and has choice in the planning of his or her care
- To ensure that carers and other agencies are consulted and involved as appropriate
- To ensure that the individual understands the role of the Care co-ordinator
- To provide contact details of the Care co-ordinator and whom to contact if the care co-ordinator is not available
- To ensure that the individual is registered with a GP and that s/he is involved and informed as necessary
- To maintain regular contact with the individual and monitor progress regardless of his/her setting
- If an individual is difficult to engage, to take all necessary actions to find out the reason and to continue to attempt to engage with him or her
- To maintain contact with individuals who have a custodial sentence in the criminal justice system (including face to face contact where possible) and liaise with mental health staff working with the individual in order to provide continuity of care. Also to ascertain any changes in location within the criminal justice system and the likely release date so that proactive care can be planned for their release. Contact with and support for carers should be maintained in these circumstances.
- To liaise with relevant services when an individual moves geographical location
- To organise and ensure that reviews of care take place and that all those involved in the individual's care are invited, consulted and informed of any outcomes. To chair the review meetings as appropriate
- To explain to the individual, significant others and informal carers the CPA process and inform them of their rights and roles
- To consider the need for advocacy for the individual and/or carers and supply information on advocacy or self advocacy schemes, taking into account the Mental Capacity Act 2005
- To identify any unmet needs and communicate any unresolved issues to the appropriate managers, through the recognised systems
- To ensure that other care systems' requirements are addressed where necessary, including a consideration of local eligibility criteria in respect of FACS (Fair Access to Services); care management; Person Centred Planning (PCP); Single Assessment Process (SAP); Health Action Planning (HAP) and Children's Assessment Framework (CAF)
- To inform and advise all service users and carers concerning their rights and options to apply for direct payments or individual budgets to promote independence and self management

- 
- To ensure continuity of care using home visits, repeat appointments etc. and provide clear written instruction on how to contact team members responsible for aspects of their care
 - To have face to face contact with the individual within one week of discharge from in-patient care or within 48 hours for individuals who have been assessed as high risk and require a more intensive care in the first three months following discharge
 - To liaise with appropriate services such as the Lead Professional and the Primary Health Care Team following discontinuation of CPA and agree with the individual a contingency plan as required

Transferable skills and expertise

- Good enough knowledge (market knowledge – e.g. clinical, housing employment)
- Regular enough contact (service user, carer and agencies)
- Engagement skills
- Networking, brokerage and commissioning skills
- Systems approach – overview
- Leadership, co-ordination, negotiation and delegation
- Communication with other agencies
- Efficient record keeping avoiding unnecessary duplication and bureaucracy
- Dissemination skills
- Preparing for and chairing meetings
- Case presentation and narrative skills
- Conflict management and challenging skills
- Planning and organisational skills
- Project management skills



Unit 4: Transition points in care

Summary

Transition points in the care of an individual are times when there is the potential for things to go wrong in terms of consistency and continuity of care, the transfer of responsibility and the exchange of important information. The management of these transition points is a crucial aspect of the work of care co-ordinators. This unit of learning focuses on these key points in the service user or carer's experience, the potential problems and their possible impact. It examines why they happen and identifies elements of positive practice that will make it less likely they occur.

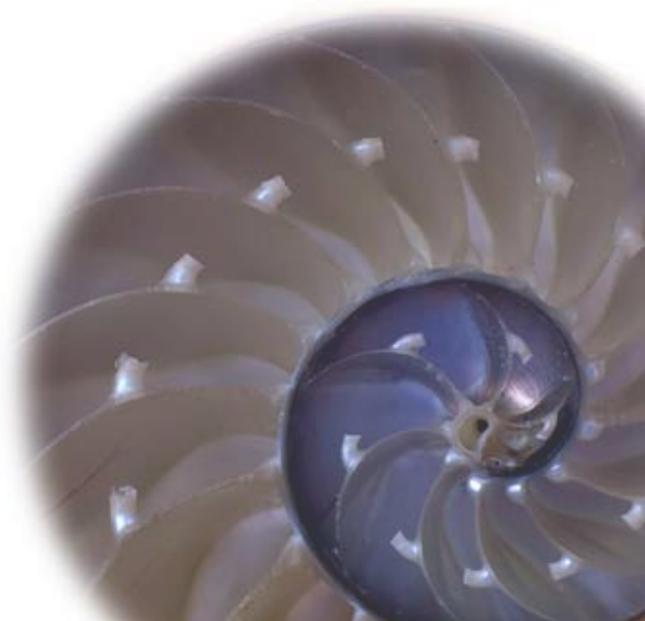
These changes may be geographical or involve a change in service personnel, system or specialism. Sometimes all these elements are involved, for example when a service user is in the criminal justice system. A common transition is the admission to, or discharge from, residential or hospital care. The factors that all these events have in common are the need for a smooth transfer of information, clarification of respective responsibilities and timely responses to the changes in circumstances. The care co-ordinator, as the name suggests, has the key responsibility in facilitating these transitions.

Learning outcomes

On completion of this unit of learning participants will be able to:

- identify transition points where there are potential threats to the continuity of care
- follow principles in reviewing and co-ordinating care at transition points
- co-ordinate effective information sharing with other agencies
- agree with service users, carers and service providers a transfer/discharge plan and contingency planning, including entry back onto CPA, if necessary
- monitor and review the effectiveness of transfer/discharge arrangements.

The unit will include triggers taken from narratives of service users, carers and practitioners. The triggers will be linked to group discussions and backed up by supportive reading and examples of evidence based and positive practice.





PowerPoint Unit 4: Transition points in care

(presentation and handouts from PowerPoints on DVD)

'Mind the gap'

Transition points in care have the inherent capacity to interfere with continuity of care and services. They are vulnerable points where things often go wrong, usually with negative consequences for the service user. These transitions sometimes happen with very little warning to those involved and require a speedy response to ensure that the required information is communicated to those who need to know. An example is when a prisoner is transferred to another prison some distance away at very short notice. On other occasions transitions are carefully planned over time, for example discharge from a secure hospital will usually involve detailed planning and preparation of services long before the actual date of discharge.

For smooth transitions to occur it is imperative that care co-ordinators and other services are aware of the people who need to know and what information should be exchanged. The whole CPA processes should provide the supporting framework and evidence for decisions relating to any kind of transition. The following activities should help participants to focus on this potentially vulnerable crossroads in care delivery.



4.i. Group activity: (20 mins)

- Watch the following four video extracts. Jot down your reaction to these narratives in relation to the possible impact of transition points as you watch them.
- Following each extract, discuss your individual reactions in groups
- Address any issues for you as CPA care co-ordinators and any implications for your practice?

-  Video extract 4.A.i service user 'A planned discharge'
-  Video extract 4.A.ii service user 'keep in touch'
-  Video extract 4.B.i service user 'problems with boundaries'
-  Video extract 4.C.ii service user 'changing services impacts'

Types of transition points

- Admission to, or discharge from, hospital or similar residential establishment
- Move to a different geographical location
- Containment in or release from the criminal justice system (could be remote from home)
- As a result of the Mental Health Act, including Supervised Community Treatments Orders, Section 117, role of Responsible Clinician
- Switch from Child and Adolescent Mental Health Services (CAMHS) to Adult services
- Switch from Adult services to Older People services
- Discontinuation of CPA processes following review (primary care, future contingencies, access)
- Switch of care co-ordinator
- Switch of mental health team (specialism)
- Admission/discharge general hospital
- Referral to/from independent sector
- Referral to/from Ministry of Defence
- Referral to/from voluntary sector



4.ii Group activity: Force field analysis applied to a transition point (30 mins)

Force field analysis is a useful technique for looking at the forces for and against your goal or plan. It helps you to weigh up the importance of each factor and how achievable the goal is.

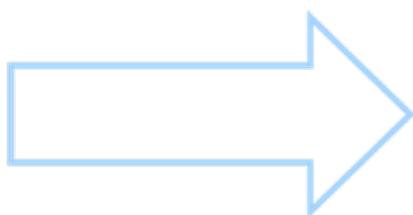
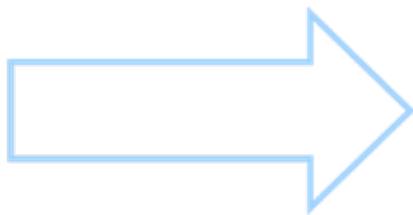
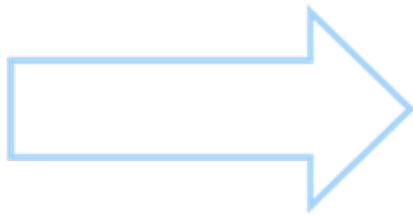
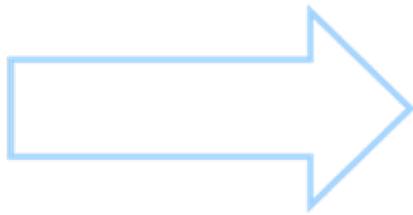
Instructions:

1. Share general experience of transition points in care (refer to above list)
2. Select one example from the Group's experience of a transition point from practice
3. Identify what a 'smooth' transition would look like. This will be your goal
4. Identify factors that could help make a smooth transition likely (left arrows)
5. Identify factors that could hinder a smooth transition (right arrows)
6. What can be done to ensure each helpful factor is maximised?
7. What can be done to ensure that each hindering factors' impact is lessened?
8. Summarise and feedback to whole group

(see next page)

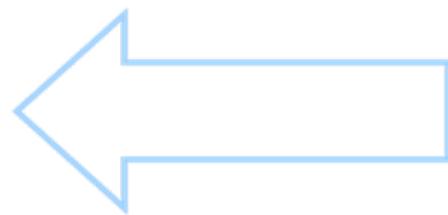
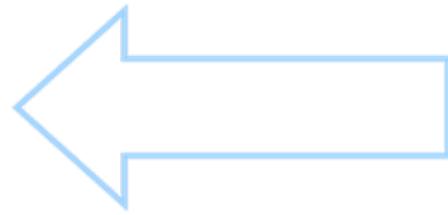
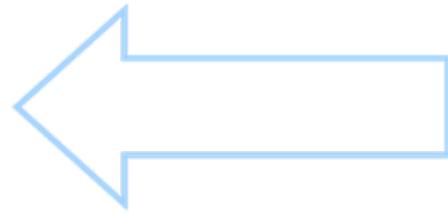
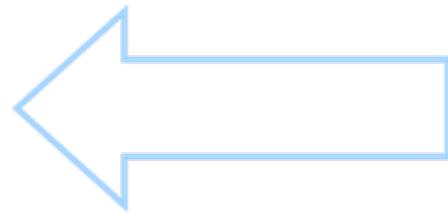
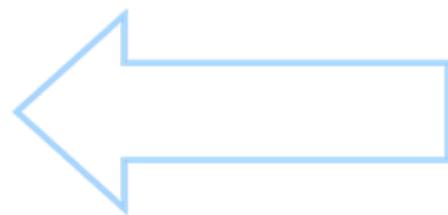
Working on transition points using force field analysis

**Helpful
forces**



GOAL
a smooth
transition

**Hindering
forces**



Unit 5: Comprehensive assessment

Summary

This unit focuses on comprehensive multi-disciplinary assessments that include service users and their carers as true partners in the process. It will address the importance of cross disciplinary and organisational collaborations and examine an assessment process that includes the needs, strengths, resiliencies and aspirations of the service user, their family and carer(s). Participants will be introduced to assessments that have an evidence base and/or are recognised as 'good practice'.

In some cases assessment will consist of two stages; the initial assessment (sometimes referred to as screening or triage) when service users are assessed to determine the best type of intervention, given their individual circumstances. The refocused CPA now requires that a judgement is made on the need for a care co-ordinator and the CPA process, using the characteristics described in unit 2.

This unit of study focuses on the second stage, a more comprehensive assessment that takes place following a decision at the initial meeting to include the service user in the CPA.

Learning Outcomes

By the end of this unit participants will be able to:

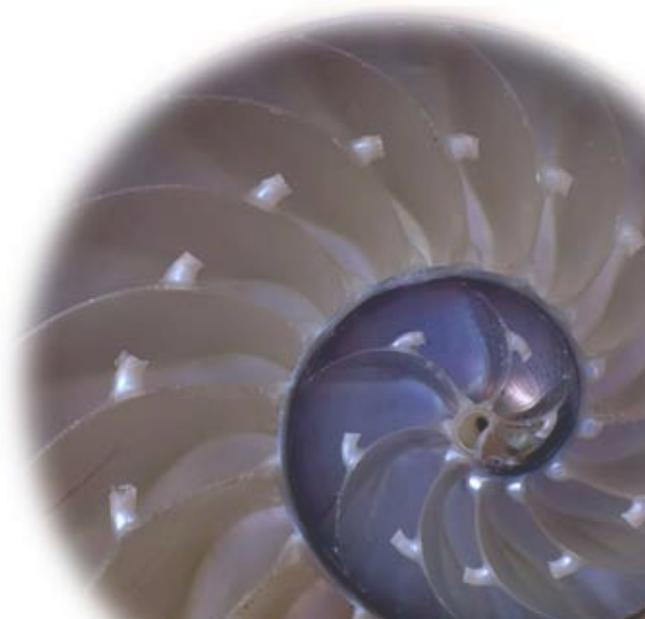
- in partnership with service users clearly define, summarise and agree their needs
- in partnership with service users, assess and accurately describe their strengths, resilience and aspirations
- consult with family and /or informal carers as a part of the assessment process, as appropriate
- outline the elements of a comprehensive assessment
- Liaise with other services/agencies when specialist assessments are indicated

The unit will include triggers taken from narratives of service users, carers and practitioners. The triggers will be linked to group discussions and backed up by supportive reading and examples of evidence based and positive practice.



PowerPoint 5: A comprehensive assessment

(presentation and handouts from PowerPoints on DVD)





Reader 5

Assessment, the gathering of information concerning an individual's mental health and related needs and strengths, is the foundation of mental health interventions. Consequently the success of an intervention relies, to a large part, on the thoroughness of the assessment process. Care co-ordinators will not always conduct the initial assessment but assessment is viewed as an ongoing process and the role of the care co-ordinator requires that they possess the associated knowledge and skills that are involved in the assessment and formulation stages of CPA.

There are some key points that should underpin this process:

1. The assessment process should represent a **collaboration** between the service user and the mental health worker as they work together to identify strengths, needs and choices.
2. The assessment process, as with any therapeutic interaction, should be socially, culturally and personally **contextual**.
3. Assessment is an **ongoing process**; it doesn't end after the first or second session. It is integral to the intervention. Information will come to light over time and circumstances do not remain static.
4. **Engaging** service users and carers and the establishment of a therapeutic relationship. It is at this time that initial boundaries are set, a reliable point of contact is made and a healthy working relationship is established.
5. It is important to acknowledge that there are issues of **power** within a therapeutic relationship. An imbalance of power in favour of the service provider has often contributed to dissatisfaction with mental health services in the past. The values of personalisation invest more self care, choice and control with the service user in an attempt to redress this historical imbalance.
6. Assessments should have **validity and focus** in that the appropriate areas of need are addressed but repetition is avoided where possible.
7. A comprehensive assessment should consider people **'in the round'**, taking into account health, social and risk domains.

The structure of assessment

The main aim of assessment is to understand as much as possible about the service user's circumstances and environment. This understanding needs to be within the individual's personal, social and cultural context if it is to have any real meaning. This involves gathering information from different sources and appraising it to make informed judgements.

Individual service provider organisations will have their own assessment tools and documentation systems. Irrespective of these systems there are a number of elements that will be included wherever assessment takes place.

It is important that the assessment elicits information about the service user's needs, including intensity, frequency, duration and consequences. It is also important to find out as much as possible

about how this has affected their wider functioning, for example, relationships, employment, leisure activities and their financial situation. It is essential to set this information alongside the service user's usual activities and their hopes and aspirations; this way it will be possible to begin to identify the strengths and resources that the patient has to help them to manage their own care.

Although the assessment interview needs to be collaborative and will, by its nature, range quite widely, it is important that it has a structure. There is evidence that, if the right questions are asked, a structured interview helps people to tell their story. It is also important to take accurate notes or record the conversation; sharing the information with patients afterwards can often help clarify how they feel; it also provides a method checking your understanding for accuracy.

The format of the assessment interview sets the tone for future sessions and it is best to plan to conduct sessions within a clear structure for example: introductions; assessment and information gathering; clarification of information; formulation; summary of session and planning of future work. It is worth remembering the importance of flexibility; issues may arise during a session that need addressing, for example risk, and it is vital that such opportunities are not missed. Each of these sections is discussed in more detail below:

- a. **Introductions.** It is important to set the right tone at the beginning of the interview, explain who you are and why you are there. It is also helpful to explain how much time you have and to reassure people that if the process is incomplete then you are able to return at another time. The importance of this initial part of the session should not be underestimated and will provide the foundations for the rest of the session and, indeed, future work.

At this stage there are a number of goals:

- To develop a healthy therapeutic alliance with the service user.
 - To explain about the service, the CPA process, your role, why you are there, what you are able to do, what the limitations are and what the specific purpose of this session is.
 - To give an opportunity for the service user to say what they expect from the session and to ask questions.
 - To check out if a service user wishes to use advocacy services or an interpreter, in the event that they are unable to represent their own interests.
- b. **Assessment and information gathering.** In order to develop a useful, coherent care plan that is designed to address the needs and strengths of the service user it is important to understand as much as possible about their background, their strengths and the nature of their difficulties. This information will come from a wide variety of sources for example existing notes, information from other professionals and possibly significant friends, relatives and carers.

The main aims of assessment are to:

- gather background information about the service user.
- understand the difficulties, needs, strengths and resources the service user has.
- evaluate the impact of these difficulties on the service user's wider social, cultural and personal networks.
- develop an understanding of the impact of the service user's wider personal, social and cultural networks on their difficulties.
- ascertain the level and nature of risk to self and others and from others (including violence and abuse)
- get an idea of the resources and coping strategies they have developed to help

- them manage their problems so far.
- Consider the perceptions of significant others, particularly informal carers and family members
- identify the need for any specialist assessments

There are a number of key areas to cover at this point (for comprehensive list see domains below):

- Previous history and contact with services, including first and subsequent episodes, medication history, significant events – although much of this information can be gathered from the service users' case notes it is important that details are checked for accuracy
 - Family background: Who does the patient live with? Who is at home? How much contact is there with others? What are these relationships like? How have their relationships been affected by their mental health issues?
 - Social background including education and employment history, leisure, interests, friendships, how they spend their time outside the home.
 - Cultural context
 - Hopes and aspirations for the future. How does the patient view the future? What would they like to do? What are the obstacles?
 - Careful consideration of safety and risk issues, including risk to self and others, risk from others, including experience of physical, sexual or emotional abuse (see below)
 - Acknowledgement and discussion of relevant aspects of positive risk taking
- c. **Clarification of information.** We often assume that we understand what people mean but there is evidence to suggest that this is not always the case and that sometimes different meanings are ascribed by the listener to the words they hear. Taking the time to clarify or check out meanings is time well invested as it validates our understanding and identifies any gaps in information.
- d. **Formulation.** Developing a shared understanding of the needs the service user has, the strengths and resources they have to manage them, and any potential risk to self and others is probably the most sophisticated part of this process; it is also believed to be the most important; if we get this part right we are well on the way to identifying strategies to deal with the issues. The clearer the description of the need or issue the easier it is to formulate an action plan. If there is any disagreement over the formulation, then it is important that differences are discussed and, if not resolved, acknowledged and recorded.
- e. **Communication and supportive documentation.** Establishing or extending an information base and communicating relevant information to those who need to know.
- f. **Confidentiality.** This is sometimes used as a reason for excluding carers from assessment and care planning (see examples from DVD). Confidentiality is about respecting the rights of the individual. When sharing information about service users with others, this is discussed with the service user first and their views taken into account. In the case of safety issues to self and/or others being identified, their wishes may be breached.

The domains of a comprehensive assessment

The following elements (CPAA 2008¹) should be included in an attempt to consider an individual 'in the round'. Clearly it will not always be possible to cover all aspects, particularly in a situation arising from an emergency. Ideally they should be addressed over time.

- Psychiatric functioning
- Psychological functioning
- Co-morbidity and co-existing problems e.g. substance misuse (current and past), learning disability, personality disorder
- Physical health needs
- Social functioning, social needs, and social circumstances
- Family, carers and welfare circumstances
- Parenting and child care issues
- Experience of violence and abuse
- Housing status and needs/unsettled accommodation
- Financial status
- Employment, education and leisure
- Risk to self or others
- Need for positive risk taking
- Medication and its management
- Capacity to self manage
- Support network (informal)
- Likelihood of maintaining regular and appropriate contact with services
- Strengths and aspirations
- Carer's involvement
- Religious and spiritual needs
- Communication, cultural, gender and access issues
- Advocacy and legal issues
- Service user's caring responsibilities

Experience of physical, sexual or emotional abuse

Many people, particularly women, who receive mental health services report previous experience of some type of violence and abuse². Mental health services have often been slow to respond to this issue. It is now recommended that the following question be included routinely in all assessments:

'Have you experienced physical, sexual or emotional abuse at any time in your life?'

Yes None stated Not asked

Of course people may choose not to disclose any history at this early stage of the assessment. The way that the question is framed allows for disclosure at a later date when it may feel safer to do so. Also, staff may not feel comfortable in asking this question until they have received the appropriate training to deal with any likely response. There are plans to cascade sexual abuse training to mental health staff.

For more details visit <http://www.cpa.org.uk/files/AbuseQuestion-CPA-refocus.doc>

¹ CPAA 2008 *The CPA and care standards handbook*. 3rd edition. CPAA Chesterfield

² Copperman J & Hill F 2006 *Women's mental health and recovery* IN Jackson C & Hill K *Mental health today. A handbook* pp. 45-55. Pavilion Pub. Brighton



Three Keys to a shared approach in mental health assessment (CSIP/NIMHE 2008³)

The three keys have been identified by stakeholders as being important if assessment is to be comprehensive and support a person's recovery and development of self management skills:



First Key: Active participation

This relates to how involved the service user and carer(s) feel they are involved in the assessment; how much they are listened to and the extent of choice they have in the process.



Second Key: A multi-disciplinary approach

A multi-disciplinary approach brings different perspectives and skills to the assessment process (including voluntary sector, as appropriate). The range and co-ordination of services often correlates positively with the effectiveness of the assessment.



Third Key: Strengths, resiliencies and aspirations

A focus on strengths, coping strategies, hopes and aspirations is essential to recovery and the development of self management skills. The inclusion of these aspects gives a balanced assessment that recognises potential and capacity for recovery.

The Three Keys guidance has spawned a number of practice based initiatives. For example, the piloting of an evaluation questionnaire based on these principles in Nottingham.

Examples of positive practice are available at :
<http://www.nimhe.csip.org.uk/our-work/cpa-positive-practice.html>



5.i Group activity

- Watch the three video extracts.
 - Jot down your reaction to these narratives in relation to assessment issues
 - Following each extract, discuss your individual reactions in groups
 - Address any issues for you as CPA Care Co-ordinators and any implications for your practice?
-
-  Video extract 5.A.i practitioner 'partnership'
 -  Video extract 5.B.i service user 'duplication'
 -  Video extract 5.C.i service user 'in the round'

³ CSIP/NIMHE 2008 3 keys to a shared approach in mental health assessment.



Trainer's notes

The following exercise (5.ii) is a form of role play. The instruction sets out how this could be organised. Preferably, members of the training team can role play the service user(s) but if this is not possible then participants may agree to take on the role(s). The exercise requires a trainer to be free of participation in order to co-ordinate the exercise and monitor timing and activities.

Alternatively, the cases could be used in smaller groups of three or four people, with one of them playing the role of service user in each small group. The case studies are examples and you could add your own or generate them from the people present.

The time required for this exercise will depend on the number of participants in the group. This will need careful planning to ensure you have sufficient time to complete the exercise.



Activity 5.ii CPA assessment and formulation activity

The group task is to make an accurate and comprehensive assessment and formulation of the service user and her/his situation. You need to consider needs, strengths and risk. This will later form the basis of a structured care plan. This activity is designed to provide the opportunity to practise elements of assessment, formulation and presentation. It has several aims:

1. To practise a structured assessment, including risk
2. To undertake a formulation based on this assessment
3. To practise presentation and narrative skills
4. To take part in group supervision

The activity will proceed as follows:

1. Read the letter. This gives a brief summary of the service user that you will be assessing. It contains some information about the individual, her/ his circumstances and how s/he came to be referred to the service
2. Discuss the information and decide who will begin the assessment interview (each person will have a short time with the service user and contribute to the assessment and formulation). It may be useful to decide on the order each of you will take part. Each mini session will last 5-7 minutes.
3. The first 'assessor' will go and meet the service user and initiate the assessment interview. This will involve an introduction, some information sharing, negotiation and engagement. The facilitator will let you know when the time is up. At this point you will go back to your group.
4. The group will function as a supportive mental health team and as a supervision group. The first assessor gives a summary to the group of the assessment so far; what has been completed; observations and any information that has been gathered. The team have a few minutes to discuss what has happened and to plan the next intervention. The facilitator will let you know when it is time for the second person to go and meet the service user.

- 
5. Assessor number 2 carries on with the assessment, trying to build on the previous session based on guidance from the group. This will also last 5-7 minutes and the facilitator will let you know when to return to the group.
 6. Repeat stage 4. Help the next person to plan what needs to be done next. Make sure the relevant domains are covered in sufficient depth but try and avoid excessive repetition.
 7. Assessor 3 then continues with the process, and so on until each member of the team has had their turn.
 8. The group can continue to plan and discuss progress when individual members are in the assessment room/space.
 9. The final person will use the time in the assessment to summarise the assessment with the service user and clarify that the team's assessment and formulation is accurate. This gives a final chance to correct any misunderstandings, agree on the formulation with the service user, or agree to disagree, if indicated.
 10. The group will present a synopsis of the assessment and formulation on a flip chart to the whole group.

If you have any questions at any time, or are unclear how to proceed, ask the facilitator

Case Scenario 1

(NOT TO BE GIVEN TO PARTICIPANTS)

Gerard's story

Gerard is a 25 year old man from an Irish travelling family. He has been settled in local council accommodation for a number of years now. He does not really like the house and sometimes fails to meet his rent obligations. He has been diagnosed as having 'depression' or possibly 'Bipolar Illness'. Gerard suffers with diabetes which is controlled by insulin injections. Gerard has previously been admitted to psychiatric units in a number of places in the country, but has had no admission now for three years and is determined not to go back to acute in-patient service. Sadly, Gerard does not get on with his consultant psychiatrist as "she does not understand me, thinks I won't take her tablets and won't listen to me, so I have nothing to say to her".

Gerard's mental health difficulties first came to prominence while still at school after an intense period of bullying. His mother still blames the school for not doing enough to protect Gerard when the bullying first came to light. At first Gerard developed a phobia about going out of the home and would pester to family to move on to another site as soon as possible. He would also claim to have received secret signs in a language of ancestors and 'hidden' within the family bible. Gerard made some repeated attempts at self harm, first by some cutting of the arms and then finally with an overdose.

Since that time Gerard has had a number of 'ups and downs' and keeps relatively well. When he begins to feel unwell, he becomes uncommunicative, stops eating and neglects his personal hygiene and appearance.

Gerard had a relationship with Lorna, soon after settling in the area. Together they had a son (Kevin) who is in good health. Lorna is described as having a 'chaotic' lifestyle and both she and Gerard have openly abused drugs and alcohol. Gerard is the main carer for Kevin and gets considerable support from his mother. However, he will on occasion 'go off the rails' and drink heavily and fall in with acquaintances that stay at his house, often uninvited.

There has been some suggestion of abuse of Gerard by Lorna (Kevin's mother) friends including, financial exploitation e.g. eating his food, using his phone and taking his money. Gerard misses Lorna and would like to re-establish contact with her, as he feels she has the capacity to change.

Gerard receives support for his son from the Children and Family Outreach team who help with cooking, feeding and other domestic tasks for Kevin. He has complained about the number of workers and agencies involved and wish they would all go away and leave him and Kevin alone.

Gerard tries hard for his son, but remains terrified social services will remove his son and is thus willing to do anything they say to avoid this happening. Despite feeling angry about his situation he is beginning to feel 'ground down' by the situation, and is becoming dependent and claims his confidence is being undermined.

When Gerard is neglecting himself he complains of feeling sick, tired and suffering with high blood pressure. He has been told that social services are keeping a close eye on the situation and he is concerned that he will be viewed as a bad father and Kevin will be removed.

Referral Letter (this to be provided for participants)

From: Dr Sally Graham

To: The Park Community Mental Health Community Team

**Re: Gerard Tobin
22 Close Drive
Marlingborough
New Town**

Dear Team members

I wonder whether you would arrange to see Mr Tobin who has been supported by me and the Field team for a few years. You will note there has recently been a re-alignment of the team boundaries and Mr Tobin now falls within your catchment area.

I am arranging for Mr Tobin's care co-ordinator here to transfer all the documentation over to you as soon as possible, but in the mean time, the following is a short summary of his situation.

Mr Tobin is a 25 year old man who comes from an Irish Travelling community, but has been settled in our district for four years or so. He has settled to be near his mum who lives close by. She has some physical health difficulties and has been living in a council house accommodation for 5 years.

Gerard has a bi-polar disorder with strong depressive elements and is maintained on medication Lithium 300mg x 3 times per day and Fluoxetine 20mg x 2 times per day.

He has a long history of mental health problems and also a history of some alcohol abuse. There is a question over whether Mr Tobin has also been taking illicit drugs. He is the main carer for his son Kevin, but gets support from social services and his mum. His partner and mother to Kevin (Lorna) seems to be an infrequent visitor to the house.

Michael Smith from the Field CMHT has been acting as Gerard's CPA Care co-ordinator, but at our team meeting today it was recommended that we now hand over co-ordination to your team, due to the reasons detailed above.

Best wishes

Dr Sally Graham
Field Team
Consultant Psychiatrist

Case Study 2

Shanel's story

(NOT TO BE GIVEN TO PARTICIPANTS)

Shanel is a 45 year old woman, born in the UK. Her parents came to England in the 1960's from Jamaica. Shanel has a 25 year history of alcohol dependency. She is divorced, and is living in a local hostel. She has two grown-up boys in Scotland that she has lost contact with. She has had several prison sentences in the past; offences range from Greivous Bodily Harm, and mugging to shoplifting and drug dealing. She has recently been caught stealing spirits from an off-licence, and when caught, she assaulted a police officer. Shanel was highly intoxicated at the time. She has a court case pending for this.

She has been known to the local mental health service for several years. She tends to pitch up at the local Accident & Emergency when she is in crisis, and gets admitted for a few days to the psychiatric ward, but rarely attends follow-up appointments. She states she has "really bad depression", and hears her father's voice at night (her father died when she was eight). She is terrified of the father's voice as her father was a drinker, and used to physically abuse her and her brothers as well as her mother. Her diagnosis is alcohol dependence; psychosis and depression. She has been offered anti-depressants and antipsychotics (Olanzapine) which are prescribed by her G.P, but no one is really sure if she takes them.

Medical tests have shown that her liver is being badly affected by her drinking, and she has been told by her G.P. (who was trying to frighten her into stopping drinking) that if she carries on drinking she will be dead in a year. Despite this, she is craving alcohol badly and finding this hard to cope with. She becomes verbally aggressive at times due to this. She is very anxious that she will get another custodial sentence at court, and is feeling remorseful about attacking the police man (who was quite badly hurt). She is frequently tearful. She feels that her life is a complete mess, she's let her boys down, and there's no hope for her ever getting herself together. She talks about drinking herself to death. She is sleeping very badly, and has been pacing her room most nights. She has also been heard muttering to herself by the hostel workers.

Transfer from Crisis Resolution team to CMHT (to be provided for participants)

From: Sinead Harrison (Crisis Team)

To: The Park Community Mental Health Community Team

Re: Shanel Aguilleira

15 The Flats

Outer Road

Marlingborough

New Town

Dear Team members

I wonder whether you would arrange to see Mrs Aguilleira as she required the intervention of CRHT last week and could do with a full re-assessment and possibly fast track back onto CPA following our successful interim re-stabilisation in the hostel situation.

Mrs Aguilleira is a 45 year old woman with a history of alcohol dependency and an underlying depression. She recently has had to be emergency re-housed in a local hostel and this seems to have exacerbated some mood and thinking disturbance. Rethink has been involved in a supportive tenancy arrangement in the past.

She has a long history of recurrent mental health problems with alcohol abuse and drugs. There have been episodes of self harming over many years that have sometimes prompted admissions to the local psychiatric unit.

We ascertain from Mrs Aguilleira's Consultant that engagement with CPA and CMHT has been problematic in past, as has her experience with medication due to reported side effects but feel a re-assessment at this point would be timely as she is responsive and requesting help? She has been prescribed Olanzapine and has been on various anti-depressants over the years but is unreliable in taking these.

Previous notes are at the hospital and will be on their way to you.

Thank you

Yours sincerely

Sinead Harrison

Crisis team

Unit 6: Managing risk effectively

Summary

Risk management should be integral to any care assessment and planning process. The CPA process involves identifying specific interventions based on an individual's support needs, taking into account safety and risk issues. Care plans should be drawn up to meet all of the service user's needs, including those needs relating to risk. This creates a recorded management plan for the elements of positive risk taking and of risk to self and to/from others. The outcome of the risk assessment should also feed back into overall clinical management, since CPA should be applied in cases where there is an increased risk related to mental health problems of harming oneself or others. These steps help to support the continuity of care, which is essential for effective risk management.

Risk management should be based on the principles and best practice outlined in the published guidance 'Best practice in managing risk' (DH 2007) see Handout Page 60. This emphasises positive risk management, a collaborative approach, building on strengths and the respective roles of organisations and individuals in managing risk.

Aspects of risk management will include crisis and contingency planning, advanced directives, information sharing, acknowledgement of differences and positive risk.

Many different tools exist for assessing and managing risk. The guidance cited above includes an overview of some of these. Each has strengths according to the type of risk and the context. No one tool is advocated for use in risk management in this unit but local documentation and tools could be incorporated into the programme.

Learning Outcomes

By the end of this unit participants will be able to:

- assess, safely determine, document and communicate levels of risk to self and others, including the risk of crisis situations occurring with individuals, families and carers
- document details of the relevant information relating to risk and communicate with appropriate others
- prioritise identified needs and levels of risk
- acknowledge and record any disagreement concerning the assessment, including source and level of risk.
- Liaise with other services / agencies in relation to risk and responsibilities

The unit will include triggers taken from narratives of service users, carers and practitioners. The triggers will be linked to group discussions and backed up by supportive reading and examples of evidence based and positive practice.





PowerPoint 6: Managing risk effectively

(presentation and handouts from PowerPoints on DVD)

Introduction

Risk identification, management and taking is an essential and continuous process in life and in effective mental health care. It is an integral component of the assessment, planning and review processes in the CPA. The principles of effective risk management are outlined in 'Best practice in managing risk'¹. This guidance document is intended to guide mental health practitioners who work with service users to manage the risk of harm. It sets out a framework of principles that should underpin best practice across all mental health settings, and provides a list of tools that can be used to structure the often complex risk management process. The philosophy underpinning this framework is one that balances care needs against risk needs, and that emphasises:

- positive risk management;
- collaboration with the service user and others involved in care;
- the importance of recognising and building on the service user's strengths; and
- the organisation's role in risk management alongside the individual practitioner's

What is positive risk management?



6.i Group activity (20 minutes plus feedback)

What does positive risk taking mean to you?

Think of examples from your own life

Think of examples from practice

What needs to be in place to support positive risk management in your practice?

Often negative connotations are associated with risk (danger or loss) but practitioners routinely assess risk as an element of their practice and we all do this as a part of being alive. Decision making often involves weighing up risks. Positive risk management means being aware that risk can never be completely eliminated, and aware that management plans inevitably have to include decisions that carry some risk. Decisions about life and care are based on weighing up the potential benefits against potential harm. This should be explicit in the decision-making process and should be discussed openly with the service user.

Positive risk management includes:

- working with the service user to identify what is likely to work;
- paying attention to the views of carers and others around the service user when deciding a plan of action;
- weighing up the potential benefits and harms of choosing one action over another;
- being willing to take a decision that involves an element of risk because the potential positive benefits outweigh the risk;
- being clear to all involved about the potential benefits and the potential risks;
- developing plans and actions that support the positive potentials and priorities stated by the service user, and minimise the risks to the service user or others;

¹ DH 2007 *Best practice in managing risk*. DH London

- ensuring that the service user, carer and others who might be affected are fully informed of the decision, the reasons for it and the associated plans;
- using available resources and support to achieve a balance between a focus on achieving the desired outcomes and minimising the potential harmful outcome. (DH 2007)

 Video extract 6.A.i service user 'positive risk taking'

Types of risk

To self: suicide, self harm, substance misuse, neglect,

To others: violence, aggression, abuse, neglect, children, carers, service providers

From others: vulnerability, exploitation, physical, sexual or emotional abuse, domestic violence

Physical health: nutrition, substance misuse, co-existent medical conditions, confusion, falls, memory impairment, wandering

Disengagement from services

Positive risk: balancing potential benefits and potential harm, resources, resiliencies, coping and self management

A risk assessment will include a history of previous incidents (frequency, severity, how long ago, patterns; mental state (delusions, hallucinations ideas, threats); emotions; statements of intent; degree of planning (needs tracking); a consideration of risk factors (age, gender, family history, housing, employment, physical health, diagnosis, substance misuse etc). Based on this a judgement (formulation) is made on the level and nature of risk, contributing factors, triggers, specificity, ways the risk can be reduced and ultimately a risk management plan aimed at reducing the level of risk.

A judgement will be made on the level of different types of risk based upon the available information. Clearly any immediate risks will require an appropriate response. The risk assessment and management plan will be made available to all those who need to know.



6.ii. Group activity (30 mins)

- Watch the following video extracts. Jot down your reaction to these narratives in relation to aspects of risk
- Following each extract, discuss your individual reactions in groups
- Address any issues for you as CPA care co-ordinators and any implications for your practice?

 Video extract 6.A.ii service user 'focus on risk'

 Video extract 6.A.iii practitioner 'focus on risk'

and From a carer's perspective:

 Video extract 6.B.i 'rights versus risk'

 Video extract 6.B.ii 'a tragic event'

 Video extract 6.B.iii 'risk to carer'

 Video extract 6.B.iv 'risk to others'

In making any assessment of risk, mental health workers will gather data from interviews, consultations with others and existing records and combine this with a consideration of population-based indicators. Sometimes service users complain that risk assessments are professionally led and that their own experience and expertise is overlooked². Their perception of the experience of risk may contrast with mental health workers' and those of carers and family. Service users' plans for managing risk have been shown to be effective and their more active involvement in the process of risk management is likely to enhance its effectiveness. An example of how this can benefit is demonstrated in the following video clips.

-  Video extract 6.A.iv service user 'self assessing risk'
-  Video extract 7.D.i service user 'what happens if'
-  Video extract 7.D.ii service user 'planning to avoid admission'

Crisis and contingency planning focuses on triggers, potential problems and consequences, individual responsibilities and actions. They should be used routinely as a proactive approach to managing potentially difficult times.

Risk assessment tools

A number of established tools for the assessment or screening of risk are used frequently in mental health settings. They often contribute to a consistent approach to working with risk. Each has its own merits and limitations. For an overview of those tools that have been tested to some extent in mental health practice settings see the appendix of the DH Best Practice document at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_076511.

The guidance also advises that these tools should be used with caution for the following reasons:

- A tool can only contribute one part of an overall view of the risk presented by a particular individual at a particular time. Tools should only ever be used as part of a general clinical assessment conducted with a service user. The results of the tool-based assessment must always be combined with other information on many aspects of the service user's life and current situation³
- 'Choosing the right tool for the job is a complex task'

² Ryan T 2006 *Risk management in mental health: people, perceptions and places*. IN Jackson C & Hill K *Mental health today. A handbook* pp. 45-55. Pavillion Pub. Brighton

³ DH 2007 *Best practice in managing risk*. DH London. P.30. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_076511

 **HANDOUT**

A summary of the 16 best practice points for effective risk management (DH 2007 p. 5-6)

Introduction

1. Best practice involves making decisions based on knowledge of the research evidence, knowledge of the individual service user and their social context, knowledge of the service user's own experience, and clinical judgement.

Fundamentals

2. Positive risk management as part of a carefully constructed plan is a required competence for all mental health practitioners.

3. Risk management should be conducted in a spirit of collaboration and based on a relationship between the service user and their carers that is as trusting as possible.

4. Risk management must be built on recognition of the service user's strengths and should emphasise recovery.

5. Risk management requires an organisational strategy as well as efforts by the individual practitioner.

Basic ideas in risk management

6. Risk management involves developing flexible strategies aimed at preventing any negative event from occurring or, if this is not possible, minimising the harm caused.

7. Risk management should take into account that risk can be both general and specific, and that good management can reduce and prevent harm.

8. Knowledge and understanding of mental health legislation is an important component of risk management.

9. The risk management plan should include a summary of all risks identified, formulations of the situations in which identified risks may occur, and actions to be taken by practitioners and the service user in response to crisis.

10. Where suitable tools are available, risk management should be based on assessment using the structured clinical judgement approach.

11. Risk assessment is integral to deciding on the most appropriate level of risk management and the right kind of intervention for a service user.



Working with service users and carers

12. All staff involved in risk management must be capable of demonstrating sensitivity and competence in relation to diversity in race, faith, age, gender, disability and sexual orientation.

13. Risk management must always be based on awareness of the capacity for the service user's risk level to change over time, and a recognition that each service user requires a consistent and individualised approach.

Individual practice and team working

14. Risk management plans should be developed by multidisciplinary and multiagency teams operating in an open, democratic and transparent culture that embraces reflective practice.

15. All staff involved in risk management should receive relevant training, which should be updated at least every three years.

16. A risk management plan is only as good as the time and effort put into communicating its findings to others.

Unit 7: Care planning

Summary

The co-design, agreement and production of a personalised plan of care lie at the heart of effective care co-ordination. Service users and, where appropriate, carers should be encouraged to take a full and active part in the care planning process. The views of other service providers, agencies and practitioners who are in a position to contribute to the care plan should be taken into account.

This unit examines principles of a shared approach to the planning of care ensuring clarity of responsibility and the effective dissemination of information. This includes encouraging individuals to consider what recovery means to them and what will enable them to recover. Clearly stated goals should reflect the needs, strengths and aspirations of individuals and promote self care/management, as appropriate, through information sharing and planning.

Learning outcomes

By the end of this unit of study participants will be able to:

- facilitate co-production, collective agreement and commitment to goals and a care plan
- follow principles of recovery and social inclusion by capturing and applying strengths of the individual in care planning
- delegate responsibilities for carrying out specific tasks that are identified in the care plan to appropriate team members and service providers
- ensure that risk management is conducted in a spirit of collaboration and is based on service users' strengths and capacity for recovery, taking into account the best practice in managing risk guidance
- develop a flexible risk management plan that includes a summary of risks identified, formulations of the situations in which identified risks may occur, and actions to be taken by practitioners, service users and carers to avert or respond to a crisis
- Record and share as agreed the planning and review process

The unit will include triggers taken from narratives of service users, carers and practitioners. The triggers will be linked to group discussions and backed up by supportive reading and examples of evidence based and positive practice.

 **PowerPoint Unit 7: Care Planning**
(presentation and handouts from PowerPoints on DVD)





7.i. Group activity (20 mins)

- Watch the following video extracts. Jot down your reaction to these narratives in relation to aspects of care planning
 - Following each extract, discuss your individual reactions in groups
 - Address any issues for you as CPA care co-ordinators and any implications for your practice?
-
- 👤 Video extract 7.A.ii practitioner 'allowing for differences'
 - 👤 Video extract 7.A.iii service user 'sign here'
 - 👤 Video extract 7.A.iv service user 'agreement?'
 - 👤 Video extract 7.C.i service user 'what's important'
 - 👤 Video extract 7.C.ii carer 'what makes people get out of bed in the morning?'



7.ii Group activity (40 mins)

Sharing the understanding

In Unit 5 Comprehensive assessment, as a group you were tasked with generating an assessment from a number of case scenarios. The purpose of this task is to take the elements of that assessment and to construct a 'formulation' of the needs 'in the round' of the person you have worked with.

Part 1

Time allocated: 25 minutes

In your groups and working collaboratively with the person playing the role of 'Service user' construct a short description (formulation) of what the key issues are for the person in terms of their needs. You can do this on a flip chart and provide the whole group with a description of your joint assessment.

Objective of this activity

This is an attempt to mirror the aspect of presenting a 'formulation' of an assessment of the care team.

Examine

How have you expressed the needs / strengths? Are they comprehensive and do they require the attention of other members of the care team or external agencies.

Part 2

Time allocated: 15 minutes

In your groups and in co-production with the 'service user' you are tasked to organise your formulation into a mutually agreed 'plan of care'. Use the form on Page 65.

1. Work in collaboration with the 'service user' and agree the issues
2. Take the list of issues you have identified from your assessment and Prioritise what you agree are the needs in order.
3. Be specific about the need you identify
4. Identify how you are going to make progress towards meeting the need
5. Identify who you will need to work in partnership in meeting the needs you have identified
6. Reflect on the aspects of the care plan, can they actually be achieved in a sensible time period?



7.iii Group activity: Personal Safety and Risk Management

(20 mins)

Using the information from your assessment, formulation and care plan, develop a personal risk management plan for the service user you have been working with. You are asked to note the issues contained within the ESC and the fundamentals from the national guidance on risk management.

Instructions:

Within your groups construct a risk plan (you may use the template from Page 66 or you may use a template you are more familiar with).

EXAMPLE

Need or strength	Outcome	Action(s)	By whom	Review date

Name of service user:
 Name of care co-ordinator :
 NAME: X
 DATE: 13.01.2009

Date of birth:

Signature of service user :
 Signature of care co-ordinator:
 DATE OF BIRTH: 21.9.1980

EXAMPLE

Need or strength	Outcome	Action(s)	By whom (CC)	Review date
Occupation: Javeria finds the lack of structured day time activity and stimulation frustrating. She recognises that this has a negative effect on her mood and mental health	Javeria to engage in regular occupational, educational and/or leisure activity that is meaningful to her.	<ol style="list-style-type: none"> 1. Refer Javeria to employment services 2. Make contact with local service user organisations to enquire about existing suitable local initiatives 3. Enquire about local educational opportunities and financial support 	Javeria	12.4.09
Physical health: Javeria is concerned about her rapid weight gain over the last year (about 10 Kg)	To reduce her weight by 5Kg in 12 months	<ol style="list-style-type: none"> 1. Apply for direct payment to fund Gym membership 2. Refer to dietician for guidance 3. refer to healthy living group 4. review medication with Consultant psychiatrist 	Javeria and SH	13.1.10
Risk of exploitation by friends. Javeria does not agree with my concerns about certain acquaintances using her flat to take drugs, using her phone without permission and 'lend' her money. She sees this as a part of their friendship	That X is aware that she can discuss and address these concerns when and if she wants to	<ol style="list-style-type: none"> 1. As X does not see this as a problem, to monitor the situation and discuss it regularly at contact meetings. 	Javeria	1.7.09
Name of service user: Javeria Khan Signature of service user : Name of care co-ordinator : Saraya Hopkins ordinator:			Javeria and SH	12.4.09

Date of birth: 21/09/1980

Signature of care co-ordinator: Saraya Hopkins

Example of Relapse plan/Advanced Statement

Name:
Date

Date of birth

Part 1. The people involved in this plan are:

Name: Contact details		Name Contact details	
Name: Contact details		Name: Contact details	
Name: Contact details		Name: Contact details	

Part 2.

The things that help me keep well and support my health are:

- 1.
- 2.
- 3.
- 4.
- 5.

I know that I am beginning to feel unwell when;

My family/carers know that I am beginning to become unwell when;

There are some things I can do for myself and these contribute to me maintaining my level of health. The things I can do for myself are:



There are a number of things I need to avoid if I am to maintain my level of health, these are;

I receive help from a number of people/agencies in the following areas;

- Area of help
- What does this support person/agency do?

- Area of help
- What does this support person/agency do?

- Area of help
- What does this support person/agency do?

- Area of help
- What does this support person/agency do?

Part 3.

What needs to happen when I am unwell and at risk to myself, or other people.

The people I prefer to be involved in part 3 of the plan are:

-
-
-
-

Signature of service user

Date:

Signature of CPA care co-ordinator /representative

Date:



Setting Outcomes

Using approaches such as 'SMART' outcomes, [Page zz](#) can be helpful in setting out care plans which are (Specific, Measurable, Achievable, Realistic and Time limited). Table 7.1 provides some information on the key aspects of setting SMART objectives. Use this information to test your activity.

Parallel processing

Recognising one's needs, strengths and outcomes is central to learning and achieving our potential in different aspects of our lives. We may sometimes need prompting, challenging and guidance from others in this respect but we are more likely to own our goals and take strategic actions if we are directly involved in the process. The co-production of a care plan is desirable for these same reasons.

Table 7.1: SMART Objectives and descriptors.

Variations of words commonly used in SMART as an acronym			
S	Specific	Stimulating	Simple Stretching Succinct Straight forward Self owned Self managed Self controlled Significant Strategic Sensible
M	Measurable	Motivating	Manageable Meaningful Maintainable Mapped to goals
A	Achievable	Appropriate	Actionable Attainable Aspirational Accepted/ acceptable Aligned Accountable Agreed Assignable
R	Realistic	Relevant	Results Orientated Resourced adequately adequate Resourced Rewarding Recorded Reviewable Robust
T	Time-.. bound limited driven constrained related sensitive specific	Tangible	Traceable Timed/ Timely Toward what you want



Service user and carer self management: A service user's perspective

By Andrew Harrison

Government policy over the last twenty years has been in the direction of people having more individualised support. Self-directed support is now central to government policy 1 and the Government has funded the transition process to ensure that everyone who is eligible for social care support can be offered self-directed support by 2011.

The idea of patient self-management first surfaced in the 1960s and 1970s as an attempt to seek more acceptable approaches to dealing with and recovering from illness, from the individual's perspective. Often this meant patients taking more control of their lives by ceasing involvement with organised health care systems.

Today the emphasis is very different; self-management is seen as an integral, even central, part of the system of care provided to people with chronic illnesses. Patient self-management or 'expert patient' programmes are not simply about educating patients about their condition or giving them relevant information, though these remain important; they are based on developing individuals' confidence and motivation to use their own skills, information and choice of professional services to take effective control over life with a chronic condition.

Many people are benefiting from speedier interventions or crisis responses but some need greater input to manage their mental health needs on a longer term basis. Improved medication, social support, through housing, benefits and advances in effective psychological therapies all combine to assist people to understand and be in more control of their lives. However, a contradiction to the idea of self management remains, in that most clinical control still effectively resides with the care providers. Also, there is a danger that patients and carers are faced with an internalised medical / psychological model which effectively leaves them with little control. Despite some of the rhetoric and empowering language, power often still resides with the care providers or commissioners

The real challenge is to maximize both self direction and the capacity for the health and social care systems to deliver effective care fairly. This requires a combination of an emphasis on self management and responsibility with the tangible support that is required to enable this to happen. It is up to users of mental health services, as well as providers, to make the best use of the available money. One cost effective way may be to encourage service users to take a greater responsibility for their health conditions, as much as they are able. In return, service providers must provide, directly or indirectly, the means to help people manage conditions more effectively.

This not only means interventions based on direct payments and individual budgets, in line with government direction and policy, but a commitment to self management training for service users and carers, awareness raising and peer group self help such as the Wellness Recovery Action Planning (WRAP) approach, the bi-polar self management training, self directed support, structured peer support and 'expert patient' programmes.

Other self help initiatives include practical help for service users and carers to set up and maintain meeting places and the means to get there. For those too unwell, institutionalized, unwilling or unable to take responsibility for themselves, the emerging care systems will need to be monitored

1 DH 2007 Putting people first: a shared vision and commitment to the transformation of adult social care.

carefully to ensure that these people continue to receive care that is compatible with their situations, in this changing system.

I propose the following self determination framework (SAFER) as a tool for service development:

Support: individuals equipped with the resources and skills necessary to assist maximum self determination and self help.

Authority: to make choices using self awareness, knowledge, individual budgets, direct payments, advance directives, medication management, employment etc.

Facts: the locus of knowledge should reside as much as possible with person / patient and they should be fully consulted and informed of options based on best available evidence and opinions.

Experts: agreement that individuals are the experts in their own experience combined with the promotion of knowledge of their condition. Resultant actions by individuals should improve their self confidence and ability to manage self and health care delivery systems more effectively and on a mutually beneficial basis.

Responsibility: an understanding that with power and knowledge comes greater responsibility to manage one's own condition to the best of one's ability; doing as much as possible to maintain and promote one's own wellness and wellbeing. In return local Trusts undertake to promote supportive interventions and structures to facilitate more effective self management.

The implementation of SAFER by local Trusts plus adoption by patients and carers could lead to many of the benefits highlighted by the Expert Patient Programmes if a commitment to training and support is clear, consistent, resourced and across the whole local health economy. Possible benefits could include:-

- increased confidence and control in their lives.
- improved management of their conditions and treatment in partnership with health care professionals.
- more effective communication with professionals and a willingness to share responsibility for treatment.
- a more realistic perception of the impact of their condition on themselves and their family
- increased capacity to use their skills and knowledge to lead fuller lives and help others

More work needs to be done to identify gaps in services in relation to encouraging self management and, more importantly, the best ways to deliver such an approach across NHS Trusts and Local Authorities.

Reading and links:

DH 2001 Shifting the balance of power within the NHS: Securing delivery

DH 2006 Our health, our care, our say: a new direction for community services.

DH 2007 Putting people first: a shared vision and commitment to the transformation of adult social care

www.in-control.org.uk In Control is a leader in developing self-directed support and individual budgets as the route to independent living.

www.expertpatients.co.uk

www.socialinclusion.org.uk

www.nationalsdcfoundation.org US Self-directed system of publicly funded behavioural healthcare for people with psychiatric disabilities.



Unit 8: CPA and Whole Systems Working

Summary

The advent of community mental health care has increased our understanding of the interdependence of teams and health and social care systems. In this unit this 'system' approach will be examined in the context of the role of a care co-ordinator. The care co-ordinator has a primary role in managing and maintaining the effective working of a network of services, resources and people. Service users with care co-ordinators have complex needs, and this complexity is an issue for the care co-ordinator, the service user and carer(s) in managing the relationships between the variety of services and systems involved in a plan of care.

There are many things which may have contributed towards someone's illness and consequently many things which may contribute towards their social inclusion, recovery and well-being. A good care plan is one which reflects the 'whole system' contributions.

This unit focuses on seeing the individual 'in the round', through understanding the myriad roles and responsibilities a service user may have and the things that are important in their lives. It will examine issues such as 'partnership relationship with service users and informal carers'; 'supporting partner agencies' and helping people maintain control over their own care.

Learning Outcomes

At the end of this unit participants will be able to:

- identify the importance of 'whole systems' approaches in the co-ordination and provision of mental health services
- articulate what this may mean in planning care for the individual
- identify internal systems for care co-ordination in the CPA process
- differentiate between external and internal systems and how they interact in the delivery of the care plan
- evaluate the role of the care coordinator in managing and navigating the systems.

The unit will include triggers taken from narratives of service users, carers and practitioners. The triggers will be linked to group discussions and backed up by supportive reading and examples of evidence based and positive practice.





PowerPoint Unit 8: Whole systems working

(presentation and handouts from ppts on dvd)

The care co-ordinator role

As noted in earlier units of study, the role of care co-ordinator is central to the effectiveness of care planning. It has been demonstrated that working collaboratively with service users and carers in the assessment, planning and implementation of a plan of care is at the root of high quality mental health care. In addition, attention has been given toward seeing the person 'in the round', that is through understanding the myriad roles and responsibilities a service user may have and the things that are important in their lives. In this unit we will explore how you, as the care co-ordinator, work in this whole systems approach.

Review of Previous Learning

This unit will build on what has already been covered in previous units of study:

Revision

- Care co-ordination involves a partnership relationship with service users and informal carers based on the involvement and shared understanding of respective roles and responsibilities of all parties in assessment, care planning, interventions and the review of care.
- The Care Programme Approach (CPA) is about the daily work of mental health services and supporting partner agencies, not just the planned occasions where people meet for reviews. CPA is an ever-changing approach to relationship building, assessment, planning and review.
- CPA provides a comprehensive framework for positive practice, recognising the service user as a person first and patient second.
- CPA is a person centred approach which acknowledges and works with the tension between managing risk and promoting safety and positive risk taking.
- CPA is an action to encourage independence and self determination to help people maintain control over their own care (e.g. through 'Advance Directives' and Direct Payments).
- Effective delivery of the CPA requires care co-ordinators to value the strengths, as well as recognising the difficulties, of all the people involved in the process; and to exercise a degree of passion and commitment in the manner in which they pursue their role. CPA co-ordinators and other members of the team alongside service users work together as active partners to clarify acceptable treatment options and choose the approach most appropriate to the problems at hand. While not all service users want to play an active role in choosing a treatment, most want practitioners to inform them and take their preferences into account.

In a whole systems approach, the roles of service users and, where appropriate, their carers, remain a central theme. The issue of engagement of service users and the networks in which they operate is critical to the successful functioning of the Care Programme Approach.

'Despite several important gaps in the evidence, there is a sufficiently robust body of knowledge on which to build strategies for strengthening patient engagement. Differences in morbidity patterns, cultural barriers and social inequalities must be taken into account when planning strategies to promote greater patient engagement. If these barriers can be overcome, the rewards are potentially

great, because people who are more informed and engaged tend to use fewer health care resources and to make more appropriate choices, leading to better health outcomes. In addition to the potential for achieving greater efficiencies in resource use, encouraging patients to take more control when they are ill may also prove to be an effective tool for improving public health¹.



Group Activity 8.i

In pairs, write and discuss the activities you are engaged in with family, friends and colleagues. These can be activities relating to work, or education, or social life. Review the range of activities that you have written down and with your partner try and prioritise them.

You may revisit these notes in later exercises.

Whole Systems Working

The notion that mental health workers try to work 'holistically' is not new. We propose to explore this issue of 'whole systems' and discover what it means for your role as a care co-ordinator. This part of the unit, introduces the notion of 'internal' and 'external' networks for care co-ordination. An internal network is one that is relatively simple to maintain contact and communicate with different services, for example it may include a plan of care where the service user attends a day care setting or receives occupational therapy. It is a network which is easy to repair if it 'breaks down'; if the personnel change it is usually simple to ensure the smooth transition to new workers who are able to pick up responsibilities for the agreed plan of care.

An external network is one where the solutions to problem solving are more difficult, where communication takes more effort and it is less easy to maintain regular face to face contact. For example, where a service user is receiving occupational therapy support from a local mental health trust, support from a charity worker, social care from the probation service and involvement with an independent service provider.

What is important for this unit of study is the recognition that different networks exist and they both present challenges and opportunities in terms of communication, problem solving and adherence to agreed plans of care.



Group Activity 8.ii

Individually think about a service user for whom you are acting as CPA care co-ordinator. Complete table 1 for them with as much information as you can. Use the ideas you generated from the earlier exercise if you have difficulty with individual sections here. (note to ensure attention is paid to maintaining their confidentiality).

¹ Coulter, A., Parsons, S. and Janet Askham, J. (2008) *Where are the patients in decision making about their own care?* Picker Institute/World Health Organisation. Copenhagen Denmark



Table 8.1 The services they make use of in the CPA plan of care are:	
Services	Internal:
	External:
Family and Carers	The family or carers actively involved in the CPA care plan are: Internal:
	External:
Education	The educational activities they are pursuing or are interested in pursuing are: Internal:
	External
Recreation	The recreational activities that are important in the CPA plan of care are: Internal:
	External
	The employment-work activities that are important in the CPA plan of care are: Internal:
	External
Faith and Meaning	The faith and meaning activities that are important in the CPA plan of care are: Internal:
	External
Other	The (insert here) they make use of in the CPA plan of care are: Internal:
	External



Group Activity 8.ii Part 2: Managing complexity

Discuss this list with your training partner and debate what this list means for you as a care co-ordinator. It may be that it is a comprehensive list, full of activity and resources that the service user is in touch with. If so, this means a great deal of information for you as the care co-ordinator in a complex network. Adding just a few more contacts substantially increases the complexity of managing this system.

Navigating the system

Consideration must be given to how such a complex system should or could be managed, the respective responsibilities of everyone involved, what roles they play in the system and how all of this information is shared.



Personal reflection point 8.iv

Review your 'CPA Care Plan system' from table 1. What methods do you use to communicate with all the people/services in this system? How do you receive information back (do you receive information back?). What role might the service user have in navigating the system for themselves? What role might you play as their co-ordinator in helping them to achieve this? How do you react when agreed actions from the care plan are not achieved or reported upon by those identified as responsible within the plan?

These questions raise important issues for care co-ordinators and the role of the service users as potential active partners in managing the CPA process. In activity 8.i you considered what was important to you in your life and in activity 8.ii replicated the activity for a person for whom you are a care co-ordinator. If these things are important to individuals then they should be included in a comprehensive and meaningful plan of care.

- Watch the following four video extracts. Jot down your reaction to these narratives in relation to whole systems working
- Following each extract, discuss your individual reactions in groups Address any issues for you as CPA care co-ordinators and any implications for your practice?

Service user

- ⊕ Video extract 8.A.i Service user 'Co-ordination of organisations'
- ⊕ Video extract 8.A.iii Practitioner 'Collaboration between NHS and third sector'
- ⊕ Video extract 8.A.iv Carer 'complexity'
- ⊕ Video extract 8.A.v Service user 'you have to work at it'



Reader 8ii

Working across systems

This learning resource emphasises the importance of 'personalisation' and 'recovery' as principles which govern the approach to person centred care co-ordination in the CPA process. It is important to consider how these guiding principles may impact on the actions of care co-ordinators.

Working across systems is a crucial element in challenging inequalities in care provision and managing the points where continuity of care breaks down. The 'Re-focussing the CPA' report identifies examples that present a challenge to collaborative working such as processes to manage the treatment of offenders within the CPA process. Another area where cross agency working under CPA is covered by statutory requirement is the protection of vulnerable people. An excellent e-learning resource for cross-agency working has been developed in Derbyshire (Breaking the Cycle of Abuse) and is available at www.breakingthecycleofabuse.org

Personalisation is the next goal of public service reform² and one potential area of action is the use of financial resources to deliver health and social care. Direct payments and Individual budgets are more widely used in social care, but there is a growing opinion that greater integration with 'health' budgets is required if the goals of service reform for personalisation are to be realised.

At a policy level, there has been increasing attention on the needs of people with long term conditions, which includes people with mental health problems. Individuals in this group constitute a relatively small section of the population but are, by the nature of their conditions, heavy users of the health care system. Chronic diseases such as coronary heart disease, diabetes and mental health problems are estimated to require a quarter of the whole NHS allocation, somewhere in the region of £15 billion.

Proponents of the proposal to put control in the hands of people who use services argue that people with these illnesses make better progress when they understand and manage their own conditions and that they are likely to be more creative in their choices and co-ordination of care across agencies through their active involvement in the process.

There are concerns that the abilities required of service users (negotiation, contracting and other communication skills) to make individual budgets really work for them, may actually reinforce any existing inequalities. This issue remains a topic for lively debate and will certainly need addressing if individual budgets are to realise their potential to transform services for patients and service users.

Clearly there is still much to do if and when this integration is to take place as currently health budgets cannot be paid directly to individuals. For service users in the CPA process the issue of whether services come from a 'health budget' or a 'social care budget' is somewhat meaningless. They consider themselves to be people who have needs and, increasingly, have the capacity to decide how and when these resources are used.

Service users who have this degree of control are in a position to determine through negotiation, the options available. This prompts the need for a different way of thinking and working on the part of health and social care providers and professionals. As a consequence, this situation over time, may have significant impact on the role of care Co-ordinators in mental health.

² Cabinet Office (2007) *Building on Progress: Public Services*. HM Government Policy Review. Cabinet Office Strategy Unit. London

This section of the learning resource will introduce some of these issues and explore the potential impact on the work of care co-ordinators as they begin to work across systems in health, social and independent care provision.



Group Activity 8.iii

Think about someone on your caseload under CPA who could, in theory, have the extension of control for their own health and social care budget: In pairs or small groups consider how things may be different by addressing the following questions:

- What package of care might they seek?
- Would they mix clinical and alternative care therapies?
- What independent, voluntary or private care services might they seek?
- Who might they employ to help them live a more independent life?

This degree of flexibility and these decisions are at the heart of personalisation and personal budgets. CSIP and NIMHE produced a report on choice in mental health³ in which they proposed a framework for increasing choice and promoting recovery through the use of budgets and other mechanisms. However, evidence of a sustained uptake of personalised services in mental health is not robust, clearly there is still much to do.

Personal Budgets

Proposals under the Our Health Our Care Our Say⁴ outlined the reforms necessary to deliver a health and social care system which could respond to the many challenges faced by a changing population with changing expectations. A thrust of the proposals centres on a commitment to the promotion of independent living for all adults. This links to values of co-production and co-delivery of solutions with the aim of independence.

Achievement of these aims will, once again, require a different way of thinking and practice for the workforce. A greater focus will be on the common assessment process across services and the people responsible for care co-ordination and delivery. The emphasis will be on promoting recovery and self-assessment with the workforce providing more support, brokerage and advocacy. These changes, where practitioners may be acting in a 'supportive planning role' rather than that of a co-ordinator, raise fundamental questions about the values, skills and competencies of the workforce.

While there are institutional barriers to joint budgets for health and social care, Lord Darzi in the Next stage review of the NHS⁵ makes it clear that personal budgets for people with long term conditions requires that health and social care resources are shared.

Individual Budgets

A recent pilot programme for individual budgets suggested that 'Individual budgets are a viable alternative way of paying for social care. Instead of local authorities buying services on behalf of an individual, that person is given control of their own budget and can direct how it is spent, allowing

³ CSIP/NIMHE (2006) *Our Choices in Mental Health: A framework for improving choice for people who use mental health services and their carers.*

⁴ Department of Health (2006) *Our Health, Our Care Our Say: A New Direction for Community care Services*

⁵ Department of Health (2008) *High Quality Care For all: The NHS Next Stage review.* Department of Health London



the care package to be tailored to their needs⁶.

The authors of this report suggest that individual budgets are different from direct payments in the degree of flexibility they provide for the service user. In their analysis, direct payments could not be used to provide health care and were more often used to employ personal assistants to help with personal care and daily living skills. Individual budgets support the purchase of a range of community based services and support systems and therefore have a greater utility for people using these approaches.

The individual budgets programme also introduced and reaffirmed the roles of support planning and brokerage within the care delivery system⁷. These are consistent with the values of the 10 Essential Shared Capabilities⁸ and are based on a process of assessment, planning, delivery, monitoring and evaluation as with the CPA process. However, it is important to acknowledge the more active role that service users have in individual budgets with self assessment and self referral as a process of re-enablement / recovery.

Clearly there are subtle issues with more substance than semantics behind the range of budget allocations and how they may be used. What is clear for care co-ordinators in CPA is that there is likely to be a greater emphasis on joint working and very close working between health and social care providers to support people in identifying needs and possible solutions. The changes in role from less co-ordination to one of more active support for self care will require care co-ordinators to keep abreast of these changes and examine the values and skills required to efficiently and effectively deliver them. Figure 8.i. illustrates the relationship between the issues mentioned above and contemporary policies.

⁶ Glendinning et al (2009) *The Individual Budgets Pilot Project: Impact and Outcome for Carers*. Social Policy Research Unit, University of York/ Personal Social Services Research Unit, University of Kent

⁷ Department of Health (2008) *Good Practice in Support Planning and Brokerage: Putting People First, Transforming Adult Social Care*. Department of Health London

⁸ Department of Health (2004) *The Ten Essential Shared Capabilities: A framework for the whole mental health workforce*. Department of Health London

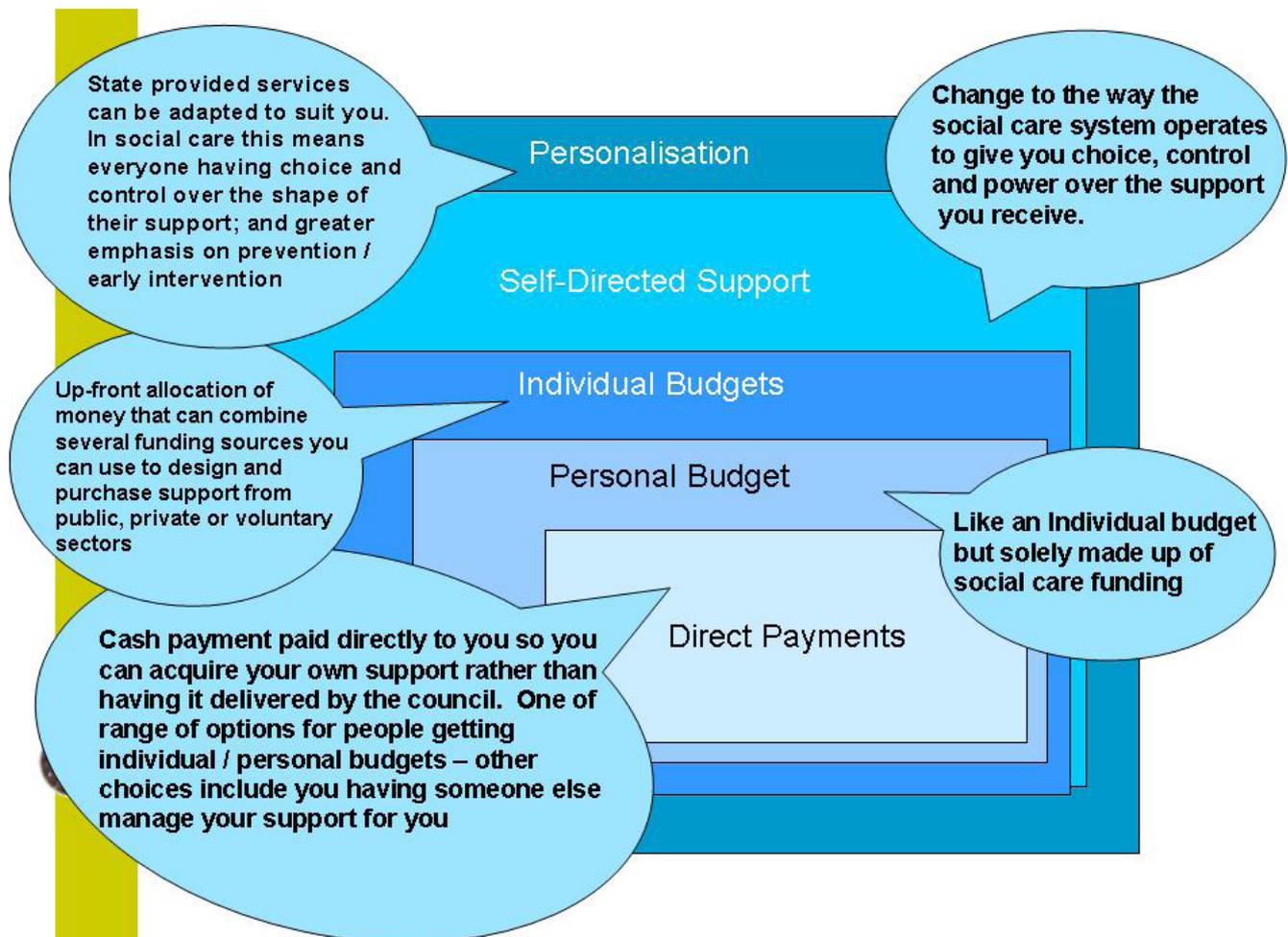


Fig 8.1 relationship between budget support and health and social care

Conclusion

This module has reflected the need for effective partnership working across agencies involved in CPA. In many cases people receiving the support of CPA are involved in a range of services (from a wide support network). Integration of these resources into a coherent plan of care rests with the care co-ordinator.

Successful cross-agency working relies on good communication, negotiation and project management skills to support delivery of clearly stated aims and outcome related objectives. Care co-ordination across agencies means ensuring that information is shared appropriately and that partners work in concert to help achieve service users' goals.



Unit 9: Outcomes, evaluation and review

Summary

This unit of learning identifies the important (and often overlooked) issues related to the systematic evaluation of care in the CPA process. It examines the requirement to review care plans against desired outcomes from planned interventions across the network of services, resources and people. The review of care is addressed as a continuous process rather than a series of one off events.

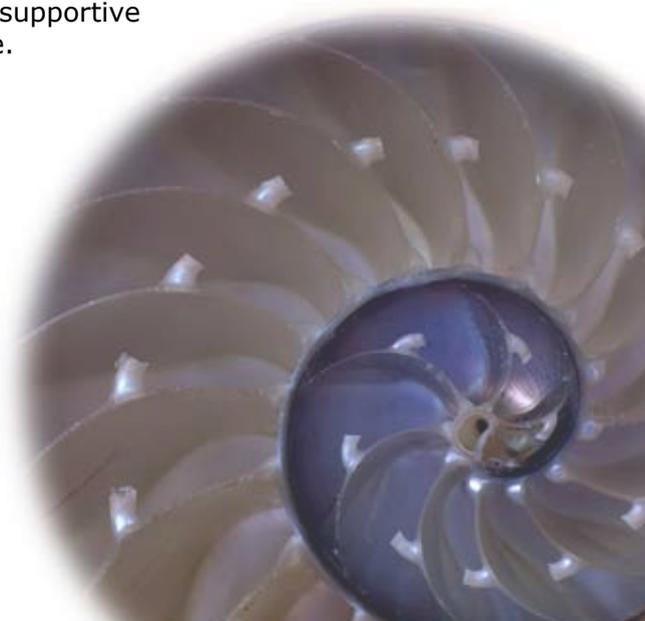
The focus is on the co-operation, monitoring and review of service responses to meet individuals' needs. Service users should experience the review of their care as a partnership process that is designed to encourage their involvement. Concepts of empowerment and participation and how these influence the involvement of individuals and carers in the co-ordination of care will be examined. Issues of efficiency, effectiveness, economy and equity and how these inform and influence the co-ordination of services will also be reviewed. The care co-ordinator's role in reviewing risk at regular intervals will be included.

Learning outcomes

On completion of this unit of learning participants will be able to:

- review the effectiveness of care interventions and renegotiate the goals, strengths and plan if indicated
- organise and co-ordinate timely reviews of care that maximise the engagement of service users and significant others
- review risk management plans regularly as service users' risk levels will change
- monitor, evaluate and explore ways to improve inter agency services for people with mental health needs
- evaluate the respective roles of all those involved in achieving the stated goals of the plan.
- examine ways in which care plan progress can be monitored to ensure that the person is able to access the facilities, resources and interventions.
- keep accurate records of reviews and disseminate as appropriate

The unit will include triggers taken from narratives of service users, carers and practitioners. The triggers will be linked to group discussions and backed up by supportive reading and examples of evidence based and positive practice.





PowerPoint Unit 9: Outcomes, evaluation and review

(Presentation and handout on DVD)



9.i. Group activity (20 mins)

Instructions:

Individuals

1. Reflect on an example of a review meeting that went well
2. Reflect on an example of a review meeting that less well
3. Identify the factors that make a difference

Small groups

4. Compare and contrast these factors and compile a list of principles to inform positive practice in conducting a review meeting.



9.ii. Group activity (20 mins)

- Watch the following five video extracts. Jot down your reaction to these narratives in relation to reviewing care as you watch them.
- Following each extract, discuss your individual reactions in groups
- Address any issues for you as CPA care co-ordinators and any implications for your practice?

- Video extract 9.A.i Service user 'A disappointing experienceto a better one'
- Video extract 9.A.ii practitioner 'control issues'
- Video extract 9.A.iii service user 'not invited'
- Video extract 9.A.iv practitioner 'attendance at meetings'
- Video extract 9.A.v service user 'learning from experience'

Parallel processing

Taking stock of progress at strategic points in time is an important facet of learning programmes. The care co-ordinator and the service user (and carers) allocate time for ongoing and formalised review; to make sense of the journey; to review goals, plans, and interventions; to make appropriate changes to the plan. There is an opportunity here to make connections with the learning context and how effective evaluation and review consolidates learning and points out new directions. It also allows the organisation (in this case the training team) to make constant improvements to the programme.

Evaluation and closure

Summary of aims and content of programme

Reflect on parallel process of review

Preparation for assessment of competencies in practice

Complete evaluation form



Group activity: (10 mins)

A closure activity:

'One thing I take away from this course is:

Feedback

Care co-ordinator learning resource: Participant Evaluation

Dear Colleague,

The purpose of this evaluation is to support the maintenance of quality and standards of the CPA care co-ordinator programme. Please help us by completing this short questionnaire on your experience of the programme that you have just completed.

Section 1 – About You.

Please respond to each question by ticking the most appropriate box.

1. Work background

Nursing	Medical	Social work	OT	Management	Other
<input type="checkbox"/>					

1 A. Name of employer organisation (please write in block capitals)

2. If you are taking part in the programme as part of your job, what is the main activity of your organization?

Statutory sector (NHS, local authority, etc)

Charity/Voluntary sector

Social Enterprise

For profit organization

Self employed

Independent applicant

Other (please state below)

<input type="checkbox"/>

3. Please indicate your age group:

<input type="checkbox"/>					
18-25	26-35	36-45	46-55	56-65	66+

4. Please indicate your gender:

Male

Female

5. Have you completed any CPA Training previously?

Yes

No

6. If you answered YES to question 6, when did you complete the last episode of CPA training?

--	--	--	--	--

In last year 1-2 years ago 3-5 years ago 6-10 years ago 10 + years ago

7. How many years experience do you have as a care co-ordinator?

--	--	--	--	--	--

None Less than 1 year 1-3 years 4-6 years 7-10 years 11 years

Section 2: About the CPA care co-ordinator programme

On a scale of 1 to 5 (where 1 is poor and 5 is excellent), how would you rate the following (please circle):

8. Venue

--	--	--	--	--

1 2 3 4 5

9. Programme structure

--	--	--	--	--

1 2 3 4 5

10. Content

--	--	--	--	--

1 2 3 4 5

11. Learning methods

--	--	--	--	--

1 2 3 4 5



12. The trainers

1	2	3	4	5

13. Overall impression of the programme

1	2	3	4	5

Section 3: Comments: It would help with the development of the programme if you could identify strengths and areas that need attention. Constructive suggestions for improvements are welcomed

(Continue on blank sheet if required)

Thank you. Please return the completed evaluation form to the trainer.

Reading and links

Care Programme Approach Association (CPAA) 2008 *The CPA and care standards handbook 3rd Ed* . CPAA Chesterfield. www.cpaa.co.uk

Coulter, A., Parsons, S. and Janet Askham, J. 2008 *Where are the patients in decision making about their own care?* Picker Institute/World Health Organisation. Copenhagen Denmark

CSIP 2006 *Our choices in mental health: a framework for improving choice for people who use mental health services and their carers.*

CSIP/NIMHE 2006 *10 high impact changes for mental health services.*

CSIP 2007 *A positive outlook: A good practice toolkit to improve discharge from inpatient mental health care* http://changeagentteam.org.uk/_library/A%20Positive%20Outlook.pdf

CSIP / NIMHE 2008 *3 keys to a shared approach in mental health assessment*

Department for work and pensions 2008 *Mental health and employment. Research report no 513 HMSO.* Norwich

Department of Health 2001 *Shifting the balance of power within the NHS: Securing delivery.* London

Department of Health 2004 *The Ten Essential Shared Capabilities - A framework for the whole mental health workforce* NIMHE/Department of Health London

Department of Health 2005 *Building bridges: A guide to arrangements for interagency working for the care of severely mentally ill people.* London

Department of Health 2005 *Delivering race equality in mental health care: An action plan for reform inside and outside services and the Government's response to the independent inquiry into the death of David Bennett.* London

Department of Health 2006 *CNO Review of Mental Health Nursing 'from values to action'* . London

Department of Health 2006 *Direct payments for people with mental health problems: A guide to action.* London

Department of Health 2006 *Our Health, Our Care, Our Say – a new direction for community services.* London

Department of Health 2007 *Best practice in managing risk: Principles and evidence for best practice in the assessment and management of risk to self and others in Mental Health Services.* <http://www.nimhe.csip.org.uk/risk>

Department of Health 2007 *Capabilities for inclusive practice.* London

Department of Health 2007 *Getting through: Access to mental health services for people who are homeless or living in temporary or insecure accommodation.* London

Department of Health 2007 *Human rights in healthcare – a framework for local action.* London

Department of Health 2007 *Independence, choice and risk: A guide to best practice in supported decision making.* London

Department of Health 2007 *Mental Health: New ways of working for everyone. Developing and maintaining a capable and flexible workforce.* London

Department of Health 2007 *New ways of working. Creating capable teams (CCTA): best practice guidance to support the implementation of New Ways of Working (NWW) and new roles.* London

Department of Health 2007 Putting people first: a shared vision and commitment to the transformation of adult social care. London

Department of Health 2008 Common Core Principles to Support Self Care: a guide to support implementation. Department of Health, Skills for Health, Skills for Care London

Department of Health 2008 High quality for all. Next stage review final report. Lord Darzi

Department of Health 2008 Making the CPA work for you. Booklet and DVD for service users and carers. available from DH

Department of Health 2008 Refocusing the Care Programme Approach: Policy and positive practice guidance. London www.dh.gov.uk/publications

Department of Health 2009 Common assessment framework for adults: A consultation on proposals to improve information sharing around multi-disciplinary assessment and care planning.

Jackson C & Hill K 2006 Mental health today. A handbook pp. 45-55. Pavillion Pub. Brighton

Morgan S, Wetherell A & Wetherell R 2009 The art of co-ordinating care: A handbook of best practice for everyone in care and support. OLM-Pavilion. Brighton

NHS Confederation 2008 Implementing national policy on violence and abuse. A slow but essential journey. June. Issue 162 www.nhsconfed.org/publications

NIMHE/CSIP 2006 Creating and inspiring hope: Integrating recovery values and principles into every day practice. A 2 day training programme for the mental health workforce. Available from CCAWI – www.lincoln.ac.uk/ccawi

Office of the Deputy Prime Minister 2004 Mental health and social exclusion: Social exclusion report.

Partners in care 2004 Carers and confidentiality in mental health. www.partnersincare.co.uk

Richards, N. & Coulter, A. (2008) Is the NHS becoming more patient-centred? Trends from the national surveys of NHS patients in England 2002-07 Picker Institute. Oxford

Ryan T 2006 Risk management in mental health: people, perceptions and places. IN Jackson C & Hill K Mental health today. A handbook pp. 45-55. Pavillion Pub. Brighton

Seedhouse, D. 2005 Values Based Decision Making for the caring Professions. Wiley. London

Shepherd G, Boardman J & Slade M 2008 Making recovery a reality. Sainsbury Centre for Mental Health.

Social Care Institute for Excellence (SCIE) 2008 Personalisation: A rough guide. www.scie.org.uk

Thorncroft, G. 2006 Shunned: Discrimination against people with mental illness. Oxford: Oxford University Press

Positive practice links

CPAA website at www.cpaa.co.uk

www.nimhe.csip.org.uk/cpapp



Appendices



Appendix I: The competences of a care co-ordinator

The competences of a care co-ordinator were published in 2007¹ and mapped to National Occupational Standards and the Knowledge and Skills framework. They are organised into the following sections:

1. Comprehensive needs assessment
2. Risk assessment and management
3. Crisis planning and management
4. Assessing and responding to carers' needs
5. Care planning and review
6. Transfer of care or discharge

¹ DH 2008 *Care Programme Approach: Care Co-ordination, core functions and competencies*

Functional Map Functional Statements (Tables 1-6)

Table 1

FUNCTION CPA 1 - COMPREHENSIVE NEEDS ASSESSMENT	
<p>Functional statements</p> <p>CPA 1.1 Clarify your role within the assessment process</p> <p>CPA 1.2 Involve the person and significant others in assessment process</p> <p>CPA 1.3 Arrange advocacy for people who are unable to represent their own interests.</p> <p>CPA 1.4 Carry out an assessment of physical, emotional and psychological needs</p> <p>CPA 1.5 Assess any immediate risk to the person or to others.</p> <p>CPA 1.6 Consult with, and refer to specialist advice and assessment if appropriate.</p> <p>CPA 1.7 With person and significant others, identify and agree actions and interventions.</p> <p>CPA 1.8 Review assessment process and next steps with participants.</p> <p>CPA 1.9 Record and provide information in line with legal and organizational requirements</p>	<p><i>associated</i> National Occupational Standards</p> <p>HSC417 (NHS KSF HWB4 - 4)</p> <p>MH14 (NHS KSF HWB2 - 2)</p> <p>MH18 (NHS KSF HWB2 - 2)</p> <p>MH25 (NHS KSF HWB2 - 3)</p>

KEY: HSC = Health & Social Care NOS; MH = Mental Health NOS; NHS KSF = NHS Knowledge & Skills Framework)

KEY: HSC = Health & Social Care NOS; MH = Mental Health NOS; NHS KSF = NHS Knowledge & Skills Framework)

Table 2

FUNCTION	
CPA 2 - RISK ASSESSMENT AND MANAGEMENT	
<p>Functional statements</p> <p>In consultation with people, family/carers, and individuals and agencies involved in their care,</p> <p>CPA 2.1 Support and encourage individuals to participate in the assessment, actions, processes, procedures and practices for dealing with the risk of danger, harm and abuse.</p> <p>CPA 2.3 Assess and record the potential impact of harm, failure to protect and harm to self and others according to degree, likelihood and effect on individuals.</p> <p>CPA 2.4 Prioritize identified needs and level of risk.</p> <p>CPA 2.5 Arrange specialist assessments where required.</p> <p>CPA 2.6 Consider and appraise the strengths and weaknesses of options to manage risk.</p> <p>CPA 2.7 Consider presenting issues and risk management options and communicate to those who need to receive them.</p> <p>CPA 2.8 Acknowledge and record any disagreement concerning the source and level of risk.</p> <p>CPA 2.9 Negotiate and agree a plan to manage risk. Identify and record instances where preferred options for action are not consistent with organizational priorities.</p> <p>CPA 2.10 Share the risk management plan with the person, family / carers, and people/agencies involved in their care, as appropriate.</p> <p>CPA 2.11 Take action to protect individuals considered to be in immediate danger.</p> <p>CPA 2.12 Agree your role and responsibilities and those of others in</p>	<p><i>associated</i> National Occupational Standards</p> <p>HSC450 (NHS KSF HWB2 - 3)</p> <p>MH16 (NHS KSF HWB2 - 4)</p> <p>MH17 (NHS KSF HWB2 - 4)</p>

KEY: HSC = Health & Social Care NOS; MH = Mental Health NOS; NHS KSF = NHS Knowledge & Skills Framework)

Table 3

FUNCTION	
CPA 3 - CRISIS PLANNING AND MANAGEMENT	
<p>Functional statements</p> <p>CPA 3.1 Assess the risk of crisis situations occurring with individuals, families and carers.</p> <p>CPA 3.2 Negotiate agreement to the risk management strategies with the individuals, carers, families, service providers, other agencies and practitioners</p> <p>CPA 3.3 Negotiate agreement on the information which will need to be shared, and with whom, in accordance with agency and legislative requirements.</p> <p>CPA 3.4 Ensure that the agreed actions are implemented as promptly as possible in accordance with the assessed urgency of the need</p> <p>CPA 3.5 Review the outcomes of actions taken to address immediate needs.</p> <p>CPA 3.6 Ensure that the results of the review are communicated clearly to all those who need to receive them.</p>	<p><i>associated</i> National Occupational Standards</p> <p>MH13 (NHS KSF HWB3 - 3)</p> <p>MH21 (NHS KSF HWB3 - 3)</p>

KEY: HSC = Health & Social Care NOS; MH = Mental Health NOS; NHS KSF = NHS Knowledge & Skills Framework)

Table 4

FUNCTION	
CPA 4 - ASSESSING & RESPONDING TO CARERS' NEEDS	
Functional statements	<i>associated</i> National Occupational Standards
CPA 4.1 Develop relationships with carers that recognizes their role and expertise and enables them to communicate their needs and preferences.	HSC387 (NHS KSF HWB4 - 3)
CPA 4.2 Provide information about the carers' rights to have their needs assessed and the procedures for this.	MH6 (NHS KSF HWB2 - 3)
CPA 4.3 Assess carer's needs in line with legislation and organizational policy.	MH7 (NHS KSF HWB2 - 3)
CPA 4.4 Provide accessible information about resources, services, facilities and support groups that are available and appropriate to the carers.	MH9 (NHS KSF HWB4 - 3)
CPA 4.5 Identify what support will be needed by carers to enable them to meet their own needs and preferences.	
CPA 4.6 Identify any risks to carers and individuals and how these should be managed.	
CPA 4.7 Identify how carers' access to resources, services, facilities and support groups will be reviewed, when this will happen and who will be involved.	
CPA 4.8 Take appropriate action to challenge discriminatory information and practice.	
CPA 4.9 Record and report on actions, processes and outcomes in line with organizational policy.	

KEY: HSC = Health & Social Care NOS; MH = Mental Health NOS; NHS KSF = NHS Knowledge & Skills Framework)

Table 5

FUNCTION	
CPA 5 - CARE PLANNING AND REVIEW	
Functional statements	<i>associated</i> National Occupational Standards
CPA 5.1 Encourage individuals and their significant others to take a full and active part in the care planning and review process, consistent with the individual's wishes.	MH19 (NHS KSF HWB2 - 3)
CPA 5.2 Clarify how information will be shared.	MH23 (NHS KSF HWB7 - 2)
CPA 5.3 Encourage and support individuals and significant others to consider what recovery means to them, and what will enable them to recover.	MH24 (NHS KSF HWB7 - 2)
CPA 5.4 Identify and take account of the views of other service providers, agencies and practitioners who are in a position to contribute to the person's care planning.	
CPA 5.5 Help individuals who are unable to exercise their rights to make decisions for themselves.	
CPA 5.6 With the person and significant others, discuss options and agree a care /recovery plan.	
CPA 5.7 Agree the role of the person and significant others in achieving the aims and goals of the plan.	
CPA 5.8 Establish with the person and significant others how the aims and goals of the person's care/recovery plan will be reviewed.	
CPA 5.9 Monitor progress to ensure that the person is able to access the facilities, resources, and interventions agreed within the care/recovery plan. Take action where this is not achieved.	
CPA 5.10 With the person and significant others, review the care/recovery plan.	
CPA 5.11 Record and share as agreed the planning and review process	

KEY: HSC = Health & Social Care NOS; MH = Mental Health NOS; NHS KSF = NHS Knowledge & Skills Framework)

Table 6

FUNCTION	
CPA 6. TRANSFER OR DISCHARGE	
<p>Functional statements</p> <p>CPA 6.1 Discuss with the person, and family/carers as appropriate, the options for transfer of care or discharge. Agree with the person and family/carers the goals for transfer of care or discharge.</p> <p>CPA 6.2 Agree a transfer/discharge plan, including the support needs of the person upon transfer/discharge.</p> <p>CPA 6.3 Agree with the person, family/carers and services involved the transfer/discharge arrangements. Implement transfer of care or discharge.</p> <p>CPA 6.4 Monitor and review the effectiveness of the transfer/discharge arrangements.</p> <p>CPA 6.5 Record and share transfer/discharge records in line with legal and organizational requirements.</p>	<p><i>associated</i> National Occupational Standards</p> <p>CM13 (NHS KSF HWB2 - 3)</p> <p>MH83 (NHS KSF HWB4 - 3)</p>

(KEY: HSC = Health & Social Care NOS; MH = Mental Health NOS; CM = Case Management NOS; NHS KSF = NHS Knowledge & Skills Framework)

Appendix 2: Care co-ordinator learning resource - Trainers' Evaluation

CPA Care Co-ordinator programme

Date(s) of programme:	
Location	

Trainers

Name of trainers	Background, e.g. service user, academic, carer, NHS trainer, Local Authority etc

Total number of participants:

Please indicate below the **TOTAL** responses of the participants for each question

Section 1

1. Work background

Background	nursing	medical	social work	OT		other
Total responses						

2. Activity of organisation

Organisation	NHS	Local Authority	Charity / voluntary	For profit	Social	other
Total responses						

3. Age group

Rating	18-25	26-35	36-45	46-55	56-65	66+
Total responses						

4. Gender

Gender	male	female
Total responses		

5. Previous CPA training:

Training	yes	no
Total responses		

6. If yes to 5, how long ago?

Years	Last year	1-2	3-5	6-10	11+
Total responses					

7. Years experience as care co-ordinator

Years	none	less than 1	1-3	4-6	7-10	10+
Total responses						

Section 2. About the CPA Co-ordinator programme

8. Venue

Rating	1	2	3	4	5
Total responses					

9. Programme structure

Rating	1	2	3	4	5
Total responses					

10. Content

Rating	1	2	3	4	5
Total responses					

11. Learning methods

Rating	1	2	3	4	5
Total responses					

12. Trainers

Rating	1	2	3	4	5
Total responses					

13. Overall impression

Rating	1	2	3	4	5
Total responses					

Section 3 - Comments. Please include a brief summary of themes of the comments made by participants. It would help if they were prioritized according to number of occurrences:



Trainers' comments - please include your comments as trainers in respect of the learning resource content, learning structures, flexibility and general usefulness. Also include suggestions for improvements:

Thank you for completing this evaluation. You can download this form electronically from the CCAWI website (www.lincoln.ac.uk/ccawi/cpa.htm) and return it by e-mail to cpa@lincoln.ac.uk

If returning by post, send to: CPA evaluation, CCAWI, University of Lincoln, 3rd floor, MHT Building, Brayford campus, Lincoln LN6 7TS

Appendix 3 - Glossary

Advance Directives. (may also be called advance decision, advance statement or advance wishes) is completed by the service user, sometimes with help from his or her carer, advocate and/or mental health professionals. It sets out how they would like to be supported and cared for if they become too unwell to speak for themselves

Advocacy. Advocacy services provide information and support to allow people who use services and their carers, family and friends to speak up for themselves and exercise their rights by representing their views and preferences. Advocates are usually professionals, rather than carers or relatives of people who use services. They are, or may have been, service users themselves

Brokerage Role. For a detailed outline of the brokerage role, the following document from Skills for Care is useful. <http://www.dhcarenetworks.org.uk/Personalisation/PersonalisationResources/Type/Resource/?cid=5390>

Care Manager. There are great similarities between a Care Manager in Social Care and Care Co-ordinator on health services. In fact there are many more similarities than differences. Both roles rely on an assessment of need and care planning to achieve agreed outcomes. The principle difference lies in the care manager's responsibility for financial costing of care packages and contracting for service delivery

Carer. Carers support people who use mental health services. They may be their partners, parents, children or other family members. They may also be friends. They care for people who use services on an ongoing basis, giving their time freely. Where someone is identified as a carer by the person using the services or by people providing services, they are legally entitled to be told of their right to a carer's assessment even if the person they care for refuses to engage with services themselves.

Common Assessment Framework (CAF) The term Common Assessment Framework (CAF) is used to describe assessment systems in adult health and social care and in children's services.

Direct Payments. These were introduced in the Community Care Act 1996. They are cash payments to service users/and or their carers to support them in choosing their own care package. Direct payments are based on a detailed social care assessment and are aimed at promoting choice in the receipt of services. A person receiving a direct payment is able to purchase local authority care, or receive care from an independent, voluntary or private provider. This approach is aimed at supporting the development of a real 'market place' in care provision. Currently in mental health, this market has not materialised, possibly due to the lack of sufficient numbers of people with access to direct payments.

Dual Diagnosis. The term dual diagnosis is used in the document to mean a dual diagnosis of mental health and drug and alcohol misuse problems unless otherwise specified.

Homeless or Unsettled Accommodation. The reference to homeless people in this guidance refers to people not in settled accommodation, this includes: rough sleepers; people living in insecure accommodation e.g. hostels, night shelters, squats, or living with friends or in bed and breakfast accommodation; and individuals or families living in temporary accommodation who are owed the homelessness duty.

Individual Budgets

A clear up front allocation of money that can combine several funding sources that you can use to design and purchase support from the public, independent or voluntary sectors.

Lead professional The term lead professional is used in this document in its ordinary sense, i.e.

the professional who has lead responsibility for an individual's treatment and care.

Person- Centred Care The key principles of person-centred care are:

- it is a continuous process not a product;
- it is a dynamic process of discussion, negotiation, decision making and review that takes place between the individual and the professional – who have an equal partnership;
- the process should be led by the individual with them at the centre, based upon their strengths, goals, aspirations and lifestyle wishes;
- the person should be encouraged to have an active role in their care, be offered options to allow informed choices, and empowered to make their own decisions with adequate information or signposting – all within a framework of managed risk;
- self care and self management is an essential element of good care/support and should always be supported.

Recovery is a concept that has been introduced primarily by people who have recovered from mental health experiences and has grown considerably around the developed world. Now many people are talking about and using the word 'recovery'. However, in England, people have differing views of what recovery means, whilst the word is being included in common usage in mental health services, a clear understanding of what this means remains limited. NIMHE has produced a brief statement on the emerging view of mental health recovery to contribute to the development of recovery-oriented services nationwide.

Section 117 is a section of the Mental Health Act 1983 that places duty on health and social care to provide aftercare for people admitted under sections 3, 37, 45a, 47 and 48 of the Act

Social Inclusion Social inclusion can be defined as people having the same opportunities to participate in, and contribute to, society and community as the rest of the population. This includes improving access to health and social care services but also to community services to enable people to participate. It involves increasing options and empowering people to have confidence in their own abilities and aspirations. Key areas are education, employment, housing, family and relationships, financial security, leisure, arts, cultural and religious opportunities and participation in civic life.

Statement of Wishes Statements of wishes and preferences, including written statements, are those that are non-binding but which have to be taken into account by those making best interests decisions on a person's behalf at a time when the person lacks capacity having been made when they had capacity.

Support Planning Role

As people begin to develop greater skill in self assessment, the role of the co-ordinator changes to one which is a support planning role. The co-ordinator may be more active in helping the individual navigate their way through the range of possible care and service options available to them. In addition, the co-ordinator may be active in liaison with people who are acting as care brokers

Unsettled Accommodation The reference to people in unsettled accommodation includes: rough sleepers and people living in insecure accommodation e.g. hostels, night shelters, squats, or living with friends or in bed and breakfast accommodation; and individuals or families living in temporary accommodation who are owed the main homelessness duty.

Young Carer Around 3 million children in the UK have a family member with a disability. Not all take on a caring role that is inappropriate to their age. Few parents want their children to be carers but it can happen for many reasons, such as families being isolated, afraid of outside interference or lack of other support.



Appendix 4: Request Form for DVD to support the Trainer’s Manual

(an online version of this form is available at : www.lincoln.ac.uk/ccawi/CPA.htm)

The DVD that supports the trainer’s manual consists of a library of narratives of service users, carers and practitioners on their experiences in relation to the CPA.

A single DVD will be forwarded by return to Trainers who will be delivering the care co-ordinator programme i.e. NOT for each participant on the programme. You will need external speakers if playing the DVD on a PC (inbuilt speakers are NOT loud enough).

The manual indicates suggestions that are classified thematically to correspond with respective topics in the manual. Trainers are free to use as few or as many as they wish according to the context and length of training.

Named individual:.....

Organisation:

Address to send the CPA DVD:

.....
.....
.....
.....

PLEASE NOTE: the individuals who agreed to be filmed for this resource gave their written consent on the understanding that the DVD will ONLY be used for educational purposes within the context of the CPA learning resource. Please manage this resource sensitively and ensure that trainers only use it for this purpose.

RETURN FORM TO:

CPA DVD request
CCAWI
University of Lincoln
3rd Floor, MHT Building
Brayford Pool
Lincoln
LN6 7TS