Care Services Improvement Partnership CSIP

National Institute for
Mental Health in England

3 keys to a shared approach in mental health assessment

"This exciting document represents an important new contribution to our programme of increasing personalisation of services in health and social care."

Ivan Lewis MP, *Parliamentary Under Secretary of State for Care Services*

October 2008

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Description	This document draws together examples of best practice in multidisciplinary assessment in mental health and social care from both practitioner and service user groups representing voluntary as well as statutory sectors. The Three Keys are the common elements of: 1) person-centrednesss, 2) multidisciplinary approach, and 3) strengths / recovery orientation.
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Forewords

This exciting document represents an important new contribution to our programme of increasing personalisation of services in health and social care.

Working together, much has already been achieved towards putting people as individuals – with individual wishes and needs – right at the heart of everything we do.

In mental health and social care, programmes such as the New Ways of Working, the Common Assessment Framework and the revised Care Programme Approach, supported by The Ten Essential Shared Capabilities and other skills-training initiatives, are helping to build more joined up approaches between service users, carers and providers across both statutory and voluntary sectors. On a wider front, Our Health, Our Care, Our Say and the Darzi Report, have taken us decisively towards our goal of adapting services to people not people to services.

This document highlights a further and crucial challenge: of achieving personalisation not only in how services respond to people's problems but also in how their problems are assessed in the first place. Assessment is primarily what determines which particular services people go on to receive and the effectiveness and efficiency with which those services are delivered. Understanding and personalising the problems is crucial if we are to avoid providing a limited and limiting service.

There are many innovative examples here of how personalisation at the stage of assessment can be successfully achieved in practice. The 'three keys' of The Shared Approach can be used to bring together the very different, though complementary skills and perspectives available from within and beyond health and social care, including the voluntary sector and the non-professionally aligned workforce, in a genuinely shared process of assessment. Also important is the emphasis in the document on strengths, resiliencies and aspirations, with the service users and carers involved, of whatever age, disability, ethnic or cultural group.

I welcome the Shared Approach as a new and distinctive contribution to the personalisation of services not only in mental health but across health and social care as a whole.

Ivan Lewis MP
Parliamentary Under Secretary of State for Care Services

The examples of positive practice given in this document aim to show the value of mental health practitioners working in partnership with those who use services and those who care for them, in a shared approach to understanding a person's problems right from the start of their journey at the stage of assessment.

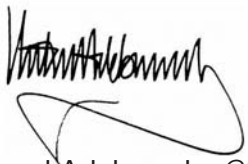
In bringing these examples together we have drawn on the many innovative ways in which highly skilled clinicians and other mental health practitioners are already working in partnership with people who use services and those who care for them, to develop genuinely shared approaches to assessment within existing resources.

We are very grateful to everyone who has contributed to this process and we hope that sharing their experiences will support the further development of person-centered services as advocated for example in Our Health, Our Care, Our Say, Putting People First and Our Choices in Mental Health, and, across the NHS as a whole, in the Darzi Review of the NHS.

As our examples show, person-centered services depend critically on person-centered assessments, that is on assessments that are carried out in ways that make sense to the person concerned and that build strongly on their strengths and aspirations as well as aiming to understand their needs and difficulties.

People who need services often say that achieving the small things has had the most impact in developing trust and strengthening partnership as a basis for recovery. A key message from our examples of positive practice is that it is vital to acknowledge a person's hopes and aspirations right from the beginning of the assessment process if the best outcomes are to be achieved. We hope that this document will inspire people to develop and work in this way.

Genuine partnership between people who need a service or support someone needing a service and those who provide it, within a shared approach to assessment is the path to sustaining and achieving the goal that we all share – recovery of a meaningful way of life.



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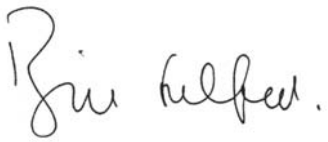

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Introduction

This booklet gives practical examples of three keys to a Shared Approach to good practice in assessing an individual's mental health problems that reflect the views of a wide range of service users, carers and of service providers from both voluntary and statutory sectors.

Three keys were identified by stakeholders as being important if assessment is to support an individual's recovery and his or her development of self management skills

The three keys to the Shared Approach are:

1) *active participation* of the service user concerned in a shared understanding with service providers and where appropriate with their carers
2) input from *different provider perspectives* within a multidisciplinary approach, and
3) a person-centred focus that builds on the *strengths, resiliencies and aspirations* of the individual service user as well as identifying his or her needs and challenges.

Many stakeholders had a positive experience of one or more of the keys but believed they would feel more empowered if all three could be brought together in a fully Shared Approach.

Who will use the Shared Approach?

We hope by extending best practice in assessment that the Shared Approach will be helpful to everyone concerned with the development and delivery of mental health and social care services in England. This includes service users and carers, policy makers, commissioners and managers, as well as staff in both voluntary and statutory sectors involved in all mental health and social care.

Making it happen

The examples given in later sections are of positive practice and some innovative approaches from different groups around the country working with some or all of the three keys.

These examples show how facilitating real participation with the service user at the beginning of the care pathway, developing relationships and understanding with carers and family members right from the start, results in increased empowerment, more sustainable outcomes and a speedier process of recovery.

The aim of sharing these examples is to provide an opportunity to extend best practice in bringing the three keys to a Shared Approach together more effectively across a wider range of contexts in mental health and social care. Used individually the three keys have significant benefit for everyone. Using them altogether the results can be even more compelling.

How the Shared Approach was developed

The Shared Approach was developed with extensive input and support from many stakeholders including individual service users, carers and service providers from both mental health and social care across a wide range of both voluntary and statutory sector organisations.

In addition to a web-based public consultation, workshops were held around the country, a full equalities assessment was carried out, and both voluntary and statutory sector groups provided many practical examples of the three keys in action.

The work has also been supported by an extensive national and international development group representing all stakeholders and a small steering group providing links to other key policy and service development programmes (see Acknowledgements).

Why the Shared Approach is important

Many service users consulted felt that assessments are all too often repeated unnecessarily and without any obvious relevance to how their care is managed. Assessment results were also often presented in a way that did not make sense to them.

'Assessed to death!' 'So what!'
'All Greek to me!'

A service user

The Shared Approach to assessing a mental health problem aims to:

- reduce the risk of repeat assessments being made
- strengthen the relevance of assessments to the individual service user, and
- support individuals to be actively involved in building self management skills as the basis of their recovery and independent living.

The path to recovery and to independence can be blocked right from the start if there is no shared understanding of an individual's particular challenges and strengths.

How the Shared Approach fits together with other policies

The Shared Approach to assessment builds on and extends the revised Care Programme Approach (CPA) as outlined in Refocusing the Care Programme Approach (Department of Health, 2008).

It also supports current policy and practice in mental health aimed at strengthening person-centred health care by using multidisciplinary teamwork more effectively. It thus contributes to the New Ways of Working programme and underpinning skills initiatives, such as the 10 Essential Shared Capabilities, that build on values-based and evidence-based approaches.

The aim of a personalised care system, as set out in particular in Putting People First, depends critically on fully joined-up working between different service providers within the multidisciplinary team. The Shared Approach is a key link particularly between mental health and social care as a contribution to the more effective use of the Common Assessment Framework. The examples of positive practice that we give below include many that illustrate the importance specifically of social work and other social care perspectives within a joined up and fully shared approach to assessment.

Bringing together mental health and social care perspectives at the stage of assessment, in an approach that focuses on an individual's strengths, resiliencies and aspirations as well as their problems, is crucial if services are to support people to live their own lives as they wish with independence and dignity. This is why a shared approach to assessment is the essential first step to personalised care planning.

More about the Shared Approach

The Shared Approach is about people who provide services working with service users and carers to find a strong voice that will help them be understood.

'Everybody's voice is heard, including families and carers'

A service user

First key: active participation of the service user and carer

It is well recognised that service users and carers should be actively involved in how their problems are treated so that they can work together in a shared process with practitioners to develop independence and self-management skills.

The kind of support a service user receives from services depends critically on how they are understood. So the Shared Approach aims to extend active service user involvement from how a person is treated to how their problems are understood in the first place.

Assessment is the gateway to care and treatment. A successful Shared Approach in assessment that includes social care as well as mental health perspectives will lead to improved and more appropriate care planning.

Second key: a multidisciplinary approach

A multidisciplinary approach is as important in assessment as it is in treatment. Different service providers – from both voluntary and statutory sectors – bring different perspectives and skills sets to the process of assessment that can help to identify and highlight an individual's strengths as well as difficulties.

Third key: strengths, resiliencies and aspirations

The approach also highlights the importance of the strengths, resiliencies and aspirations of service users and carers, as well as identifying needs and challenges.

Strengths-based approaches, particularly as they extend to individual aspirations as well as strengths and resiliencies, represent a wide agenda that can only be adequately met through the full diversity of resources of a well-functioning multidisiciplinary team that includes social care as well as mental health skills and perspectives.

There is growing recognition, particularly from the narratives of service users and carers themselves, that individual strengths, resiliencies and aspirations, are essential to recovery and developing self-management skills.

Agreeing to disagree

A shared understanding will not always mean full agreement. It is really important that different views, including different service user and carer views, are acknowledged and mutually respected. This is important because it helps to support a balanced understanding as the basis of mutual engagement in a shared process of recovery.

The practical examples in the sections that follow show the importance of hearing each other's differences as well as agreements.

'Things often go wrong right from the start because carers and families really can't understand how the person concerned thinks and behaves as they do. Having someone to help them understand at this early stage, even if they don't agree with it, gives a very different basis for subsequent engagement'

A carer

Bringing it all together

In the remaining sections we give examples of some of the innovative ways that the three keys to the Shared Approach are being used in practice. We can only include a small sample but other examples and more detailed accounts of the ones described here will be included in the website (see Next Steps).

These examples, which are all based on real people's stories but with biographical and other details changed to ensure confidentiality, show how practical the Shared Approach can be as well as indicating some of the challenges that it presents and how they can be overcome.

For ease of reference, the examples are described separately under the three keys. But the examples also show how effective the Shared Approach can be when the three keys are used together.

Making it happen

The following are some of the key ideas from stakeholders about how the Shared Approach can be made to work really effectively in practice:

- be creative about participation and don't underestimate a service user's ability to make a contribution as a full partner to the assessment process
- be innovative in the methods used for assessment and choose approaches that make sense to the person themselves given such factors as their age, cultural background and possible disability (including 'making reasonable adjustments')
- remember that assessment should be an on-going comprehensive process that is central to engagement and care
- find ways of levelling the balance of power between service users and service providers (for example seeing them in their home where appropriate)
- provide support for carers both in their own right (including providing Carer Assessments) and also so that their understanding can be brought into the service user's assessment
- ensure a multidisciplinary approach that includes social care as well as mental health perspectives
- use an expanded model of the multidisciplinary team that includes non-professionally aligned staff, the voluntary as well as statutory sectors, and those working in services other than health and social care such as housing and the police
- use available assessment resources to explore strengths and resiliencies as well as needs and challenges
- seek to understand an individual's aspirations and build on the contribution particularly of non-professionally aligned workers in responding to them as a key component of a recovery-oriented approach
- build alliances between voluntary and statutory sector teams to ensure appropriate service provision particularly for minority ethnic groups.

All of these are illustrated by the examples in the next three sections.

Training

In the consultation a number of respondents noted the importance of training to support using the Shared Approach. A range of training resources are already available, many including service users and carers as trainers, for example through the 10 Essential Shared Capabilities, the Whole Life workbook and Whose Values? (See References and further reading.)

The time factor and other resource issues

The Shared Approach is not about adding yet another assessment but about sharing best practice in the assessments we already do.

Respondents to the consultation noted that while there might be some initial up-front costs (such as spending more time listening to each other) there were many ways in which implementing the Shared Approach could lead to more effective overall use of resources, including saving time.

Here are some of the examples respondents gave:

- "… If everyone communicates better, treatment is focused... (and) … there should be fewer problems… and therefore resources would be used more effectively. Being actively involved and supported should be more of a positive experience for the patient and carers. This should result in enhanced self esteem and more rapid improvement"
- "If people with mental health problems are able to retain their jobs or enter into employment they will gain a better quality of life, both mentally and financially. If they become employed, their redundant disability benefits will remove a burden on the taxpayer and the employment taxes they pay will contribute to the nation as a whole".
- "…this could lead to a reduction in duplication and repetition in the assessment process".
- "Any effort given to improving the experience of care, and particularly at the earliest points in primary care would produce significant savings in direct treatment costs and the wider burden of care on individuals and their families" (relating to eating disorders)
- "If successful the potential improved management of risk through shared approaches, should decrease the financial and emotional cost of incidents which could be minimised by effective communication"
- "Potential saving during joint working and better sharing of information and managing risks"
- " It may look as if it will cost more, making allowances for what the user and carer want and need. In the long run if it is listened to and tried, (the Shared Approach) could save money as the user/carer will be receiving what services are relevant to their needs. This in turn will relieve lots of anxiety and depression and lead to a happier life and less use of the services"

1 examples of the first key active participation of the service user and carer

The first key to a Shared Approach is that as far as possible the service user concerned and the carer should participate as full partners in how an individual's mental health problem is understood.

This does not mean that people should be forced to participate: some people choose not to choose. This is important in many ways. In particular, it may provide an opportunity for family members to highlight a person's strengths at a time when the person themselves is not engaged.

The examples of positive practice that we give below illustrate some of the many practical ways in which active participation can be supported in a variety of different and often challenging contexts.

Example: group support and participation for people with severe learning disabilities

The Psychotherapy service for people with learning disabilities at Springfield Hospital in London developed a group approach to empowering people with learning disabilities to play a full role in how their problems are understood.

Assessment always involves a psychiatrist and a psychologist or psychotherapist, and much of the work of the Unit is carried out within groups. Problems are worked on together, with the agreement of the individual concerned, including a shared approach to understanding letters from outside professionals and drafting replies. Sheila Hollins describes an example.

"A letter arrived for 'Peter' following an assessment of his future housing needs. The psychologist leading the group said 'We have a letter this week for Peter' and with Peter's agreement, this was read to the group as a whole. The group came to a shared understanding of the letter. They drafted a reply using accessible language. This was typed up and edited further by the group before it was sent off. The reply had Peter's name on it together with others in the group.

"Working in this way has meant that group members felt fully engaged and that their problems were understood in their own terms. Professionals, including those from outside the service, began to relate to group members as people with their own views and a positive contribution to make to how their problems were understood and managed, instead of seeing them as people 'for whom things need to be done'."

Example: poetry and the creative arts

The creative arts are a powerful resource for extending participation. Gilian Sichau (an occupational therapist) and Bernie Collins (a mental health nurse), for example, have run 'Mental Wealth' sessions at Broadmoor Hospital with poet David Neita, on building 'Communication as a vehicle for inclusion" (www.claveneita.com).

These sessions often made vital contributions to understanding an individual's mental health issues, for example by helping those concerned to acknowledge and talk about issues that although important would otherwise have remained hidden.

Example: starting from people's own ways of understanding their problems

Innovative examples were given of supporting participation in particular with young people who may feel excluded by traditional assessment processes. Unless an assessment is made in terms that the persons concerned can understand a shared approach is impossible.

James Farrington, sports therapist and physiotherapist with the GRIP Team (Gloucestershire Recovery in Psychosis early intervention team) in Gloucestershire, described his approach to assessment:

'I always try to find out what people's interests are and I rarely discuss mental health problems such as psychosis directly. I have successfully engaged a number of young service users to take part in community based facilities including snow boarding, playing golf, cycling, swimming, indoor rock climbing and badminton.'

Emma Patten, a senior community support worker with the GRIP team, takes a similar line:

'I find it more meaningful initially to discover what the service user's interests are, about how they are and what they enjoy. I will also find out where they are more comfortable to meet, as some, especially young people, find it difficult to meet up at a mental health resource centre as there is a stigma attached to this.'

Example: Participation and minority groups – Simon's Circles

Sharing Voices, a voluntary sector organisation in Bradford, has developed a variety of approaches that allow people from minority groups to feel safe and included as a basis for understanding their mental health needs.

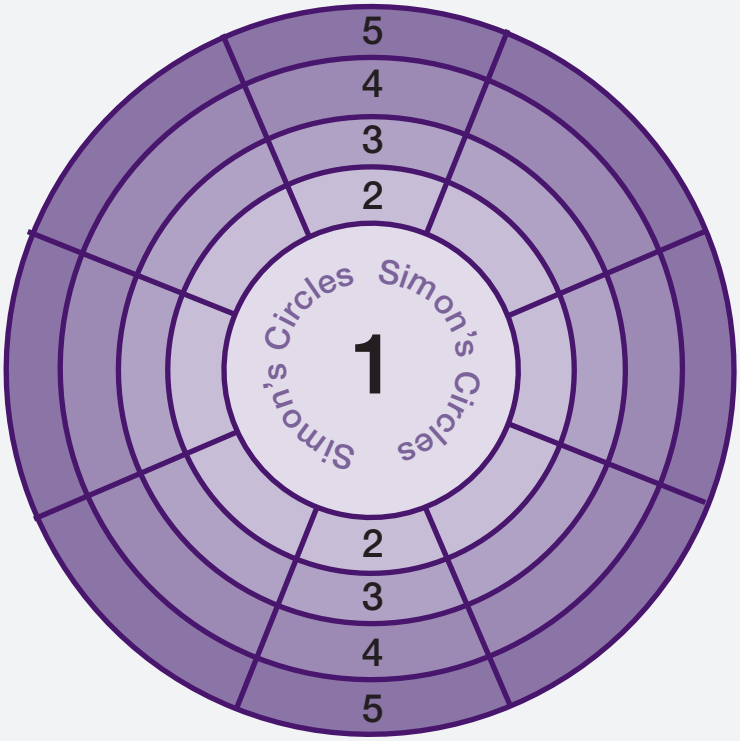
Sharing Voices works with young people in schools using a multi-agency approach that involves school nurses, schools' inclusion managers, community development workers (CDWs) from Sharing Voices, educational psychologists, learning mentors and youth workers.

The aim is to enable young people experiencing distress to gain support at an early stage and to facilitate access routes into services if needed, particularly child and adolescent mental health services (CAMHS).

Simon Hendy, a youth worker at Sharing Voices, has developed an approach to assessment based on a set of circles that allows a young person to define their own needs and what is important to them and how they would like support around issues that are affecting their lives. An example of one of Simon's Circles is given in the following Figure.

As the Figure shows, the young person puts their problems in their own terms at the centre. They then work outwards through the circles building on their own ideas for problem solving. Sometimes young people do not want to talk about themselves so they are asked to define the needs of an imaginary character. This is followed up further by talking and observations to establish if the imaginary character is really a reflection of the young person themselves.

Information from Simon's Circles is linked into other assessments undertaken by the school nurse, learning mentors and inclusion managers. The assessment is holistic and based upon the self defined needs of the young person themselves.



Simon's Circles – please see full explanation in text above'

Level 1) Centre of the circle – name of the individual (i.e. the individual is at the centre, this stimulates conversation around self image/worth/identity.

Level 2) Issues identified by the individual (i.e. from the discussion based sessions where the individual has engaged with you, the issues that affect their emotional health should be coming to the surface/place in the next level of the diagram).

Level 3) Current coping mechanism (how do you cope with the issues emotionally? i.e. anger; drawing, sing, writing poetry, substane misuse, isolation and self harming etc/place in the next level of the diagram.

Level 4) Measure/discuss/record current state of emotional health (i.e. discuss implications around issues from point 3 then measure/record the result – from the implications of the findings, is your emotional heath poor, undefined, good, could be better etc?/place in the next level of the diagram).

Level 5) New coping strategy to support the individual's emotional health, including empathy and positive regard.

NOTE: This asessment should only be undertaken when the individual has trust with the worker (i.e. after 3-4 one to one sessions or when the individual decides to confide/disclose the issues that affect their emotional health).

Example: leveling the power balance – assessment at home

In the consultation many service users and carers said that full participation and partnership in assessment was difficult because of the differences of power between themselves and service providers.

Jonathan Greensides, a consultant psychiatrist with the Crisis Resolution and Home Treatment Team at Chase Farm Hospital in London, shows how carrying out assessment in a service user's own home can help to reduce the power imbalance.

Ms A is a 31 year old lady of Nigerian descent who had completed two years of a three year accountancy degree. She was brought to the emergency assessment centre by the police under the Mental Health Act (MHA) after being found in the street in her night clothes.

She told the assessing doctor that neighbours were talking about her and that they had caused her to develop a skin rash. She also felt that they were making her 'more and more white' by using supernatural forces on her.

She was detained in hospital under the MHA. However, neither she nor her family wished her to remain on the ward. They were planning to take Ms A back to Nigeria to seek help. Ms A's mother as next of kin thus applied to have her discharged. This was not opposed and she went home. However, the family agreed to the involvement of the home treatment team.

Through gentle engagement with Ms A and her family (principally her mother) we have managed to engage them with services, and to commence and supervise medication. It is early days but there are already encouraging signs of recovery: Ms A believes her skin is improving, her self care is better, she is beginning to eat 'normal' food, and is going out of the house alone.

Jonathan notes that their success was because the initial assessment and all subsequent contact took place in the service user's home. Home is far less threatening than the hospital environment as it is "us in their home" rather than "them in our hospital" and this alters the balance of power in favour of the service user and family.

Also crucial was the family's presence at all visits resulting in shared assessment process. As a result there was better understanding of the family's values and beliefs. It was also important that the home treatment team includes workers from a Nigerian background.

Example: leveling the power balance – giving information

Another powerful way of leveling the power balance is to give service users and carers more information before the assessment. Trevor Friedman, a consultant psychiatrist who leads the liaison psychiatry service at Leicester General Hospital, sends National Institute for Clinical Excellence (NICE) guidelines to service users with long term and complex problems (like chronic fatigue syndrome) to read before their appointment.

Alex Mitchell, a consultant psychiatrist in the same service, has extended this approach by using a treatment preferences form that service users can complete while they are waiting for their outpatient appointment. This allows them to think about the options for treatment so focusing the assessment process more effectively around their particular needs and strengths.

Example: leveling the power balance – co-writing histories and letters

The co-writing of a person's story between them and the clinician can also equal the power balance.

Michele Hampson, a consultant psychiatrist with Crisis Resolution and Home Treatment team at Nottingham, has developed a standard template for assessment that uses service user's direct input to how their stories are recorded. This reduces the risk of misunderstandings and helps the process of coming to a genuinely shared understanding. A similar approach has been adopted with letters, these being addressed primarily to the person themselves and copied to their general practitioner.

Susan was a 26 year old who in the past had been abused by a family friend. She was said to suffer from an emotionally unstable personality disorder but her difficulties could be better understood as traumatic stress disorder. This latter understanding was put in a letter from Michele Hampson addressed to Susan and copied to her GP. Susan shared the letter with a carer who was greatly relieved by this insight into her problems. For the first time the carer could understand why Susan behaved as she did which had a significant positive impact on their relationship.

The effectiveness of addressing an assessment letter to the service user depends critically on the assessment process itself being shared. This is why the co-writing of histories is so important. It means that the assessment is a genuine partnership between clinician and service user, allowing the service user time to think about and 'digest' the input of the clinician, rather than being simply offered a diagnosis and treatment plan.

Example: what about crisis situations?

If someone is unwell, particularly in a crisis situation, they may not be able or want to be actively involved in how their problems are being assessed. Rather, assessment should be on-going so that an individual can bring in their own understanding of their problems when they are well enough to do so.

Mick O'Driscoll, a nurse specialist working with Michele Hampson in the Acute Care Network at the Queen's Medical Centre, Nottingham, describes 'Martin's' story to show how important time can be for someone in crisis.

Martin was admitted to the acute care ward, detained under the Mental Health Act (MHA) and accompanied by police officers and the MHA social worker. Martin suffered from a paranoid delusional disorder which when untreated and acute put others at risk, especially neighbours he believed were entering his property. This had once led to serious physical assault on the teenage daughter of his next door neighbour after which Martin was admitted to a forensic unit.

Martin was threatening and aggressive on admission. The police stayed around for the first half hour and extra nursing staff were in attendance. His anger appeared to have peaked and so we gradually reduced the extra security until there were just two people trying to negotiate with him. Despite his threats, our instinct was that he wanted to talk but was too angry to ask for this.

Finally, he accepted a cup of tea and sat down with staff. We listened and gave him time and eventually he was able to focus on his two main worries about admission. He feared his water pipes would freeze and then burst and that his house would be flooded. He was concerned too that he would not be able to visit his elderly mother who lived in a nursing home close to where he lived.

After discussion, Martin went home accompanied by two nurses to make sure his house stayed warm. He returned to the ward visibly settled. The next day, he began to accept medication and within a week, he was having unescorted leave from the ward, visiting his mother and his home and fully engaging with our treatment plans for him. He remained in hospital for approximately another five weeks – a significant reduction on previous lengths of stay.

Example: the vital role of carers

Stakeholders gave many examples of positive practice showing the importance of including carers as active partners in the assessment process both in their own right and because of the important insights they may bring to understanding the service user's mental health issues.

The STEP Team (Southwark Team for Early Psychosis) illustrate the value of support for carers that is based on partnership between voluntary and statutory providers. They offer a range of services for carers in partnership with a voluntary organisation for carers, Making Space. Carer's feedback has been very positive:

"When we finally got help from services and understood what was going on, it was a relief"

"Family support is one of the most important things in people's recovery"

Examples from carers also showed how much pressure their involvement can put on them. Julian Hughes, a consultant psychiatrist with the Psychiatry of Old Age Service in Northumbria Healthcare NHS Foundation Trust, gives this example.

An old age psychiatrist visited an elderly man at home who had presented to his GP complaining of poor memory. Mr Jones was assessed with his wife present at his request. She described an incident after a shopping trip, when her husband suddenly started emptying the contents of the shopping bag onto the floor in an angry and aggressive way and then slumped in a chair. Later he could not recall what had happened. Mrs Jones appeared concerned and kept on catching the psychiatrist's eye with a worried look.

The psychiatrist alerted the senior nurse at the day hospital, Helen Keenan, that Mrs Jones might have other things she wished to discuss. She was invited to a carers' group where she revealed she had felt threatened by her husband. She also said that she was concerned about his erratic driving. Mrs Jones was offered more support and it was recommended to her husband that he have a formal driving assessment.

This story illustrates the need for assessment to continue over a period of time, the importance of a holistic approach that includes understanding the person in their context, and the key role carers may play in achieving a fully shared understanding of the problems and hence realistic plans for tackling them.

Example: a carer's assessment and managing confidentiality

Confidentiality is sometimes given as a reason for excluding carers. This is one of the many situations in which a teamwork approach may be helpful.

Nathan Gregory, team manager and Gabby Mabbott, social worker, describe how this works within GRIP, the early intervention team in Gloucestershire (see page (to be inserted)).

As a team we (in GRIP) try to work with people's families. Sometimes service users do not want us to share information with their families and of course we respect this.

It's a problem when the carer requires a carer's assessment but the service user refuses permission because they are worried we might say something they don't want us to. As service providers we are here primarily to work for the service user and have to be careful to avoid damaging a trust that we have worked hard to develop. But at the same time carers need our support and are often the ones that enable service users to live in the community.

One member of our team was faced with this problem and so a different member of the team, Gabby, carried out the carer's assessment. The service user was happy Gabby was not going to disclose any information about them. The carer provided a great deal of support and was worried. Gabby gave her information about looking after her own mental health, made sure she knew who to contact if worried and put her in contact with a support organisation for carers. Gabby also arranged for her to spend a weekend at a locally organised carers' retreat.

2 examples of the second key a multidisciplinary approach

The second key to a Shared Approach is that assessment should as far as possible be based on inputs from service providers with different perspectives and skills.

Mental health problems are complex and experienced by different people in very different ways. This is why a 'one size fits all' approach to assessment can never work. Usually, a balance of different approaches works best for any particular service user.

Example: a balance of perspectives

The Enfield Crisis Resolution and Home Treatment Team at Chase Farm Hospital in London provided many examples of the importance of a balance of perspectives from different team members where there is disagreement about how a problem should be understood and hence the best way to offer care. Ndidi Mbagwu, team leader, gives an example in which the Mental Health Act was used.

Ms Zion had a long history of schizo-affective disorder, of hostile behaviour, and of non-compliance with treatment/medication. For months she had only talked to her care co-ordinator through the door and had not had any medication or bought food. She denied any mental illness saying she had knee problems and wanted her doctor contacted immediately.

Ms Zion was admitted to the Mental Health Unit under Section 3 of the Mental Health Act because of concerns about her safety and welfare. Although she refused medication, she showed no psychotic symptoms. Accordingly, she was discharged with support from the Home Treatment Team (HTT). However, she again refused access and was discharged back to the community mental health team (CMHT). After a further Mental Health Act Assessment she was again admitted into hospital for treatment. On this occasion she was referred to alternative community services provided by the TULIP Assertive Outreach Team, a service for 'difficult to engage' service users with a long history of mental illness.

Throughout this story there were differences of view about Ms Zion's problems and how to manage them between the HTT and the CMHT. But it was through a balance of approaches that sustained attempts to engage her eventually resulted in an effective care plan.

Example: an expanded model of the multidisciplinary team – non-mental health services

Other examples of positive practice from stakeholders illustrated the importance of an expanded model of the multidisciplinary team that includes positive roles for non-professionally aligned staff (community development workers (CDWs) and support time and recovery (STR) workers), the voluntary as well as statutory sectors, and services other than health and social care, such as housing, employment and the police.

The importance of working closely with services other than health and social care is illustrated by a perinatal mental health clinic that has been set up within the maternity services of the Leicester Partnership Trust by Renuka Lazarus, a liaison psychiatrist working with the perinatal team. The clinic is held on maternity service premises and assessments and care planning are carried out jointly between mental health and midwifery staff. This joint approach has reduced stigma and been helpful in involving carers of patients with post-natal depression in their assessment and developing care plans. The way the service has been set up directly reflects feedback from patients and carers who are involved in all meetings of the East Midlands Perinatal Network.

Example: an expanded model of the multidisciplinary team – services other than health and social care

Chris Snowden, team leader and acting service manager for the Crisis Resolution and Home Treatment team, Nottingham, gives an example of how a tenancy support worker, as an expert in housing, can make a vital contribution in a crisis situation.

Joseph was referred to the crisis resolution/home treatment team (CRHT). His marriage had recently broken down and contact with his two sons was sporadic. His ex wife's continued control of their finances risked him losing his home for non-payment of rent. He was depressed, had previous hospital admission for severe depression with thoughts of suicide, and he owned a rope that in the past he had said he would use to hang himself.

One morning, Denise, the tenancy support worker, found him in a state of extreme distress and expressing clear ideas of suicide. He had received an eviction order as his ex wife had not been paying the rent.

Joseph agreed to go with Denise to the CRHT office. On arrival he was seen by a nurse and the situation was then discussed by the team. The plan, to which Joseph agreed, was that Denise should go with him to the bank to arrange a loan. She would also help him get an early appointment with a solicitor for legal support to regain control over his finances and ensure his own rights were protected. Supported by CRHT staff, Joseph telephoned his brother and explained the situation. He agreed to provide a short term loan.

Joseph got his bank loan and an appointment with a solicitor was arranged for the following day. Joseph had by now greatly improved and was much more optimistic. He was encouraged to contact CRHT during the evening/night if he needed extra support. The team telephoned him in the evening to offer support and a home visit if needed (he declined this).

Helping Joseph through this crisis involved the team as a whole but the expertise of Denise, as the tenancy support worker, was crucial to understanding the real core of his problems and to providing prompt and expert intervention. The input provided by the CRHT and tenancy support worker in this instance quite possibly prevented a suicide.

Example: an expanded model of the multidisciplinary team – the voluntary sector

Sharing Voices, Bradford, as a voluntary sector organisation, works closely with local statutory services to provide a fully joined-up approach for people from minority ethnic groups.

A recent project is an innovative 'In Reach' partnership between Sharing Voices and Bradford's District Lynnfield Mount Hospital, set up to support people from BME (Black and Minority Ethnic) communities entering mental health acute wards for the first time. The project is facilitated by the local FIS (Focus Implementation Site for the Department of Health's Delivering Race Equality programme). It employs a multi-disciplinary approach to make sure that culture, faith, spirituality and family issues are taken into account in assessment and care planning.

Ward staff at Lynnfield Mount Hospital refer people admitted to the hospital for the first time to In Reach, and CDWs from In Reach then visit the wards. Sharing Voices is the only voluntary sector organisation in Bradford that can make referrals direct to mental health service. This two-way process thus allows the skills and expertise of In Reach to interact with the different but complementary skills and expertise of the ward team.

A young student from Iraq's visa had expired. Normally he would have returned home, but the political situation there was deteriorating, he became completely withdrawn and depressed and he ended up being admitted under the Mental Health Act to Lynnfield Mount Hospital. Sharing Voices received a referral from the ward staff and a CDW with the In Reach project, with the same cultural background as the student, went to visit him.

Ward staff were anxious because the student had already attacked a nurse. But the CDW greeted the student with the embrace that is traditional to their culture and he immediately calmed down. He said he didn't want medication but to talk and he went on to explain his concerns about being in hospital.

The result was that the ward team could understand for the first time the student's problems and this in turn led to a care plan that built on the resources of his own culture. The CDW arranged a visit to a local Arab mosque and it was agreed the Imam would visit him on the ward and also try to get in touch with his parents in Iraq. His father travelled to the UK and supported his son. He is now back in Iraq with his family and is doing well.

This example illustrates how joined up working between voluntary and statutory teams can help to engage service users from minority groups in a process of culturally appropriate assessment that in turn delivers more sustainable outcomes.

3 examples of the third key strengths, resiliencies and aspirations

The third key to a Shared Approach provoked more differences of view. This was because, although there are a growing number of evidence-based resources for assessing strengths and resiliencies (see References and Further Reading), some service providers felt that talking about an individual's aspirations might raise expectations that could not be met by health and social care services.

This is important because the experience of many service users and carers is that aspirations are often the key to recovery.

The examples in this section show how understanding and responding to aspirations is an aspect of assessment to which non-professionally aligned workers and the voluntary sector can contribute within an holistic process that becomes the basis of a person-centred and recovery-orientated care plan.

Example: aspirations and non-professionally aligned workers

One of the keys to bringing aspirations into a person's assessment is simply to recognise that they may be quite low key and practical: '… just to be able to go for a walk in the park"', as one service user put it. It is these practical day-to-day activities with which STR workers and CDWs as non-professionally aligned staff, are already involved.

Jenny Correia, an STR worker with the crisis intervention and home treatment team at Chase Farm Hospital, says there is no obvious place on their CPA form to include these 'aspirations of ordinary life'. The result is that many things that really mattered to her clients, and that she could help them with, often got overlooked by the team as a whole in the assessment process.

The team has now begun a small trial with an amended version of the assessment form that they use to build on this important aspect of the Shared Approach.

Example: resources for strengths-based assessment

As mentioned above, there is a growing number of assessment resources for looking at strengths and resiliencies in a recovery-oriented model (see References and Further Reading).

Paul Fitchett, an occupational therapist in Adult Mental Health on the Assessment Ward at the Queen's Medical Centre, Nottingham, describes how an extended process of assessment through activity can contribute to a rounded strengths-based approach.

A young woman, Sally, was admitted to the assessment ward following repeated episodes of self-harm and suicide attempts. Psychiatric assessment showed 'no formal mental illness'. However, a joint psychiatry/occupational therapy interview together with a occupational therapy assessment, gradually revealed the underlying causes of her distress. The woman had deep difficulties in forming new supportive relationships following her move into adult supported residential accommodation from foster care, unresolved grief from her birth mother's death and a lack of realistic and achievable life goals and consequent lack of structure, purpose and hope.

Engagement in valued practical activities (such as cooking) quickly revealed unexpected levels of skill and determination and helped her start to rebuild her self esteem. We supported her in signing up with a local college and in developing a relationship with a new residential worker. A memorial ceremony for her mother was conducted by the hospital Chaplain. Support from the CRHT team contained any short term self harming behaviours and she successfully moved to her new home.

This example also illustrates how on a practical level, occupational therapy assessment is often merged with engagement and treatment facilitated through activity. Assessment, engagement and treatment, instead of taking place in a fixed order, may happen together within the context of everyday activities (in this case baking biscuits).

Example: strengths – another key role for the voluntary sector

Resources for recovery are often blocked by cultural barriers and misunderstandings. The effectiveness of the voluntary sector in helping to overcome such barriers is illustrated by The Listening Imam project run by Sharing Voices, Bradford (see above).

The project was developed in partnership with an Imam employed by a local Muslim charity. It aims to tackle issues of distress at a very early stage and to provide service users with support from within their own religious framework. This includes spiritual/religious understanding and practical support as well as legal issues within the faith. Over the last year the Imam has seen over 50 people and has visited the psychiatric wards when people have asked for support.

A mother and father of Pakistani origin were concerned about their two and a half year old son who they believed had a number of behavioural problems. Physically the child seemed to be in perfect health and mentally he appeared to be acting his age.

A hakima, a woman regarded by many within their culture as having religious knowledge of such things as jinn (evil spirits), had told them they had given their child the wrong name and should change it. The hakima said their son was abnormal because he had been affected by a spell possessed by a demon. The hakima concluded this using 'verse calculation' where the age, day and month of birth of the child is taken and then a search is done in the Holy Quran using the numbers only.

But the Imam explained that verse calculation is prohibited in the Religion of Islam. He told them that their child was a two year old and acting his age. As a religious leader, he showed them how the Quran, instead of causing distress was a source of strength, power and ability to heal.

As a respected religious leader with authority, the Imam's reassurances were effective in helping this family where those of a child psychiatrist or other professional would not have been. The story thus illustrates the important contribution that religious and spiritual leaders can make to understanding and thus resolving mental health issues. But in this instance the story also shows how a problem (the child's behaviour as wrongly interpreted by the Hakima using verse calculation) can be converted into a positive strength (appropriate reliance on the Quran) through the resources that the voluntary sector brings to cultural understanding of mental health issues.

Example: The Listening Imam and support for carers

The Listening Imam project with Bradford's Sharing Voices team has also shown how cultural and religious understanding can turn a difficulty into a resource of strength for carers.

Mr M was a white middle aged British Muslim convert suffering from progressive memory loss due to dementia. He couldn't recall his recent conversion to the Islamic faith. This was a cause of great distress and concern amongst his friends and loved ones who knew that his last approach to life was through Islam, a religion he adopted as his code of life and sincerely believed in as the truth. Should they deal withhis failures to maintain Muslim practices from a Shari'ah point of view or from a Western point of view?

The Imam explained that to fulfill one's obligation in the religion of Islam one had to be of sound mental health as well as physical health. Otherwise the laws of the Shari'ah – covering such matters a obligatory worship, the application of personal law, criminal law and rules of buying and selling – immediately become inapplicable.

It was vital that Mr M's carers had the authority and specific religious guidance of the Imam on which to draw as a strength for helping them to understand and then manage his reversion to non-Islamic practices. As with the previous example, mere reassurances would not have been sufficient.

Example: learning from each other

The growing number of self-help groups in which service users and carers share different ways of understanding and managing experiences of mental distress and disorder are an important resource.

Genevieve Smyth, an occupational therapist with the South London and Maudsley NHS Foundation Trust, described how staff also benefited from a Hearing Voices group that she ran on an in-patient rehabilitation unit.

The success of this group depended on all acknowledging that there was no definitive way of understanding hearing voices and that all views (both staff and service users) were important and deserved respect. The group highlighted the individual's relationship to their voices and how they understood them and hence could develop their own coping strategies.

Staff were supported to work together while acknowledging their different opinions about the experience of hearing voices. It was a challenge to some staff to let go of the 'expert' position and to avoid pathologising the service user's experience.

Next steps

NIMHE East Midlands is supporting the further development of the Shared Approach as part of the values-based practice workstream from October 2008. We are working together on a communications strategy to include a website component.

Implementation of the Shared Approach will also be supported by a number of joint initiatives with other workstreams. These include:

- a development project with the DRE programme
- production of gender equality training materials within the 10 Essential Shared Capabilities
- shared workshops with the recovery-based Whole Life programme (NIMHE Eastern)
- a development network within the Royal College of Psychiatrists.

There will also be individual service development projects with a number of the groups who contributed examples of positive practice.

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