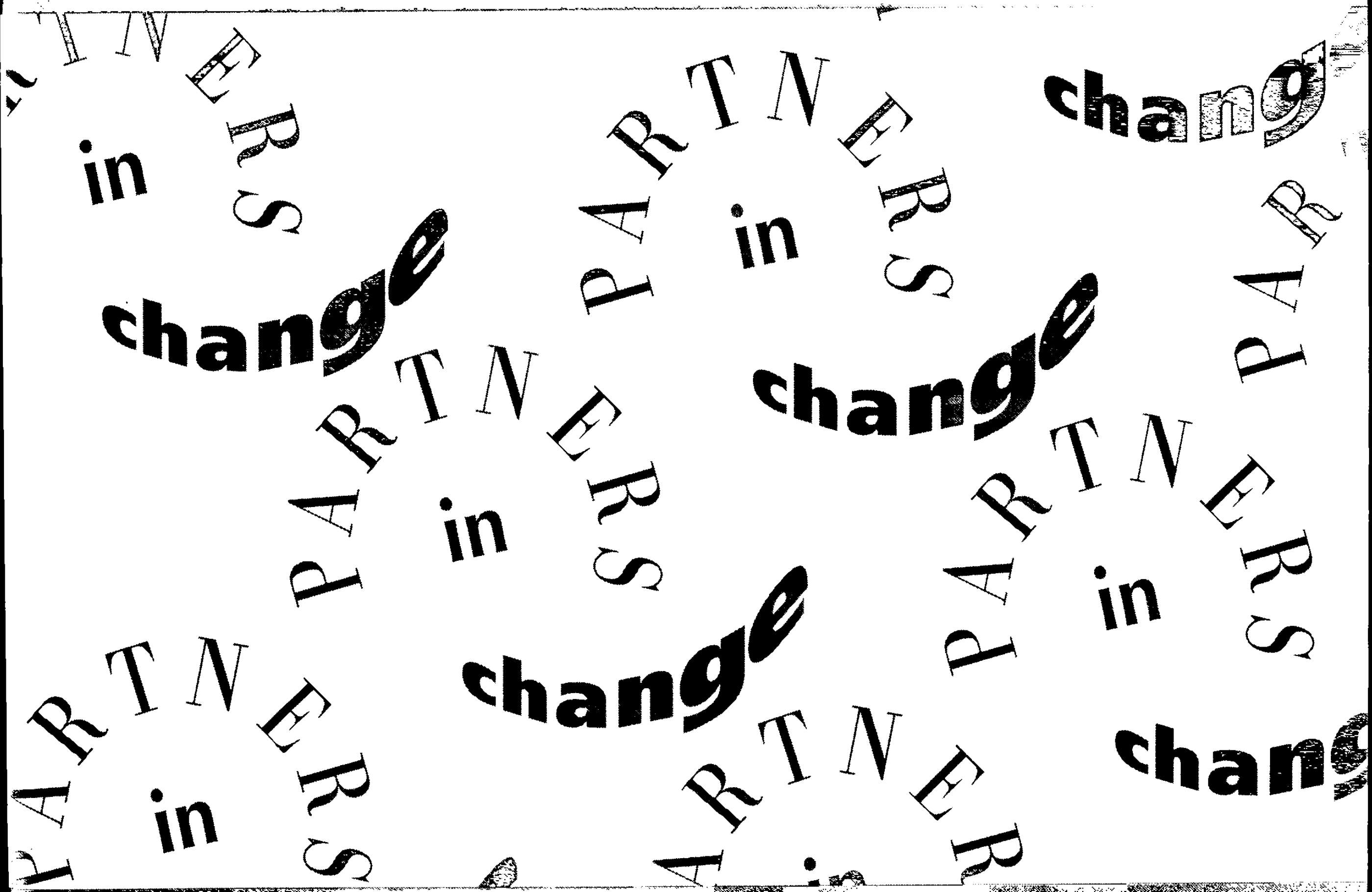
PARTNERS IN CHANGE

CARE PLANNING IN MENTAL HEALTH SERVICES



Rose Echlin
with additional material from Judith Buck

Better Futures

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KING's FUND CENTRE

Better Futures

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The King's Fund Centre is a service development agency which promotes improvements in health and social care. We do this by working with people in health and social services, in voluntary agencies, and with the users of these services. We encourage people to try out new ideas, provide financial or practical support to new developments, and enable experiences to be shared through workshops, conferences, information services and publications. Our aim is to ensure that good developments in health and social care are widely taken up. The King's Fund Centre is part of the King's Fund.

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Preface

Better Futures was a two-year project which focused on improving the quality of life of people with serious and long-term mental health problems. During the period 1992-4, the King's Fund Centre funded a programme of development work in five localities in England and Wales – Clwyd, Leeds, Salford, Swindon and Tower Hamlets. Working in partnership with service users, carers, statutory and voluntary agencies, each locality developed its own programme of work based on local need, context and service provision. The project has produced a variety of ongoing service developments.

The major areas of work were:

- service user participation – helping service users to speak for themselves;
- individual care planning – helping professionals to identify and apply good practice;
- needs-led services – using small grants to set up individualised services, such as a community artist post, and a work introduction scheme;
- planning a community mental health service. In one locality, the work involved the reprovision of acute services from the local psychiatric hospital and the development of a pilot local mental health service.

The ideas in this booklet come mainly from reports on the action learning programmes carried out during 1993-4 in three of the project localities – Clwyd, Leeds and Swindon – which focused on assessment and care planning for individual service users, and from discussions of a working group which met at the King's Fund Centre during 1994. The members of the working group were Thurstine Basset, Jim Brooks, Judith Buck, Rose Echlin, Sara Hammond-Rowley, Veronica Hilton and Barry Wood. The initial reports were written by Thurstine Basset (Swindon), Roger Blunden (Clwyd) and Judith Buck and Rose Echlin (Leeds).

Names and identifying details of both service users and workers in our examples have been changed to protect individual privacy. As far as possible, all the material has been checked out with the people concerned.

Partners in Change will be of primary interest to mental health workers in health and social services and their managers. These will include workers in acute and long-term community mental health teams as well as in day and residential services in both statutory and voluntary sectors. Our work will also be of interest to primary care staff who provide continuing care to mental health service users. We have also attempted to draw out the implications of good care planning for health and social services commissioners.

Acknowledgements

Thanks are particularly due to:

- the service users who contributed their time and experiences to this work. Without them, *Partners in Change* could not have happened;
- the members of the action learning groups in Clwyd, Leeds and Swindon who made time for the work in their already hectic schedules and contributed their ideas, experiences and written material to this booklet;
- Thurstine Basset, Jim Brooks, Judith Buck, Sara Hammond-Rowley, Veronica Hilton, and Barry Wood who took part in a working group which met at the King's Fund Centre during 1994 and drew together the lessons from the three local projects;
- Margaret Hirst, Joan Tugwell and Andrew Wilcox-Jones who contributed some of the written material;
- Janet Hadley who edited the original manuscript.

Chapter 1

Beyond the rhetoric

The lives of many people who have serious and enduring mental health problems can be dominated by dull routine, isolation and hopelessness. For most, there are few opportunities for exercising the choice and control which could lead to real improvements in their quality of life. Changes in this situation can be brought about by professionals supporting service users to achieve the goals that they themselves identify as being important for a better life.

Partnerships with professionals and service users working together to bring about change in people's lives can evolve in the process of individual needs assessment and care planning. Better Futures projects have explored the nature of effective partnerships and have demonstrated how people's lives can be changed for the better. They have done so against a background of considerable change and confusion within the community care system.

The Care Programme Approach (CPA) and Care Management have been introduced, if not fully applied, in the health service and local authorities. Recently, supervision registers have made their appearance. There is a real danger that the pace and scale of change in organisations may lead purchasers and providers to get distracted from the task of improving services. Much of the guidance and literature on care planning and management is theoretical; there is a lot of exhortation to 'do the right thing' but very little about the practical difficulties faced by both users and professionals. As a result, professionals often find themselves working in isolation, with working days dominated by paperwork rather than helping people's lives improve.

In *Partners in Change*, we share our experience of going beyond the rhetoric, to deliver what users want. We hope that this booklet will:

- help professionals to reflect on their practice and consider new approaches;
- give health and social service commissioners the confidence to question providers about how they deliver services;
- encourage partnerships with service users who often struggle to maintain a precarious existence in the community and deserve better;
- make the voice of direct experience listened to in all parts of the mental health system.

Creating choices

The ideas presented here are drawn from three action-learning programmes established in Clwyd, Leeds and Swindon as part of the King's Fund Better Futures project. These programmes focused on improving quality of life for individual service users, defined in their own terms. Having clear aims enabled us to maintain our focus and prevented us from being knocked off course by the organisational and managerial changes happening all round us. The work covered many of the features of good care programming and care management, including staying in touch, identifying and solving problems, creating choices for people and involving workers in other parts of a service or other agencies.

Although the work in each project area varied in response to local needs and concerns, the three programmes shared the following common aims:

- to enable staff to get to know individual recipients of services as *people* rather than cases;
- to explore in detail their current use of services and existing networks of support;
- to plan ways with the person of improving their quality of life.

All three project areas were in different stages of transition from institutional to community-based services, and each set itself additional goals which included:

- to provide a focus for thinking about the needs of people with serious and long-term difficulties during the transition period;
- to help staff from different agencies and professions understand each other's work and how this links together in a community service;
- to support and learn from each other in carrying out the work;
- to draw out the implications of the work for practice, management and organisation, in order to influence how local mental health services are developed.

In each locality, an action learning group was set up, consisting of professionals from health and social services and the voluntary sector. There were some local variations in membership. In Leeds, two service user consultants joined the group and, in Swindon, a carer consultant took part. The Clwyd group included managers who joined in order to ease the application of lessons learnt from the project work to service development. Each professional participant agreed to work with at least one client, usually someone with whom they were already working, over a twelve-month period.

Why action learning?

There were a number of reasons for establishing action learning groups, including:

- the core values of the project - i.e. the uniqueness of the individual and the need to develop options and choice – could be put into practice through the action learning process;
- professionals from different agencies could enrich their practice and understanding through sharing ideas and information;
- the three projects could provide information about how to develop needs assessment and user-led services. This information would complement existing material on models and content of care management and care programmes.

The action learning process

The action learning groups organised their work along similar lines. Each met regularly over a twelve-month period to review progress and plan the next stage of their work. Between meetings, the members worked with service users on specific tasks and prepared to report back at the next meeting. King's Fund Centre development staff and an independent consultant facilitated these regular meetings.

The basic structure of the work followed this pattern:

- getting the involvement of one or more service users;
- getting to know the person;
- drawing up a personal profile which included strengths and interests as well as needs and wants;
- planning with individual users to achieve what they wanted;
- reviewing action and current and potential service possibilities.

While involved in the work with individual users, the action learning groups also looked at imaginative solutions to meeting need, such as combining service responses with mainstream services open to everyone and working with volunteers and befrienders.

Chapter 2

The policy background

Better Futures was a short-term project, and therefore its action learning programmes were not specifically linked to the local development of the care programme approach (CPA) and care management. The issues raised by CPA and care management, however, provided the background to the Better Futures project as it got under way in 1992. CPA and care management are continuing to evolve and implementation is still not complete in all the localities.

Influences on CPA and care management

The ideas underlying CPA and care management have been around for a long time. Statutory aftercare was first introduced under the Mental Health Act 1983 for people on specific sections, but implementing it, without properly developed community services, always proved difficult. 'Case management' (as 'care management' was previously known) was a feature of the 'Care in the Community' pilot projects funded by the DHSS for people resettled from long-stay institutions. These were evaluated and publicised by the Personal Social Services Research Unit at the University of Kent.[1]

In 1989, Research and Development for Psychiatry (now the Sainsbury Centre for Mental Health) instituted a series of case management projects for people with long-term mental health needs, and evaluation has shown that it can make a positive contribution to people's lives.[2]

Other influences have been the wealth of research literature on case management in mental health coming from the USA, particularly the studies of assertive outreach schemes such as the well-known service in Madison, Wisconsin[3] and its replication in England, at the Maudsley Hospital, London.[4]

Case management was eventually renamed 'care management', not only to reflect the preferences of service users, but also to signal that it has elements of community and service development as well as individual casework.

Care management in the 1990s

Care management was introduced as a local authority duty for all priority service client groups under the NHS and Community Care Act 1990. Implementation was delayed until 1992 to give local authorities more time to prepare. CPA was originally introduced in 1991 for people leaving psychiatric wards and was subsequently extended to cover everyone referred to the specialist psychiatric services. This has led to confusion about who CPA is for and whether everyone needs the same detailed assessment. Links with local authority care management systems have not been particularly clear.

Split services

A care programme includes a social needs assessment if this is relevant, so it would make sense to have a single person responsible for coordinating provision across health and social services. In many places, the staggered start date has allowed health and social services to set up *separate* systems, with the result that an individual may have a keyworker for CPA *and* a care manager. However, where CPA and care management form a single system, it is more common for the NHS to take the leading role, involving social services where necessary. There are similar problems of responsibilities split between agencies in child protection services, and the loose links between health and social services have meant that lessons for mental health services have not been learnt.

Splits in a system which is supposed to deliver coordination and continuity of care undermine CPA in a number of ways. Our work showed the need for both the good relationship and the direct care-giving associated with CPA. It also highlighted the importance of linking with key people in a person's life and with main service areas (e.g. housing), smoothing pathways into leisure and work opportunities and, in some cases, creating new services. The latter activities are more typical of care management. In Wales, interestingly, CPA does not apply because it is felt to be implicit in the role of care coordinator as described in the All-Wales Mental Illness Strategy.

Politics of costs and public concern

The introduction of care management was partly a response to political concern about rising levels of public expenditure as health services transferred the costs of caring for people leaving hospitals to the social security budget. Local authorities must now assess people for community care within limits of a specific social security budget.

Public concern about the perceived dangerousness of people with a severe mental illness also shaped CPA policy. The need for planned follow-up for people leaving psychiatric hospital was first mooted in the Spokes Inquiry (1988) into the killing of social worker Isabel Schwartz. Concern was further heightened by the case of Ben Silcock, the young man who climbed into the lions enclosure at London Zoo and was badly mauled. The Ritchie Inquiry (1994) into the death of Jonathan Zito also highlighted the ease with which people can slip through the net on discharge from hospital. Government response has been to strengthen the protective aspects of CPA through the introduction of a supervised discharge order and supervision registers. One result is that the debate about community care for people in long-term contact with mental health services is being conducted increasingly within a framework of restrictions, rather than improving quality of life and opportunity.

Efficiency and protection of individuals and the community are good objectives as part of a package of aims, but they may amount to fewer options for individuals. More money may go into protection (i.e. keeping people in hospital) than into improving the quality of life of people living in the community. The House of Commons Select Committee (1994) has highlighted inadequate funding of community mental health services in inner cities.

Keeping quality in our sights

The policy initiatives of CPA and care management have therefore had to face a series of difficulties, which has meant professionals coming under increasing pressure in terms of workload and bureaucracy, and managers and commissioners having to adjust to rapid organisational change. In the current climate, risk reduction seems to be a higher priority than making those improvements in someone's quality of life which could sustain them in the longer term. Opportunities offered by new structures of assessment and care planning are therefore being missed.

Action learning addressed these difficulties by turning professional attention to the everyday reality of lives wherein services are being received. Attention to each individual and the fabric of their daily lives meant that new possibilities became visible. Assessments and care planning carried out in action learning environments often generated creative options for service delivery, highlighted unforeseen needs, produced unexpected feedback for commissioners and managers, and pointed to new directions for service development.

Chapter 3

Working with individuals

Each of the action learners undertook to do some detailed work over a twelve-month period with one or more service users, to improve their quality of life. About 20 service users were involved in the three localities, and professionals had contact with another twelve who either withdrew from the programme before it was completed or dropped out because their workers decided to leave.

The service users

In the main, workers invited service users that they already knew to join the programme. All had a history of serious and long-term mental illness and were usually people about whom the workers had some concerns but with whom they had not done any detailed work or had tried and failed. They were living in various sorts of residential care, with parents or in their own accommodation, and most were on long-term medication. Many were not involved with day services.

Explaining the purpose of the action learning programme to service users proved difficult at times. We wanted to make sure that each person understood what was involved and what rights and sanctions they had in controlling the material that was shared in the action learning groups. Inevitably, a lot of time went into explaining a complex and unfamiliar process. The approach that we used in the three localities allowed the work to evolve according to the pace and needs of the individual service user.

Overcoming fear of change

We underestimated how frightening the idea of change could be. For some, even the slightest change could appear to threaten their existing resources such as their homes or benefits. We began to understand how fragile some service users felt that their hold was over their basic life supports and how greatly they worried about losing the little that they had. In general, their everyday experience was one of powerlessness.

For some, the reassurance that improvements in their quality of life could be limited to the very small steps forward that they wanted to make was enough to gain their agreement to participate but, with others, even starting the process of negotiation was impossible. The service users who dropped out of the programmes did so during or at the end of the needs assessment stage, when possibilities of change were being opened up. This suggests the need to carry out this process very slowly over numerous visits and to progress in very small steps at the individual's own pace.

BOX 1

Making contact with Julia

Julia was a client of our team for many years before I was introduced to her. I knew her from conversations with colleagues, and everyone in the team agreed that she seemed suitable for the Better Futures project. I met her first on a joint visit with a community psychiatric nurse (CPN), and we tried to reinforce the fact that I would be working alongside the CPN rather than replacing her. As Julia saw it, she was living a life of dull routine and soon grasped the aims of Better Futures. She was a lively and generous woman, with many interests which she had let lapse over the years.

Initially, I tried to engage her in talking about her enthusiasms, rather than looking at issues which might have appeared closer to her mental illness. This process may have been slow, but the framework of Better Futures enabled me to feel justified in taking time to get to know Julia, and for her to build up confidence in me.

We got to know each other well over the weeks, and the fact that I was not seen as an official, but more as a friend, helped to establish rapport.

Women in long-term services

The majority of the service users invited to join the programme were men (while the majority of the action learners were women). This gender imbalance was unintentional and not recognised until the results of the programme were analysed. This pattern reflects the gender mix in long-term services in some of the Better Futures localities – 70 per cent men and 30 per cent women. This may be due the fact that women develop mental illness later in life and have by then acquired better coping skills. There are other factors too. Women are more likely to seek psychological help, whereas the mainstay of long-term services is help with everyday living. People who have moved into this service area are thought not to benefit from psychological help. There is also evidence from MIND's 'Stress on Women' campaign that women feel uncomfortable in male-designed and dominated services and may choose to stay away.

Much of the literature on working with people with long-term needs stresses the importance of 'engagement' and developing a close relationship. Particular care needs to be taken with women, some of whom will have been abused in the past. In view of current concerns about the potential for abusive relationships between therapist and client, the option for women to have women workers should be made available.

BOX 2

Anne's story

Jo had been Anne's CPN for some time. When she approached her about taking part in Better Futures, Anne initially seemed quite keen. As Jo started to collect information about Anne, she realised that, apart from her symptoms, she knew very little about her. It became clear to Jo, however, that Anne was very distressed by questions about her past and she decided that it was not in Anne's interests to pursue the work. Over the following months, Anne deteriorated and was eventually admitted to hospital. When she came home, she asked Jo if they could take up their work together again. Because of their past experience, Jo felt that she did not have the skills to help Anne and referred her to the psychology service. Pat, a woman psychologist, started seeing Anne every week. She found out that Anne had been sexually abused as a child. The prospect of any close relationship was terrifying to her.

In allowing themselves to be led by service users, professionals had to decide when to step back and when to press ahead. For this reason, professionals using this approach need to be committed to user-centred planning and to have experience of working with people with long-term needs, as well as receiving feedback and support from colleagues, as the action learners did.

Race and culture

Race issues were not really covered in our work. Professionals worked with three individuals from ethnic minority backgrounds. Two of them did not choose to explore their backgrounds, but the third did. Insufficient work was done on this to draw any conclusions, but there is a need, given that black voluntary sector workers were critical of the racial and cultural awareness of white staff, to address this issue more fully.

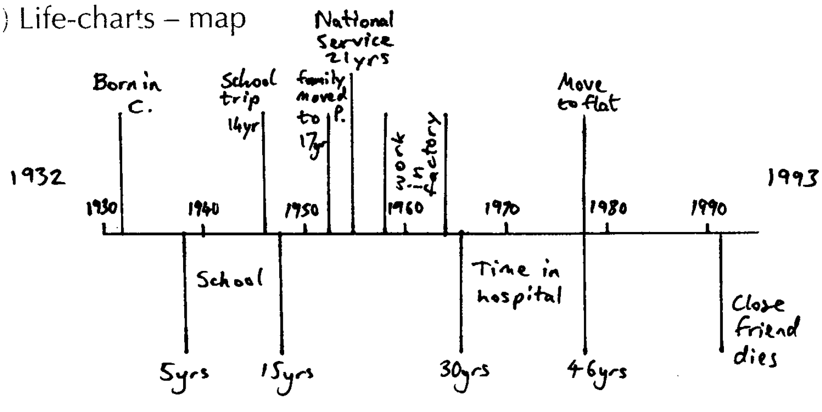
Getting the whole picture

During the project, the professionals took time to get to know the person with whom they were working, using a variety of methods besides formal assessment. It was difficult for some to accept that they did not already know a person with whom they had been working for a long time but, using different techniques, everyone gathered additional information. We used picture profiles, checklists and life-charts to explore each person's current use of services and existing support networks (see below). We also discussed their present and past experience to find out about their strengths, interests, likes and aspirations (see below). It was not easy for everyone to recognise that by such unconventional means they had achieved a thorough assessment and re-assessment. However, after discussion and support in the action learning group, this way of working was accepted as a valid and professional approach.

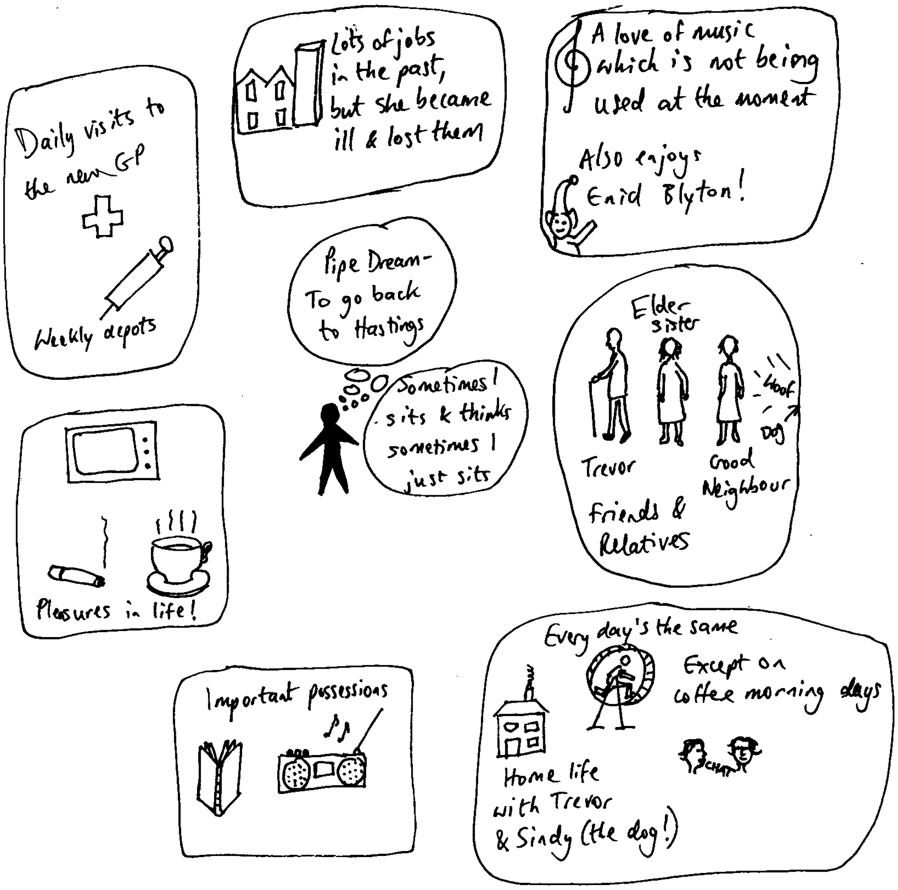
Because the assessment is carried out away from formal work settings, care needs to be taken that service users realise that the activity is part of an assessment process and are not caught off guard by the informality of the situation.

BOX 3
Three unconventional assessments

(a) Life-charts – map



(b) Life-charts – picture



(c)

Jack, a CPN, talks about his work with Clive, a young man living in residential care. At the start of the action learning programme, nothing was happening in his life and he had no desire to do anything.

'I had been working with Clive for some time but, partly because my time was limited and partly because Clive tended to keep his distance, he was not someone I had been able to get close to. He had significant long-term mental health problems, and I was very aware that he was not fulfilling his potential.

Clive had talked with some pleasure about once playing 'pitch and putt' and expressed an interest in doing this again and in learning more about golf. This coincided with one of my own hobbies and seemed to offer an ideal opportunity to meet Clive more informally. There were problems to be overcome concerning cost and equipment, but the enthusiasm was there and a game was set up.

As well as providing Clive with an interesting and rewarding leisure outlet, it offered us the opportunity to develop a relationship which allowed Clive to talk naturally and openly about himself. A picture of his past and of his hopes and needs emerged in the course of normal conversation in a way that would have been unlikely using more structured assessment tools or in a more traditional client–worker relationship. As a result of these encounters, based as they were on a more equal footing, both Clive and I achieved, for the first time, a highly valued relationship and discovered where we were going in our work together'.

As a result of this work, Clive now attends a day centre, takes part in a number of activities in his community and has made some friends. Jack feels that Clive has the potential to develop further.

The need for a variety of assessment tools

Workers found that having a range of tools helped, first of all, in getting the person interested and then in eliciting a fairly comprehensive set of information. For example, pictures could sometimes be more powerful than words in expressing what people wanted to say, and life-charts enabled a person's whole life to be looked at – not just the hospital admissions and periods of living on the edge of society. This part of the work showed that users had a very wide range of needs that were not just health-related (see Fig.1), and therefore any tools used needed to have a holistic focus.

The role of managers

A key factor in the success of this approach was the support and agreement of managers to methods which may be more time-consuming than traditional ones. Permission to test new techniques freed workers to be creative and imaginative. They had the scope to try out alternative assessment methods as part of a range of useful techniques. These could then be used in their everyday work.

Service-related

Place of safety
Rescue from law
Crisis contact point
Psychological assessment & input
Planned and structured support
A psychiatrist who understands
Formal review process recorded, agreed, signed
Full assessment (including carer)
Information and update on treatment and state-of-the-art psychiatry

Support

Someone to listen
Reassurance
Individual attention
Continuous support
Independent advocate
Help in making decisions about relationships
Counselling over previous relationship
Facilitation of contact with ex-partner
Medication – help to come off or stay on
Alternatives to medication

Accommodation

More suitable
Security of tenure
More independent
Privacy

Material

Money
Make-up
Clothes
Regular meals
Cigarettes

Work

Job skills
Career guidance

Day-to-day living

Help with self-care
Financial management
Confidence/assertion
Make own decisions
Small steps towards independence
Coming off medication
Living with or without medication
Self-medication

Close relationships

To be loved/needed
A girlfriend

Socialising and friends

A safe friend
Alcohol-free ordinary social environment
Don't want to always be with people like myself

Hobbies/interests

Cats
Watching football
Concessions (not demeaning)
To be able to afford interests

Figure 1 Range of needs identified – Swindon group

Making a plan

The action learning groups used what the individual service user wanted as goals (see Fig.2). Each goal was broken down into often very small steps so that progress was visible, if slow. These steps could be described as problems to be overcome or needs. For example, wanting to move house instantly creates a number of tangible problems which need to be resolved – finding somewhere suitable, buying furniture, budgeting to pay rent and bills, learning to keep house, shop and cook, dealing with repairs. On a more personal level, coping with the stress of moving may be an issue, as well as the need to negotiate new relationships with parents, if the person is moving out of the family home.

Working with what the person wanted did not present major difficulties. People often chose goals that might be difficult to attain quickly but were within the range of ordinary hopes and aspirations. A few were related to the person's mental health problem. Some changes were very small but significant to the individual.

One of the advantages of working towards goals was that it narrowed the range of problems to be solved to those that were immediately relevant. It was easier to track the reason for and content of particular interventions during the year. Without a focus such as this, professional work can be limited to short-term thinking and crisis resolution.

Using a project approach

Breaking the work down into small steps means that professional work can be organised as a series of projects. Peter Huxley has drawn parallels between this way of working and the task-centred social work of the 1970s.[5] There, however, contact with the client terminated with completion of the task; in our model, where the aim is continuity, service user and worker would progress to the next small project.

Pace and style are both crucial in helping users of mental health services meet their objectives. As some workers found, impatience to achieve results is likely to end in failure. Presenting choices and options in a low-key way was more likely to succeed than offering an organised package of care. This suggests that while workers need to be aware of an individual's overall level of need, too much change at one time may feel overwhelming. Working on one goal at a time may be more effective.

BOX 4
Small changes can lead to changes in self-perception

For many years, home for Ted had been a hostel. Though happy living there, he was approached to be part of the Better Futures initiative to help him broaden his options, as life outside the hostel was limited to going to a day hospital. Working with him over the year (life map, identifying interests and goals) revealed many aspects of his life that were not previously known. His goal was modest – he wanted to learn to cook. Managing this fairly quickly, he was then able to enjoy shopping and eating more healthily. Once he could cook, he began to budget for himself, something that had previously caused problems at the hostel.

These seemingly small triumphs, which most of us take for granted, gave him a greater sense of himself. He began to be uncomfortable about going to the day hospital, feeling that it was reinforcing negative ideas about himself.

His goals now include finding things to do outside the hostel and day hospital, following up his interest in gardening and aeroplanes.

Putting the plan into action

For a plan to work, professionals needed to anticipate problems and think of possible solutions. All were working under considerable pressure. Most of the community mental health team workers involved in the programmes had to manage huge caseloads – 50 was quite common. In residential and day care settings, some contended with staffing levels which could not accommodate staff absence or vacant posts.

- Change the way I feel about myself; increase sense of self-esteem
- Learn to be more assertive
- Understand psychiatric diagnosis, its implications and treatment
- Work out what I want out of life
- Budget and cook for myself
- Improve diet
- Find some outside interests
- Manage my finances
- Find an occupation, alternatives to day provision; complete course of study
- Move house

Figure 2 Summary of individual goals – Leeds group

Crisis work with individuals and their families was a way of coping with pressure. It was also 'safer' than working with someone to bring about changes in their life. In a crisis, options are reduced, usually to increasing the person's medication or getting them admitted to hospital. Developing the supports that might keep someone out of hospital brings a whole array of options into play, and it becomes difficult for busy and unsupported professionals to deal with this level of uncertainty. In the new mood of unease about community care, managers may also prefer certainty to risk-taking.

It was not easy for professionals to take the initiative, but it turned out to be essential, particularly where other professionals were involved and there were no formal channels of communication. Professionals called planning meetings to share information and solve problems rather than for routine monitoring purposes.

There is some evidence from the work that service users found this problem-oriented style of meeting easier to attend than care review meetings, even when a large number of people were present. Involving service users in planning meetings and deciding who should be invited help to make multi-professional meetings useful to service users.

Finally, service user consultants in the Leeds action learning group advised that the number of people attending a planning meeting was less of an issue than the venue. It had to be somewhere safe and familiar, but not necessarily the person's home, which might feel too intrusive. The local health centre or a day centre where the person felt comfortable were both possibilities.

Creating choices

Offering service users choices demanded three resources that were in short supply – information, money and time. Most professionals had a working knowledge of statutory services but were sometimes hazy about the voluntary sector.

Information

One of the localities had produced, and one was in the process of producing, a directory of local mental health resources. Not all professionals found such written information particularly helpful in providing options to suggest to service users. They were more likely to refer if they already knew the staff in the other service. This is one of the reasons why information needs to be provided interactively – a person on the end of the telephone as well as a directory, to talk through the options and advise on people to link with.

BOX 5
A planning meeting for Alan

Alan had been offered the tenancy of a flat. Except for some time at college, he had been living with his mother, and things were becoming more difficult at home. Previous attempts to move had failed, and Alan was becoming worried that he would not manage the move this time.

The action learner knew that a number of people were involved with Alan, although they were not in touch with each other. She and Alan called a planning meeting to bring together all the relevant people who could help and support him in the move – his CPN, housing support worker, his GP and his mother. His psychiatrist was also invited to attend but declined.

The meeting was held at the doctor's surgery, a venue that everyone felt comfortable with. All the people present agreed to offer some help or support to Alan in moving house. The tasks identified ranged from buying and moving furniture, decorating and help with budgeting to personal support. His mother turned out to be in favour of the move; until then no one had been sure of her views.

At the meeting, people offered to carry out certain tasks. These were written down and circulated to everyone present. A further meeting was arranged a few weeks later, as support at a time of major change needed to be flexible and responsive. Previously, workers had scaled down contact without realising that there was no input from anyone else. The planning meeting that Alan organised (with help) brought together an effective network which could work at his pace and respond to his strengths and needs.

People come into the mental health services through many different points of entry and often have most contact with staff who lack a formal mental health training. So GPs, housing support workers and day service staff also need access to information and the opportunity to discuss it with someone knowledgeable.

Money

We found that small amounts of money were essential to improve the quality of life of individuals who were existing on welfare benefits. Often, workers would find that they were stuck because they could not find very small sums. People in work tend to take for granted the rising cost of educational and leisure activities and forget that they are beyond the reach of most people on benefits. The following are some of the things that people needed money for:

- gardening tools;
- expenses for trips and outings;
- entrance to a sports centre;
- a computer (or access to one);
- a ticket to a football match;
- some make-up;
- expenses for a volunteer or befriender to accompany two or three people on an outing.

In theory, direct payment was not the only way in which some of these items could have been obtained, but in reality, any alternative method proved difficult and exceedingly time-consuming to organise. For instance, one action learner was working with a user who was a lifelong supporter of his local football club, but he could no longer afford the £15 entrance fee to matches. His worker spent much time trying to extract a concessionary price from the club but to no avail. Another worker put a great deal of effort into contacting charities and training agencies to see if she could get funding for a computer but was also unsuccessful. We concluded that direct access to some funding which could pay expenses for volunteers and befrienders as well as for goods and services was vital to the success of this work.

As a result of Better Futures, Leeds social services has commissioned a pilot flexi-fund to which service users and their keyworkers can apply directly. A panel including service users will decide whether the application meets the criteria for the fund and make the award accordingly. The Leeds scheme is being evaluated to see what contribution it makes to people's quality of life. Other places have devolved budgets to care managers (Nottingham) and to long-term support teams (Lancashire).

Time

The most important resource of all is time. Hard-pressed professionals appreciated the chance which the project offered them to plan their work, but this was very untypical of their normal working life.

Time to support people to do new things and the ability to take a long-term view were crucial in helping some people to bring about change. Having money to do something was not enough on its own. Making the arrangements for people to attend something was also not effective; the service user might attend once or twice (perhaps to please the worker) but would often not continue. Low-key support and a long-term view seem to be the main ingredients in moving forward.

BOX 6
Access to a sports centre

One person's goal was to do more sport. A brainstorming session enabled the action learning group to look at ways in which someone who has great difficulty in being with new people, could make use of the local sports centre.

Barriers to going to the sports centre included an intimidating atmosphere, expense, debilitating side-effects of medication and going somewhere new for the first time. Ideas for overcoming the blocks included encouraging the sports centre to offer low-key, 'safe' sessions at off-peak times, making use of concessions available, developing more flexible sources of funding to pay session fees, finding an 'oppo' – a companion who could share the enthusiasm and be both a support and partner (for badminton or squash). Several ideas about where to find an 'oppo' emerged:

- a council for voluntary service volunteer;
- a volunteer with shared interests;
- a student on a local sports course;
- an 'ad' at the sports centre or by asking at the desk.

Finding the right supporter would involve some detailed and lengthy networking (the action learner did not himself have time to provide this type of support).

Sessional workers, volunteers and befrienders can potentially be used as supporters if some funding is available to support, train and pay expenses. One of the action learning groups considered making use of helpers outside the multi-disciplinary team. Some of the workers had had mostly unhappy experience of volunteers. Volunteers had been misguidedly expected to carry out their tasks without professional input. Projects using volunteers need to invest time in educating ordinary members of the public that are recruited, particularly into allaying their anxieties about media portrayal of mental illness, and professionals need to provide ongoing support for them.

Finally, time might be needed to create new opportunities or services. Most of the things that participants wanted, such as housing and access to mainstream leisure facilities, involved a lot of work to arrange but were quite straightforward. Sometimes people wanted to do something such as gardening where the effort required could not be justified for one person, although it might be possible to develop an allotment for three or four people. Most professionals do not have the time or the skills to set up a scheme of this type. Development officers who might once have done this sort of work are now almost extinct in NHS Trusts; service development is seen as part of the general management role. Development officers are more common in social services but their brief is not always clear. Increasingly, statutory services are looking to the voluntary sector to develop this type of service, but it does depend on professionals being willing to network with voluntary agencies and help them in finding resources.

Interpreting successes and failures

Over the course of the year, a number of people moved house, took up day activities or learned new skills. It would be wrong, however, to credit the action learning programmes alone with these changes since there are so many other influences on people's lives. Nevertheless, the progress made during the year seems to have been positive and service users and workers have made some favourable comments.

The Clwyd programme was evaluated by the Health Services Research Unit at the University College of North Wales.[6] Over the twelve months, individual service users showed an improvement in social functioning. The other two programmes relied on self-evaluation. The return rate of evaluation forms was low from both users and workers. Two were completed by users in Swindon and one in Leeds. The users were appreciative of their workers' efforts on their behalf: 'The worker encouraged me a great deal through the past year, she helped me a lot'. One said that the approach had brought him out of his shell and made life easier.

We learned how important it is to take a long-term view of someone's life when assessing progress and not to be too hasty in interpreting success and failure. For example, a young man was admitted to hospital largely because no alternative accommodation was available. Relationships with his parents were strained, and he had been living a separate life in the family home in very poor conditions. Matters had come to a head when his parents joined a carers' group and realised that their home situation was intolerable. Although it would have been better if the crisis could have been avoided, at least the hospital admission brought the situation to an end and meant that the problems at home had to be sorted out. The admission to hospital might be seen as a turning point leading to a more satisfactory phase of the person's life.

Measures of outcome therefore need to be treated warily. An apparently positive outcome may be achieved with little effort from user or worker. On the other hand, a lot of hard work may result in a seemingly negative outcome, such as an in-patient admission, but this may have a beneficial long-term effect.

Outcomes for action learners

The workers had mixed feelings about the work with individuals. While some of them appreciated the results, they felt that they would not normally have the time to work in this way. One worker commented:

'It made a real difference to a service user and offered reassessment of a long-standing situation. However, we are constrained by time factors (as ever) and for the work to be undertaken thoroughly a great deal of time is needed.'

The action learning programmes challenged the professionals to work in different ways which some found difficult. Barriers to change emerged as:

- denial – 'We're already doing that.'
- distancing – 'These people lack motivation.'
- feeling devalued – 'I am not getting anything out of this.'

It took time for professionals to accept new ideas. Some were not willing to do so and left.

The main benefits identified by workers who participated throughout included:

- more individual-centred work – a focus on the person rather than the forms-driven process of care planning;
- time to anticipate and solve problems, rather than just respond to crises;
- time to produce creative options;
- the opportunity to practise new techniques – in particular, people's life stories were used to good effect.

Outcomes for user consultant action learners

The user consultants in the Leeds action learning group learned that professionals do not have all the answers. In their interactions with professionals, users can often receive the impression that they do. In reality, professionals and users need to work together to find answers, with service users feeling empowered to bring their own ideas about solutions to meetings with professionals.

Individual care planning – tricks and traps for practitioners

Assessment

- Take time to get to know the person.
- Try different ways of eliciting and recording information.
- Try different settings away from your base.
- Find out about the person's strengths and interests as well as their needs and problems. For example, have they had a job in the past? If so, what skills did they use? Have they had any hobbies or interests? What do they enjoy doing at the moment?
- Resist the temptation to make assumptions about what the person is capable of.
- Remember that any change can appear threatening, particularly if past experiences of change have not been good.

Planning

- Find out what the person wants and agree a way forward.
- Break the work down into many small steps.
- Allow time for the person to take in new ideas and get used to them.
- Do not jump in and make all the arrangements yourself; allow the person to go at their own pace.
- Allow them to rethink and change their mind about what they want to do.

Resources

- Try to find some funding for activities and equipment.
- Do offer support, or find someone else to do so, when change is happening; giving someone the resources without the time to support them seldom works.
- Involve other workers where appropriate; be realistic about your own skills and do not try to meet all the person's needs yourself.

Organising the work

- Plan, plan, plan! Anticipate and solve problems; do not wait for crises to happen.
- Work on one goal at a time.
- Organise the work into small projects so that you know why you are visiting the person and what you are working on together.

Linking with other people

- Get to know the people who run the services that you want to use.
- Involve the person with whom you are working in communications with other people.
- Face-to-face communication is often more powerful than a telephone call or letter.
- Call planning meetings to provide extra support when needed and solve current problems rather than wait for the routine care review meeting.

Chapter 4

Issues for professionals

Attitudes and techniques

The essence of this kind of mental health work is the ability to see service users as people, and this often means a shift in workers' attitudes. Many workers took time to accept that they did not know people with whom they had been working, sometimes, for a very long time. They found that they needed to learn new techniques, including:

- using empowering methods of assessment;
- planning the work around goals and objectives;
- being proactive in solving problems and, when necessary, contacting key people (with the person's permission);
- learning how to use information about local resources;
- making links with other workers and services;
- developing new services.

These techniques are administrative and developmental and, on the surface, might seem to be outside the range of what is normally considered to be the professional skills required for work of this kind. Yet in reality, this type of work is highly skilled, drawing on reserves of judgement and experience. Risk assessment sits somewhere between the skills listed above and the following:

- up-to-date knowledge of medication – its purpose, effects and side-effects;
- ability to give advice on reduced and intermittent use of medication;
- crisis planning; many service users now like to use crisis cards, and key-workers need to keep a record of what the user wants;
- psychological and self-help approaches to managing communications within families, sharing information and coping with 'voices';
- knowledge of welfare benefits.

Not all professionals need to be expert in every skill, but each team of workers needs to have a clear idea of the competences required to work with people with long-term needs and to either develop those competences within the team or know where to access them.

Action and vulnerability

In one group in particular, the issue of staff vulnerability quickly came to the fore. Some professionals were anxious about revealing the detail of their work to other people. They were used to a 'policeman's notebook' style of reporting within their staff groups and found it difficult to share their work in depth with workers from a wide spectrum of agencies.

Sometimes underlying such anxieties lay uncertainty about the limits of the professional role. There were instances of workers going along with stuck family situations ('I think his family copes with him very well'), which would then lead to the inevitable crisis. Some episodes also showed that not all workers were good at assessing risk. In general, they were practised at knowing when someone required intensive support. Some were less good at seeing the long-term risk inherent in certain situations involving families or neighbours, or risks to physical health. Again, a lot could be learned from child protection services about assessing risk in a fragmented system. This stresses the need for coordination of professional input and clear, open channels of communication.

This does not mean that professionals should interfere without being asked in all aspects of a person's life. It might be appropriate to give constant feedback on the reality of the situation to the person or family and to make low-key, unpressurising suggestions about ways of resolving a difficult situation.

Sharing with colleagues was often encouraging and allowed workers to take more risks. For example, in a planning meeting with a service user and other workers, a CPN was able to ask the service user if her mother could contact him if she became aware of any problems. The CPN had very infrequent contact with the service user when she was well and had no way of knowing when extra support was needed.

Setting goals

The locality groups used what individuals wanted as the goals which they worked towards. This may raise objections, including:

- users do not know what they want;
- users want things that are unrealistic;
- users change their minds about what they want.

Many people, put on the spot, would be hard put to say what they want. Part of an empowering assessment process would be to help people to explore what they want, perhaps by trying out a number of opportunities and services to find out what suits them best. This is a dynamic, continuing process, which might last for a year or more. The need for a lengthy assessment period should not preclude all change in the meantime (for example, making someone stay in hospital until the process is completed). On the contrary, it can provide the background of continuity necessary for someone to identify important changes they want in their life and begin to make them.

Very few people wanted things that were completely unrealistic. On the whole, they had low expectations and tended to be unambitious. Sometimes, goals could be aimed for but would not be achieved for many years if at all. For example, one participant's wish to 'get married' might seem a long way off but his need to gain confidence in mixing with other young people and to make friends of both sexes could be reasonably accommodated. These were necessary steps to achieving what he wanted.

Some people did need to stop and reconsider their goals, perhaps because of a change in their situation. Owing to the continuing assessment process, most people had the opportunity to become clearer about what they wanted and generally stuck to this during the year.

Networking and the development role

' Do you want to know what has really improved my quality of life? ... Disabled Living Allowance. '

For most mental health professionals, the traditional model of work with service users is one-to-one, the out-patient interview, the flying home visit. People's needs cannot be easily encompassed within this model. A skilled and sympathetic worker, able to access other agencies and resources when necessary, can make a lot of difference to people's lives.

Professionals often felt that they had to try to meet all of a user's needs themselves even when they did not have all the skills to do so. Knowing when to call on the skills of other professionals or seek expert advice from welfare or housing specialists is an important skill in its own right. Professionals were unsure about the boundaries of their role and were sometimes reluctant to take the initiative in communicating and liaising with other workers, particularly outside their own agency.

In order to offer people choices, professionals need to know what is available locally in statutory, voluntary and mainstream services. For example, the church hall group addressing the welfare needs of the local black community may be more appropriate and acceptable to a black user than a standard mental health day centre. Without good information networks, such informal, self-help community groups are sometimes more difficult to identify but they may appropriately meet a user's needs.

Helping someone to access services is part of offering choice, but sometimes the service or opportunity that is required does not exist. One way of developing new options is for two or three professionals to work together on a project such as an allotment, which three or four service users could work on, or a weekend support scheme.

The Clwyd Better Futures group used their King's Fund Centre grant to fund small service developments worked up by community mental health teams. Small sums of money – up to £5000 over two years, but often much smaller sums – were available to support these developments. The most successful projects involved users, carers and the voluntary sector. The Clwyd teams also took the opportunity to develop direct links with local colleges, training agencies and employers. (They found that they could not rely on intermediary agencies, such as the Department of Employment, to make the connections for them.) Working with colleagues in this way can help to foster a team's cohesiveness and sense of purpose.

Chapter 5

Management perspectives

Partners in Change has implications for managers and this chapter is particularly addressed to middle managers.

Just as professionals need to work proactively with their clients, managers also need to be proactive in managing the service. When individual professionals have been working in a service for a long time and acquired a fair amount of autonomy, it is sometimes difficult to manage assertively. Team-building strategies, such as the learning forum described below and team projects where members cooperate on tasks, may help. Multi-agency training, involving service users and the voluntary sector may also have a part to play.

Making time

The approaches described here require time. We found that some managers were unsympathetic to complaints of work overload and, in order to cope, professionals managed their workloads defensively. They gave some service users low priority and saw them infrequently so as to make time for people who were of immediate concern. They did not discharge people (which would have made the prioritisation explicit) since this would lead to managers adding a new case, needing more active work, to their workload.

Within residential or day care services, there is often conflict between time spent working with an individual and managing the day-to-day fabric of the service. Staffing levels are not adequate or flexible enough to accommodate for vacant posts and absences. Work often proceeds at the pace of the service rather than that of the service user.

Many people who would benefit from long-term specialist mental health services in the community are stuck in the areas of acute provision, where the approaches described here are hard to maintain.

Reducing the workload

Experiences in Better Future localities (and also national indications) suggest that two types of management response would be appropriate to this central resource issue. First, workloads need to be reduced. Individual workloads of between 8 and 20 people in specialist mental health teams would allow for the intensive assessment, planning and development of networks and resources which we recommend. Local negotiation of workload size will depend on complexity of needs, vulnerability of service users and the existence of complementary resources and support networks.

Identifying priorities

Second, the people who would benefit from this kind of assessment and care planning should be identified and prioritised. Workers in all settings offering services to people with on-going and serious mental health problems, would have a small number – two or three – of designated people who were judged as likely to benefit from this approach, to work with. People who will potentially be subject to new restrictive mental health legislation seem to be particularly appropriate for this way of working.

Decisions about priorities need to be made openly. If someone has good support and is managing well, there may be no need for secondary mental health service involvement. Explicit negotiations between service user and worker can produce agreements about reviewing progress and also about who may contact the service if the person needs extra support. Many service users like to do this through a crisis card on which the worker can keep a record. If contact is cut back and no markers are set to alert a team that a user may need more support for a time, their next contact with the person is likely to be as an in-patient.

Managers with a realistic view of the timescales required to work positively with people are crucial to the development of services for people with continuing needs. Many of the professionals who took part in the action learning programmes felt that managers were more often interested in throughput than in achieving quality outcomes for individuals. Managers are also under pressure but do need to listen and learn from the experiences of workers. They also need to collect evidence about the outcomes of different patterns of work in order to justify any changes in activity levels to senior managers and purchasers.

Sometimes it is possible to create time for detailed work with a small number of individuals by making use of groupwork and consultation skills. Running a group with a colleague from outside the secondary mental health service is an opportunity to share skills and increase the competence of non-specialist workers. Consulting with primary care workers about people with whom they are having difficulties may be a more appropriate response and use of time than accepting a referral to the secondary service.

Encouraging a team or group of workers to share the task of making links with the services that users might want to access is a cost-effective approach. If this task is shared, it need not be time-consuming and will pay dividends in improved communication and cross-fertilisation of ideas, as well as more choice for service users.

Personal development and learning

The successful implementation of individual care planning often requires a cultural change within services; the support of managers is essential to bring this about.

The action learning group provided a model of how opportunities could be provided for professionals to learn from their work, help each other to plan ahead and anticipate problems. Although some professionals found it difficult to share the detailed content of their work, there was evidence that working with others was a generally supportive experience, which enabled professionals to be more adventurous.

As a rule, team clinical meetings are too cursory to allow much real sharing to take place. Without overloading workers with meetings, some better ways need to be found to provide mutual help and shared learning. A forum meeting every two or three weeks might fill the learning gap without taking too much time.

Managers should develop a clear view of the range of competences required to provide a service to people with long-term needs and should devise a training strategy to meet them. Without a strategy, workers going on an ad-hoc collection of training courses may be a costly way of achieving little.

Supervision

Good supervision is essential if professionals are to develop in their role and feel supported in their work. The underlying purpose of supervision is to ensure that a worker is competent and able to do their job. In supervision, the manager seeks to maximise both competence and efficiency by:

- developing personal competence either through allowing the worker to reflect on and learn from their work or by identifying gaps in knowledge and experience which can be met through training;
- helping to manage individual workloads by making explicit decisions about prioritisation and discharge;
- helping to assess risk;
- providing support and a sounding board for ideas.

Multi-agency training

Sharing ideas and learning across agency boundaries can be a powerful way of increasing creativity and confidence. There are two ways of creating multi-agency learning opportunities – through conventional training courses and events and through shared projects.

Joint training

Joint training between health and social services is now becoming more common. Multi-agency training, involving both users and the voluntary sector, is not yet on the agenda. The case for wider involvement in training is that many people from a wide range of agencies and service users themselves have a part to play in providing a coordinated service to people with long-term needs. They need to share their understanding and experiences and develop common working methods and protocols. We found that people such as residential care workers and general practitioners, who had the least training in working with people with long-term needs, often had the most contact with service users. Because there is so little investment in developing such networks, a great deal of potential remains locked away.

Shared projects

Shared projects are another way of crossing agency boundaries. Projects can be quite small – organising a meeting or running a working group – or produce service developments. The advantage of a project approach is that the task has to be clarified and the amount of time required can be defined in advance.

Managing the work with individuals

Work with individuals must be based on a care plan with clear goals. A work pattern of 'maintenance' visits with periodic bursts of crisis intervention is likely to be unsatisfactory for both worker and user. Organising the work around goals or outcomes means that is possible to measure progress, however small, and ask relevant questions about setbacks and problems.

Information and money are vital resources in enabling professionals to work with service users on improving their quality of life. Written information about resources and services in the statutory and voluntary sector has limitations since professionals may be reluctant to refer to someone that they do not know. Some easily accessible money needs to be part of the care plan. A small budget held at team level will pay for activities and equipment and possibly expenses for volunteer befrienders. A larger budget can be used to employ sessional workers to meet more individualised needs, such as a worker who speaks the same language or providing support to a parent in keeping their child at home.

Planning for flexibility and continuity

Many of the people with whom we worked do not fit easily into the standard nine-to-five community mental health team model. They were often reluctant to use day services and a few led unconventional lives, moving from place to place but always coming back. Some only needed to be in touch with secondary services at times of crisis.

It is a great challenge to provide a service to people whose needs are not routine. Managers need to ensure that their systems are able to cope with irregular participation. In one locality, we found that people who 'disappeared' for a time were discharged. When they returned, they had to be re-referred before they could get specialist help and in the meantime, the accident and emergency department was their only source of help. In another locality, the CPNs routinely discharged people who were admitted to hospital, thus making the whole process of discharge planning and identifying a keyworker difficult. Services organised like this seem designed to make service users look like 'difficult customers', when it is the service itself which needs sorting out.

Chapter 6

Commissioning change

Commissioners of services have a crucial role to play in the delivery and development of high-quality, comprehensive and integrated services. This section links our work on individual care planning to more strategic concerns.

Assessment and care planning are fundamental to identifying appropriate service responses for people with serious and continuing needs, and should not be separated from the rest of the service. The emphasis on forms, reviews and computerised statistics makes it seem as though they can. The first requisite for successful care planning is that the elements of a comprehensive service are in place but, by itself, this is not enough. Good systems also need to be in place which allow people both inside and outside the mental health service to communicate, liaise and work cooperatively together.

Changing service content and systems will inevitably have an impact on the staffing, management and culture of mental health services. This may seem like a daunting agenda for the very small number of people involved in commissioning mental health services. What can commissioners achieve?

Strategy and planning

Health and local authorities have key roles in creating a shared vision of how local mental health services should evolve. From this long-term vision an integrated strategy for the development of, and change to, community-based services can be created. The services commissioned should reflect the strategic direction. It is crucial that commissioners take account of the concerns and interests of service users, their families and friends in every aspect of their work. Successful individual care planning for people with ongoing needs involves:

- provision of continuums of health and social care;
- access to a range of ordinary community facilities;
- the development and support of people's ordinary networks.

Joint mental health strategies and the development of jointly commissioned services can ensure that these elements are available. The most important function of a strategic document is to describe the direction that local services should take, rather than how the strategy should be implemented. This is not always well understood, witness the manager who was called away from a Better Futures meeting to attend an 'emergency' strategy meeting.

The strategy is a working tool which can change as circumstances and knowledge alter and it should not act as a barrier to opportunistic development.

Commissioners need to purchase an integrated continuum of care ranging from protective environments to care at home. At the present time, most resources are still tied up in hospitals, although the majority of people with long-term needs live in the community.

Commissioning and service development

The role of commissioners and their relationships with providers are still evolving. We would like to see commissioners take an active role in service development, working alongside providers to change services. The channels for change that are currently open to commissioners – needs assessment for populations, contracting and competitive tendering – are not enough to bring about the changes in culture and practice that we advocate. Change needs to start with developmental relationships, and commissioners can begin to develop these by working closely with others on major service changes, such as individual care planning. From this cooperation can come a detailed understanding of what is needed. This can then be reflected in service specifications and contracts. A contract can reflect particular concerns of service users and specify 'items', such as the option for women to have women therapists and for women-only space to be provided in hospitals and residences. 'Spot' contracting, usually done by social services commissioners, can provide very individualised care packages for people and small-scale, localised responses to identified need.

Deciding on priorities

Responsibilities for commissioners include deciding which client group(s) to prioritise. The number of central directives that have to be implemented makes it imperative that services for people with serious and long-term mental health problems are a high priority.

In thinking about numbers of people requiring a service, commissioners will want to look at morbidity rates (the expected number of people with mental health problems) and compare this with the actual number using services. There is always a difference between morbidity rates and actual use of services but, if there is a large gap or over-representation of particular groups in parts of the service, some further investigation is needed. The Better Futures work highlighted the fact that the majority of people with long-term needs do not use specialised services such as day hospitals/centres or specialist community teams. A rough calculation in one of the localities showed that about 10 per cent of people with continuing care needs were being cared for by specialist community teams and services. Another 10 per cent were in hospital. It must be assumed that the remaining 80 per cent were being served by acute community mental health teams, primary care staff and the voluntary sector, or were not receiving a service at all. Calculations were based on the formula of two people with severe mental health problems per 1000 suggested by the Mental Health Task Force.[7]

The number of people on care programmes may not be a reliable guide as not everyone who requires coordinated care has a care programme.

Individual care planning

Individual care planning should guide the purchasing process. It is crucial that commissioners' perspective and level of planning are linked to the planning work with individuals.

Because most of this work is carried out within a one-to-one relationship, it is not easy for commissioners to understand what is happening. It is however possible to make some assumptions on the basis of activity levels, working methods and staff skills. Action learning groups made this process visible, and issues highlighted by the individual care planning work were taken up locally to produce specific, responsive developments.

The action learning groups highlighted areas in which commissioners need to ask tough questions of providers, especially about workload, timescales, inclusive services, management and styles of working.

Workload

Workload is dictated not only by the number of cases per professional, but also by the needs of service users and the intensity of the work. Depending on the vulnerability of users, and the context of work, workloads of 8–20 people are realistic to enable positive work to be done. Large caseloads lead to 'hidden' prioritisation with resources going to those in crisis.

Timescales

Timescales for achieving results also need to be realistic. Although filling in an assessment form may take an afternoon, helping someone to understand what they want out of life and make real choices could take a year or more. This does not mean that an individual's immediate needs (such as for housing) should be put on hold while they explore long-term life goals. Commissioners need to understand that assessment and review are a continuing process and there is no substitute for time spent with the person. They also need to understand that services for people with long-term needs cannot be time-limited and throughput is not a good measure of productivity.

Responsive services

Commissioners should check that services are inclusive and that women or people from black and minority ethnic groups are not deterred from using them.

Working on an outreach basis means that people can be helped in a more individual way, at least initially. Services that are centre-based are not very effective at reaching vulnerable people. Working with people at home or in places they normally go to may be more helpful.

Organisational issues

Throughout the Better Futures work a range of resources were identified as important contributions to flexible and responsive services. These include the following.

- A variety of professionals to work with people who may have complex needs. As well as professionals, teams which include generic workers can provide more of the practical support that people need over a longer period, including evenings and weekends. The aim should be a 24-hour on-call service, although this may be difficult to achieve initially.
- A fund which can be easily accessed by users and workers, held either at team level or centrally. The fund would increase the range of choices for service users and could be used to pay for activities and equipment as well as expenses for volunteer befrienders.
- Strategies for team and individual workload management able to make time for detailed individual work.
- Clear referral and discharge criteria and explicit prioritisation systems which do not place individuals at risk.
- Services with an understanding of the attitudes and competences required to work with people with long-term needs, and a strategy for bridging the gaps, through training or other means.

Commissioners need to have some knowledge of interventions that have been shown to be effective and that service users feel are helpful. Building up a network of contacts to increase the inevitably limited experience of individual commissioners is a good strategy for meeting gaps in knowledge and developing their confidence about purchasing decisions.

The key areas where people can become lost to the system are the relationships between parts of a service or between agencies. The most crucial interfaces are between hospital and community and between health and social services. Understanding how these work locally is very important. Proactive commissioning can create bridges between services, since it is usually the organisational system that is at fault, rather than the service user. Multi-agency groups in the project areas, including users and carers, used information from local action learning groups to respond to the problem areas identified. They looked at areas such as the relationships between local primary health care and community mental health teams, and between hospital and community services.

In both hospital and community settings, there is often quite intensive work going on but poor mechanisms to keep each other informed and pass on information. For example, in one locality, a professional working closely with a service user and his family in the community, was surprised to meet him as an in-patient in the hospital.

This is an area where detailed questions need to be asked and detailed answers given. In response to a question about discharge planning, an answer such as 'Our CPNs are always on the wards' or 'A social worker attends all ward rounds' is not very clear. A more helpful answer would be: 'Our policy is that the keyworker will carry out an initial assessment within 48 hours of admission and convene the first discharge planning within seven days.' Other important interfaces that the Better Futures work stressed, and about which commissioners should be asking questions, are relationships with:

- users individually and collectively;
- relatives, carers and friends;
- other community teams (e.g. acute, rehabilitation);
- primary care;
- the voluntary sector;
- community groups (including black and ethnic minority groups and women's groups).

The final organisational issue for commissioners is referral and discharge policies. Referral criteria, particularly to specialist teams, should not select out people with the most severe problems. Discharges need to take place because someone no longer needs a service, not because they are currently using a different part of the service or their lifestyle does not fit in with service organisation.

Monitoring and evaluation

Good coordinated information systems are vital tools, particularly for identifying potential long-term need as well as the impact of hospital closure and the changes in service provision on the lives of people currently using services. Collecting the data opposite will help establish in what way people use services.

Some of this information is already collected routinely. Commissioners may wish to collect other elements for specific planning projects. Providers need this information in order to offer a service and commissioners may wish to make sure that they are collecting it or have a plan to do so.

Outcomes

Professionally defined outcomes

Evaluation is essential if we are to provide meaningful care programmes which really are flexible and responsive to need. Clinical audit provides an opportunity for professionals and users to investigate the effectiveness of care in relation to a wide range of factors, and to develop working methods in response to information generated through the audit cycle.

It is important to be specific about the aims of our work, and clinical audit can help to clarify how these aims can be realised. Services will have many different aims for the client group as a whole, and service users will have goals which are specific to them as individuals. Both can be evaluated through the use of clinical audit. (See Fig.3.)

User-defined outcomes

Partners in Change describes elements of user-led care planning. The outcome of the work was defined by the individual service users themselves, in the context of their strengths, aspirations and potential. Monitoring progress towards each personal goal meant that professional intervention could be negotiated, appropriate and responsive to the current situation.

If interventions are based solely on professional perceptions of problems, professional responses and outcomes are produced. A comment from a service user in one of the localities illustrates this:

'According to you as workers, I'm a success because I have a place of my own, am a member of MIND and take part in social activities. In fact, I'm hanging on by my fingernails and I can't easily get the daily help I need to keep going. Every day is a struggle.'

Data set

In-patient information

Referral and discharge policies
Number of admissions
Average length of stay
Use of Mental Health Act
Maximum and minimum length of stay
Number of stays longer than 3 months
Number of repeat admissions by person over 12-month period

Out-patient information

Number of attendances
Average number per session
Number of non-attendances (1st appointment)
Number of non-attendances (2nd appointment)

Same information for day services.

Community services information

Number of people on CPA, s.117 of the Mental Health Act 1983 and supervision registers
Comparison of names on CPN and social services workload with previous in-patients
Analysis of discharge plans

Primary care

Number of people with long-term needs registered with GPs
Comparison with people on CPN and social services workload

An example of an audit mechanism for evaluating work with one service user may relate to quality of life:

eg. Maxine aims to increase her leisure activities

STRUCTURE	PROCESS	OUTCOME	AUDIT METHOD
Clear assessment of Maxine's leisure needs	Carry out assessment with Maxine Identify Maxine's perception of her needs formulate goals eg. to spend one day a week away from the hostel eg... eg...	Implement goal plan eg. swimming on Tuesday with Kate (keyworker) eg... eg... eg...	Record when Maxine goes swimming Record reasons why Maxine doesn't go swimming (eg. pool closed not enough staff family visit) Administer Lancashire QOL Profile (Leisure Domain) Repeat and review every 3 months

Fig.3

Conclusion

The action learning projects highlight the importance of ongoing and interactional assessments in the planning of community care for individuals. Such assessments reveal the complex needs and wishes of people with long-term and serious mental health problems, and raise questions as to the quality of services that they receive. The issue of time, of pressures of work, of the importance of defending spaces in which service users and professionals can communicate more fully, recurs constantly and suggests a specific course of action for all professionals concerned to deliver quality services.

Also important were the feedback and support that workers received from colleagues, which gave professionals the confidence to use their initiative, support individuals in making changes in their lives and come up with creative solutions to problems. The evidence is that such work has a wide range of benefits, for individuals, professionals and service delivery systems. It forges networks, encourages different ways of working, develops partnerships and creates positive and unexpected change.

Where commissioners plan for such work, and managers support its continuation, professionals can help improve the quality of people's lives and their own work by making visible what formerly could not be seen.

Appendix 1

Protocol for approaching service users

Each member of the action learning set is requested to make contact with one-to-three individuals with serious and long-term mental health problems at the start of the programme. The aim is to try out a different style of working in which the professional gets to know the individual as a whole person, attempts to understand their needs and wants from their point of view and works out with them a plan for meeting those needs. In the second part of the set, we will look at resources used and organisational barriers to meeting individual needs, but it is really during the first part of the set and subsequent dissemination of the lessons learnt where confidentiality is an issue. The people contacted will need to know:

The purpose of the action learning programme

- to improve the quality of life of a small number of people with serious and long-term mental health problems;
- to learn more about achieving continuity of care for individuals by sharing experiences with other professionals and service users.

The content of the work

- you will spend some time with each individual at home or in the service settings that they use regularly in order to get to know them;
- you will think together about what the person needs in order to improve their quality of life and ways of achieving it;
- you will do some thinking with professionals from other disciplines and agencies during meetings of the action learning set about the person's needs and how best to meet them;
- you and the individual may need to involve other people (professionals and others) in order to achieve the goals that you have identified together.

What we mean by confidentiality

- names and other identifying details will not be revealed outside the action learning group;

- trust is an important part of confidentiality; we will not step outside the person's wishes;
- we will respect the person's privacy and only reveal information about them and their situation after discussing it with them first;
- the person will know what is said about them;
- only relevant information about individuals will be given in the action learning group;
- in certain very exceptional circumstances, other duties and responsibilities may override the duty of confidentiality;
- the same points apply to other professionals that we may come across in the course of the action learning work.

Arrangements for preserving confidentiality within the action learning programme

- only information that has been discussed with the individual will be revealed;
- details that they do not wish revealed will remain private;
- they will be spoken of respectfully at all times.

Arrangements for preserving confidentiality outside the action learning programme

- participants may use stories about individuals to illustrate lessons from the programme, but every care will be taken to conceal the identity of individuals;
- care will be taken to ensure that lessons about the work are disseminated in a way which does not invade the privacy or personal lives of the individuals involved.

Working through the protocol

All of the above will have to be discussed at some length and you may need to make several visits or have several contacts before the person can understand what is involved and agree that they want to be part of it. You may wish to work through the contents of the protocol in a different order from the way in which they are laid out above. Communicating a complex piece of information like this is a very high-level skill and you should use your judgement about how much the person can take in at one time and whether to persist with getting their agreement if their initial reaction is negative. The important thing at this stage is to develop a trusting relationship so that the work you do together has a chance of being effective.

Appendix 2

Areas of people's lives checklist

Background

What is the person's history?
What are the key points in their life?
In what ways and how successfully has the person been involved with mental health services in the past?
How have their culture and race affected their lives and their experience of receiving mental health services?

Relationships

What are the relationships in their life?
Are they involved with family or relatives?
Who are the people who care for them (service providers but also friends, neighbours, shopkeepers – anyone who has shown care and support)?

Personal status

What is the person's view of their own worth?
Do they feel valued by other people?
What choices and decisions, both large and small, can they make about their lives?

Home environment

How much personal space does the person have?
Is it easy to get around on public transport from where they live?
Is their home warm and comfortably furnished?
Do they have sufficient household equipment (e.g. for cooking, laundry)?
Do they have any personal possessions (e.g. photos, gifts)?
Do they have a pet?

Places and activities

Over a week, how does the person spend their time? (Look at evenings and weekends as well as 9–5 activities)
Where do they spend their time?

Preferences

What does the person like doing and find motivating?
What activities do they have negative feelings about?

A desirable future

What do they want out of the future, e.g. more activities, a job, friends, somewhere better to live?
What will happen if nothing changes?
What will help the person to get what they want?
What will get in the way?

Some suggestions for using the checklist

- Treat the document as a guide rather than a questionnaire.
- Try to memorise the sections or use it for reference.
- Use the document in the order that seems appropriate rather that working through each section in turn.
- Try to find out what the person (and their family) want; try not to make too many early assumptions about this.
- Focus on the person's strengths, ambitions and interests; these are the assets that you can build on.
- Treat this assessment as a new beginning; you will probably have already carried out a needs assessment with the person and be only too aware of their problems. Be objective about this process.
- If the person finds it difficult to express themselves, spend some time with them (with their agreement) in different settings to get some of the information that you need.
- Reflect on the process as you go along. Think about whether it feels different and what you liked and disliked about it.

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PARTNERS in change

The lives of many people who have serious and enduring mental health problems can be dominated by dull routine, isolation and hopelessness. Real changes in their quality of life can be brought about by professionals supporting service users to achieve goals that they themselves identify as being important for a better life.

Partners in Change shows how service users and professionals can work together as partners in the assessment and care planning process. It also shows the changes which can be brought about in users' lives and in professionals' work satisfaction.

The information and advice provided have been based on experience in developmental initiatives in Clwyd, Leeds and Swindon. *Partners in Change* is therefore a practical book, in touch with the day-to-day realities of mental health services and realistic about the constraints affecting both users and professionals. It nevertheless offers inspiration to mental health workers who want to help users achieve a better future.

Of related interest:

Terry Philpot. *Managing to Listen. A guide to user involvement for mental health service managers.* King's Fund Centre, 1994.

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