



August 2008

**USERS' MANUAL:**  
**PARTNERSHIP IN COPING**  
**SYSTEM OF RECOVERY**

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## PART ONE

### INTRODUCTION

At a fundamental level the philosophy of the PinC system empowers the person to direct his /her own recovery. This involves the person drawing on their own strengths, in particular their existing strategies to cope with their immediate mental health concerns and, where appropriate, their ability to develop new coping skills.

In developing the system a major decision taken was to use the person's own way of understanding their situation and to use their own words to document their understanding in all of the steps of PinC. We felt that the process of reclassifying a person's thoughts, emotions and behaviours according to a predetermined system of classification, e.g., ICD 10, HoNOS etc, does not only negate the person's own interpretation of their world but would reduce their sense of involvement in the helping process and leads to disempowerment and possible lack of commitment.

The system consists of 8 guided steps

Step 1 creating a working alliance that includes core conditions (empathy, unconditional positive regard and genuineness),

Step 2 identification of experiential threats

Step 3 identification of concerns

Step 4 prioritising concerns

Step 5 identification of personal strengths, i.e., coping strategies

Step 6 setting goals to deal with concerns

Step 7 achieving goals through actions based on personal strengths

Step 8 reviewing progress to achieving goals

Although written as a series of steps the PinC system is not a linear process in that the mental health worker and client may move back to earlier stages before continuing.

The system is specifically designed to work in both community and in hospital settings **where key worker/case manager/primary nursing/case work systems are operating.**

The creation of PinC involved the process of building on thoughts, ideas and theories relevant to mental health and recovery. In other words, PinC was not created out of a vacuum but derived from existing thoughts, ideas and theories on mental health care as well as from the experiences of the clients and mental health workers involved in its development.

The first observation that we make is that the development of the PinC system does not involve rocket science! Its construction was simply making use of what has been around for a number of years combined with evolving thought, ideas and theories of mental health and recovery. What we say about PinC that is distinctive is that it provides a straightforward structure for the application of these existing ideas, theories and personal experience. This structure makes the most of, and plays to, the strengths of, what many competent mental health workers do anyway - often intuitively.

The second observation we make is that in using the PinC system a person does not need to be a rocket scientist! Initially it involves the use of a straightforward process and is easily followed. However the user does require an understanding of the philosophy behind the system and of the methods used in applying the system to ensure that they are confident and effective in their work. Because of this, it is recommended that a three day training course is undertaken for its initial use.

If you are interested in knowing more about the training on how to best use the system contact Eamon Shanley at [jubb-shanley@bigpond.com](mailto:jubb-shanley@bigpond.com) or log onto the website [www.recoveryPinC.com](http://www.recoveryPinC.com)

You can find details of the theory behind the PinC system by reading the papers by Shanley, E., Jubb, M. and Latter P. (2003) and Shanley E. and Jubb M. (2007) and research into the use of the system by Jubb-Shanley, M. and Shanley, E. (2007) referenced below.

### **Issues of Terminology**

In a particular setting such as hospitals the individual receiving help may be referred to as a patient, in the community usually a client. In an organisation such as an NGO the individual may be referred as a consumer or service user. Throughout this handbook the term '**client**' is used to refer to the person who is being helped with his/her mental health concerns. Similarly the term '**mental health worker**' is used as a generic name to refer to the person who is helping the individual deal with this/her mental health concern.

Where reference is made to both mental health worker and client in their working alliance the term '**partners**' are used

## OVERVIEW OF PARTNERSHIP IN COPING (PINC) SYSTEM OF RECOVERY

### Background to Partnership in Coping (PinC)

The PinC system was developed by mental health consumer representatives and mental health nurses working in inpatient, community and educational settings primarily in Western Australia. It was designed to not only accommodate cross cultural variations but also to be used across disciplines and organisations.

Details of the system and the theory underlying it are available in the following publications:

Shanley, E., Jubb, M. and Latter P. (2003). Partnership in Coping: an Australian system of mental health nursing. *Journal of Psychiatric and Mental Health Nursing*, 10, 431-441.

Jubb-Shanley M. and Shanley E. (2007). Trialling of the Partnership in Coping system. *Journal of Psychiatric and Mental Health Nursing*.14, 226-232

Shanley E. and Jubb M. (2007). The recovery alliance theory of mental health nursing *Journal of Psychiatric and Mental Health Nursing* 14, 000-000

The PinC approach is based on the Recovery Alliance Theory (RAT) (Shanley and Jubb-Shanley (2007). This theory outlines the assumptions used and the philosophy and the methods of interactions between mental health workers and clients in which clients apply their strengths in coping with their mental health concerns with the help of a mental health worker.

Our understanding of mental health is that, at different times in people's lives, they may have difficulty in coping with their mental health concerns to the extent that they may benefit from the involvement (or increased involvement) of mental health services/organisations. Mental health concerns cover a wide range of experiences that have, as a common feature, psychological disturbance that is disruptive or likely to be disruptive to the person's way of life. The classification of the person's experiences into a diagnostic category, while important to psychiatrists, is not seen as helpful to the work of other mental health workers in the mental health field. Instead the mental health workers' contribution relies on accepting the person's own understanding of their concerns (not the psychiatrist's or the mental health worker's) and the level of involvement of the mental health worker depends on the degree to which the person is coping with their concerns. Stated simply, the work of the mental health worker in using the PinC system is to apply a problem solving approach in helping the person prioritise their concerns, set goals and use previous coping strategies to achieve these goals.

### **Working Alliance**

In the PinC system the client and the mental health worker engage in a partnership within a working alliance. The presence of the working alliance particularly early in the engagement is, according to research findings, the best predictor of outcome in psychotherapy (more so than any particular psychotherapeutic approach). (Henry et al. 1994)

Therefore it is crucial in helping the user of the service that this alliance is established as early as possible in the engagement.

The working alliance consists of three components, namely bond, goals and tasks.

**Bond** - is the foundation of the working alliance and its initial development is the main focus of the first of the 8 guided steps in PinC. Success of the ensuing partnership depends on the growth and maintenance of this bond throughout the engagement. The bond (therapeutic relationship) involves the creation of core conditions of empathy, unconditional positive regard and genuineness (see page 10-13 for more details). These conditions help create a positive relationship between the partners (mental health worker and the client) such as mutual trust, acceptance, confidence and feelings of a common purpose (Bordin 1994).

**Goals** - involve an agreement between the partners in achieving specific goals. The goals are primarily established by the client with the support of the mental health worker

**Tasks** - concerns collaboration on the action to be taken as outlined in the guided steps of PinC.

Within PinC, the bond, tasks and goals are integrated in a systematic way in the partnership designed to give clients the major responsibility in undertaking tasks towards achieving their goals.

### **Role of the mental health worker**

The main focus of the mental health worker's role is to follow the 8 guided steps of the PinC system. Other tasks associated with the work of mental health workers such as nurses may be to monitor and report on signs and symptoms and drug side effects. This is seen as a secondary function of the role of the mental health worker and constitutes only a small part of their collaborative role with other mental health colleagues principally doctors.

PinC requires the use of interpersonal and social skills already possessed by many competent mental health workers including mental health nurses (Shanley and Jubb-Shanley 2007) such as

1. everyday speech.

The use of everyday speech and narrative minimizes the inequality in the power relationship, improves communication and helps develop a helping relationship. Reclassifying what clients say and do into predetermined categories is excluding of them. The ordinariness of the relationship and the ability of the mental health worker to be friendly and approachable go some way in demonstrating a common humanity with clients.

2..competence in engaging with clients in variable context and times

These encounters may be impromptu or planned. For example, they may meet at the individual's house or at public places such as the cafe or local park. These encounters demand interpersonal skills beyond those used in engaging with clients in more predictable setting, e.g., appointments in interview rooms etc.

3. self-disclosure

The use of calculated self-disclosure by mental health workers can facilitate the clients' understanding of their own thoughts, emotions, behaviour and circumstances, Self-disclosure can enhance the therapeutic relationship which has a positive effect in helping the client feel understood (Burkard et al. 2006).

4. unscripted dialogue

By the nature of their role mental health workers deal with unpredictable behaviour and situations ranging from social exchanges to the client's expression of intense anger. Planned and

unplanned encounters may occur in variable contexts and at variable times, e.g. inside and outside the regular 9-5 schedule in the hospitals or in the community and require the mental health worker to 'think on their feet' and interact accordingly.

#### 5. holistic perspective

Mental health workers use a holistic perspective of the client's experiences. Both mental health workers and clients recognize that issues outside the remit of the traditional medical model are a legitimate concern. For example many psychiatrists and clinical psychologists have a much narrower perspective in focusing on the application of their expertise to clients' health, such as prescribing medication and the application of specific techniques such as cognitive behaviour therapy.

Through the use of these interpersonal and social skills the mental health worker:

- acknowledges that the responsibility for getting well and staying well is the client's responsibility and not that of the mental health worker
- recognizes and builds on the strength and resilience of the client
- promotes the experience of hope, empowerment and connection
- focuses on helping clients employ their skills to cope with their mental health-related concerns and not necessarily to help cure them
- value and uses the client's contributions to the process of recovery

## PART TWO

### **Working Through the Phases of PinC**

It is acknowledged that most experienced mental health workers are competent in interpersonal and social skills and those reading this manual will recognise aspects of their own work in the description of the stages of PinC. What is helpful to these mental health workers is that PinC provides a structure and process in which they can apply these existing skills and provides a process that can accommodate their further development.

Other less experienced mental health workers and students will also benefit from using this manual in further developing their basic skills by working through the guided steps of PinC. For their benefit some additional information on each of the steps is provided in the recommendations and suggestions contained under '**Notes**'.

Although set out in 8 guided steps or stages, the PinC system is not necessarily a linear process. In their working alliance, the mental health worker and client may move back to and forth to and from earlier steps before completing all the stages.

### **Phase One -establishment of core conditions (bond)**

#### **Aim**

- To establish a working alliance particularly the core conditions in the relationship with the client, namely unconditional positive regard, genuineness and empathy (Rogers, 1957)
- To exchange information with the client

## **Action**

The core conditions of Unconditional Positive Regard, Empathy and Genuineness form the bedrock of the working alliance between the client and the mental health worker. The following is a brief description of each condition.

### **Unconditional Positive regards**

To establish this condition the mental health worker conveys to the client the feeling of being viewed as a worthwhile person despite the fact that from time to time they may disagree, have different values or behave in what others may see as an unacceptable way. In other words, the client recognises that the mental health worker values him/her without making their regard dependent on the client behaving in a way that meets with the worker's approval

### **Empathy**

The mental health worker attempts to understand the client's experience from the client's point of view and communicates this understanding in a way that fits with the client's mood and content of conversation.

The client feels that the mental health worker has gone some way in placing themselves in their position and experience what it is like "to walk in their shoes".

### **Genuineness**

Being genuine means more than just being honest with a person. It means an internal honesty for the mental health worker who conveys it to the client. Rogers (1980) described genuineness or congruence thus: 'when my experience of the moment is present in my self awareness and when what is present in my awareness is present in my communication then each of

these three levels matches or is congruent' (Rogers 1980 p 15). It is worth reflecting on this statement in order to understand it fully.

Being genuine doesn't mean the mental health worker discloses all. The MHW shares with the client feelings and sensations that are a response to the person, that are relevant to the immediate concerns of the person and are relatively persistent or particularly important.

The client, for his/her part, appreciates that the mental health worker is open in being him/herself and not putting on a front.

The presence of these core conditions has been shown to have a powerful therapeutic effect on clients for many kinds of problems even without any additional techniques being employed. However increasingly it is recognised that offering a structure, such as the PinC system is appropriate in helping a person with mental health concerns deal more immediately with those identified issues. A major advantage of the PinC system over techniques such as cognitive behaviour therapy is that PinC offers a more holistic and humanistic approach designed specifically for the work of mental health worker.

## Notes

In engaging with the person that has mental health concerns an area conducive to relaxed social interaction is arranged.

The following is an example of how a mental health worker might start to engage with the client:

- Initially the focus of conversation is likely to be on 'safe' factual topics, e.g. aspects of their surroundings eg weather, recently events eg football games, films, television program, and topics that

are non personal or directly related to the client's reason for being in hospital.

- The conversation progressively moves to open discussion that embraces aspects of clients' life, common interests, likes and dislikes.
- Later the conversation moves to the narrower issue of clients experiences such as their subjective feelings and what they see as happening to them.
- Mental health workers provide information such as the gaps in the clients' understanding about the organisation they have engaged with, the type and level of help they are to receive, their rights and, the service they can expect.
- The mental health worker may also obtain information about the clients' psychological and social circumstances and enquires about general and positive aspects such as interests (likes, dislikes), strengths, talents, goals and support systems available. The mental health worker explains his/her role and how they (both client and mental health worker) can work together using the PinC system.

## **Phase Two (optional) - Identification of experiential threats (at risk screening if appropriate)**

### **Aim**

- To determine the degree of risk presented by the client.

### **Action**

Clients' degree of risk is best assessed by mental health workers who already have established a positive relationship with the client.

Standardised forms are usually provided by the individual service to help make this judgement.

### **Notes**

Documentation for assessing risk will be available from your own services or other organisations that you are working in conjunction with.

## Phase Three - Identification of concerns

### Aims

- To identify concerns experienced by the client

### Prerequisites

- 1/ establishment of core conditions (as the initial phase of the working alliance).
- 2/ identification of experiential threats (risk assessment, if required, by completion of 'at risk' screening (optional).
- 3/ (a) spare sheets of paper on which to draft the person's concerns  
(b) possession of the Range of Life Experiences document

### Action

A description of the client's concerns is written on the PinC Head Sheet (See Figure 1) of the PinC Process Records.

### FIGURE 1

#### PinC Head Sheet

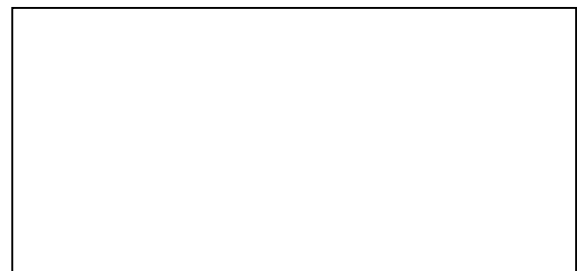
Date:

Case Manager/Case Worker/Support Worker:

Other Support Workers:

Concerns Prioritised:

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.



### Please Note:

Any number of concerns may be prioritized.

Documentation is in the client's own words written in a clear understandable language directly by the client or transcribed by the mental health worker. Professional jargon, unless used by the client, should not be recorded on the PinC Process Records.

## Notes

A basic assumption of the PinC system is that there is little therapeutic value in using a medical diagnosis. That is, having a category into which the person has been fitted, adds nothing of major benefit to the work of the mental health worker. It doesn't make any difference whether you think the person is experiencing depression, anxiety or schizophrenia. What is important is that your understanding of the person's concerns is based on his or her understanding of their experiences. Establishing a relationship that is genuine, that you are managing to grasp the person's experience (empathy) and that you value him or her without it being conditional will help you both start the process of clarifying the nature of the person's concerns and subsequently working to sort them out.

Identifying core meanings of the concerns raised may be helped by such questions as

- What do you make of that?
- Why is it important to you?
- Are there other ways of examining these concerns?

For many clients the task of describing, discussing, clarifying and recording the nature of their concerns has been shown in itself to be of considerable help e.g. identifying and challenging blind spots. Care should

be taken that the discussion does not invalidate the client's experiences or infer that their concerns are trivial or insurmountable.

The task of clarification of concerns may also reveal issues such as the clients' external locus of control perspective. The statement 'I have to visit my mother every weekend', may infer that the individual believes he/she has no choice in the decision. This revelation may provide insight for the client into his/her sense of control over his/her own life.

In their interaction with clients there is an opportunity for the mental health worker to increase the client's sense of control. Ways of increasing the client's influence over the interaction includes the Socratic method of dialogue e.g., refraining from offering a solution or an interpretation that the mental health worker might feel is very obvious solution and instead encouraging the person to explore the issue much further and to arrive, at their own pace, a solution or interpretation. This interpretation may or may not be the same understanding as the mental health worker).

The process of identifying concerns involves breaking down the whole story into smaller, more manageable concerns and then helping the client to priorities them Before arriving at the final statement of each concern the client is encouraged to discuss examples of each concern and to consider the frequency of occurrence of the problem and the severity of effects on his/her life.

Examples of questions to tease out the precise description of the concern:

- Can you expand/give me an example of the concern you've mentioned - what has led to the episodes themselves and the consequences following them?
- Has this issue always been a problem?
- How often does it occur?
- How has it affected your life?
- Which aspect/s of the concern do you want to do something about?

Where the mental health worker feels that the description of the concern is still unclear he/she may seek clarification by asking

- Are there any other ways of looking at the situation?
- How do others see the situation?

The aim is to help the client to reach a definition of the concern through their own reasoning processes. It is not the mental health worker's position to point out what they see as obvious concerns or indeed solutions to these concerns. When the concern is clarified by the client it is accepted by the mental health worker and treated as legitimate even when the mental health worker does not see the concern as 'real'.

Concerns not amenable to the skills of the mental health worker and outside his/her remit are referred to an appropriate colleague, discipline or service.

## **Phase Four - Prioritisation of concerns**

### **Aim**

- The client identifies concerns in order of priority

### **Prerequisite**

Establishment of working alliance

Identification of experiential threats (optional)

Identification of concerns formulated

### **Action**

Concerns described in the record sheet are listed in order of priority.

The client may require help in determining the order of priority of their concerns. Practical issues such as the time available, degree of difficulty and resources available should be taken into consideration.

### **Notes**

The number of concerns ranked depends on the estimated time and effort needed to deal with them. No more than six concerns are recommended though the client may decide on identifying more.

## **Phase Five - Identification of existing coping strategies**

### **Aim**

- To identify coping strategies used by the client in addressing the concerns that have been identified as being the highest priority.

### **Prerequisite**

Establishment of core conditions (bond)

Identification of experiential threats (optional)

Identification of concerns

Prioritisation of concerns written in the PinC Process Records.

### **Action**

The coping strategies to deal with the concern that the client considers as the highest priority are explored. (Other concerns are addressed in their turn).

The actual concern (with its original wording) or the Concern Number is recorded on page two of the PinC Process Records (see Figure 2) followed by descriptions of strategies previously used by the client in addressing this particular concern.

Once a precise as possible definition of the 1<sup>st</sup> concern is determined, each of the strategies that the person had previously used to cope with that concern is examined.

Questions that the mental health worker may find helpful in discussing the concern mainly include personal resources and social resources the individual possesses;

- Was there a time when the issue wasn't a concern?

- How was the concern successfully dealt with previously?
- What did **you** do to deal with this concern?
- What did **your family** do to assist you in dealing with this concern?
- What did **your friends** do to help you in dealing with this concern?
- What did **non-mental health agencies/facilities** do to assist you in dealing with this concern?
- What did **mental health services** do to assist you in dealing with this concern?
- What **other resources** did you use in dealing with this concern?

It is recommended that the process of identifying resources that the person had used in the past to cope with their concern should adopt the 'normalisation' process i.e. start with the person's own strengths moving to the person's family and social network and as a last resort considering the resources within the mental health services.

It may be that the strategies the person used in the past may not be considered effective by the mental health worker e.g., self medicating with alcohol or other drugs when depressed. Negotiating with the person about the effectiveness of particular strategies may result in alternative strategies being adopted.

**FIGURE 2**

**PinC Process Records**

<p><b>CONCERN DESCRIPTION or NUMBER:</b></p> <p><b>Coping Strategy/ies used previously:</b></p>
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**Notes**

Coping with a particular concern can be helped or hindered by the person's general characteristics such as degrees of self efficacy, optimism, cognitive abilities and general personality traits such as openness to experience and agreeability. The process of achieving the goal of coping with specific concerns can also bring about changes in these general characteristics which, in turn, can help the person's general ability to cope with other concerns. Thus the long-term goals of the PinC system are to improve these characteristics that impact on the person's ability to cope.

Coping strategies can be understood in terms of the person trying to 'think through' the concern (cognitive approach), e.g. re-appraising the experience, and in 'acting through' the concern (behavioural approach), e.g. taking medication, avoiding trigger factors etc. Alternative coping strategies may involve cognitive avoidance (becoming resigned to the

problem) and behavioural avoidance (acting out or finding distractions).

See Table 1

**Table 1**

<b>Strategy</b>	<b>Approach strategy</b>	<b>Avoidance strategy</b>
Cognitive	1 Logical/Analytic and positive reappraisal	3 Acceptance/Resignation
Behavioural	2 Seeking Guidance Support and Actions taken in Problem solving	4 Seeking alternative rewards Emotion Discharge

1. Cognitive approach strategies (logical/analysis and positive reappraisal).

These strategies involve paying attention to one aspect of the situation at a time, drawing on past experiences, mentally rehearsing alternative actions and their probable consequences and accepting the reality of a situation but restructuring it to find something favourable.

Examples of Cognitive approach strategies are ignoring unwanted thoughts or perceptions, concentrating on planning or resolving some problems.

2. Behavioural approach strategies (Seeking Guidance Support and Problem-solving)

These strategies include seeking guidance and support and taking concrete action to deal directly with a situation or its consequences.

Examples of behavioural approach strategies are seeking help from others including professional help.

Other behavioural approaches that may give the person a greater sense of control over his/her concerns are to display what might be considered

mental illness related behaviours such as contacting police for protection, shouting demands to be left alone or telling voices to shut up.

### 3. Cognitive avoidance strategies (Acceptance/Resignation).

These strategies are aimed at denying or minimising the seriousness of a situation or its consequences as well as accepting the situation as it is and deciding that the basic circumstances cannot be altered.

### 4. Behavioural avoidance strategies (Seeking alternative rewards and Emotion Discharge).

These strategies involve seeking alternative rewards by becoming involved in new activities. These strategies include openly venting one's feelings of anger and frustration and behaviour that may temporarily reduce tension, such as acting impulsively and doing something risky. Examples of behaviour avoidance strategies control include distraction (passive listening to radio, music or watching TV) and active distractions (playing a musical instrument, writing a diary or gardening and socialising with family and friends).

Although written here as discrete ways of coping there is often overlap between the strategies and indeed one strategy can usefully lead to another. For example the use of social support of family and friends has been shown to lead to approach coping strategies such as positive reappraisal and seeking guidance and support and less on avoidance coping (Moos et al 1990).

As a footnote, it should not be assumed that the person's social network is always a useful resource. Sometimes negative aspects of the network

whether family or friends such as conflict and criticism are harmful to the person's recovery (Moos and Holahan 2003),

### **PinC and Cognitive and Behavioural strategies of coping**

Individuals who rely more on approach coping strategies rather than avoidance strategies tend to adapt better to life stressors and experience fewer psychological symptoms (Holahan and Moos 1991). It has been shown that people who develop mental health problems have less reliance on approach coping strategies and more reliance on avoidance coping strategies (Deisinger et al 1996). The PinC system, by its design, helps the client to focus more on both cognitive and behaviour approach strategies of coping with less emphasis on avoidance strategies.

Goal oriented cognitive and behaviour strategies such as those encouraged in the PinC system predict a decrease in symptoms of anxiety disorder, somatoform disorder, alcohol dependence, and thought disorder ((Vollrath et al 1996). Coping strategies of distraction and venting emotions predict increased symptoms of major depression, dysthymia and several other conditions (Vollrath et al 1996). While the PinC system promotes the use of approach coping (active coping) as an important strategy, avoidance coping can also be useful. Their usefulness depends on the interaction between the person and social resources and the situation being encountered.

Despite what the mental health worker may feel are solutions to the client's situation the decisions as to what coping strategies are used will primarily rest with the client. Whether the strategies work or not will be determined during the review by both the client and the mental health worker. The likelihood of failure in the eyes of the mental health worker should not warrant overriding the desire of the person to use a particular coping strategy. Even if the goal has not been achieved the selection and

use of a particular coping strategy is a learning experience for the client and will affect the client's perception of dealing with that or similar concerns in the future.

Should the client have difficulty in identifying previous coping strategies the mental health worker may consider giving examples of strategies other clients have used. (Obviously it would be more useful if the client came up with their own strategies). For example contacting friends when lonely (behavioural approach) or the use of relaxation, sport, music, or meditation (behavioural avoidance) which are not aimed at addressing the concern directly but at managing or altering their emotional response to the concern. Examples of coping strategies used by clients that have been devised in collaboration with consumer representatives are recorded in the document Range of Life Experiences. Please Note: **These examples should only be used as a prompt when the person has difficulty in identifying their own strategies.**

## Phase Six- Setting of goals

### Aim

- To define a goal or goals that addresses the concern or part of the concern.

### Prerequisite

Establishment of core conditions (bond)

Identification of experiential threats (optional)

Identification of concerns

Prioritisation of concerns written in the PinC Process Records.

Identification of existing coping strategies

### Action

The process of creating each goal is divided into two stages

The first stage is a statement of the goal. The client will be encouraged to write the goal using the following format:

'I will .....' (clients goal)

The second stage is also part of the first statement and will state the action the client will take to achieve the goal.

'..... .by.... ..' (actions to be taken by client)

The complete statement will read:

'I will.....by.....'

Although written together each stage is dealt with separately namely identification of the goals and then consideration is given as to how best to achieve the goal using existing coping strategies. However the goal and the action agreed upon to achieve it are open to modification in light of feedback so they are compatible with one another.

In the PinC Process Document the first part of the goal statement ['I (client) will....'] is to contain the **goal statement** while the second part of the statement ['by...'] is to contain the **action** or means of achieving the desired outcome. The date when the outcome is to be achieved and when the means of achieving the outcome are also recorded. (Note that success or otherwise of the working alliance is judged according to the outcome statement and timeline). The review dates relate to the **action** to be taken **NOT** when it is intended to achieve the goal itself. For example if the client's goal is to reduce his feeling of loneliness one action that he may take is to join an internet chat line. The review date refers to when the action has been carried out, namely, when he will have joined the chat line list not when he will reduce his sense of loneliness. The section on 'goals' in the PinC Process Document is completed and is signed by both partners.

**Figure 3**

<b>GOAL:</b> I will ...  <b>Date to be achieved:</b>	
<b>ACTION:</b> By ... (state how this will be done)	<b>Date when action will be taken.</b>

Action Number	Dates actions are to be reviewed.		

Client's Signature:

Date:

Mental Health Worker's Signature:

Date:

## Notes

### Identifying Goals

The aim is to help the client to clarify what options are possible in terms of things being different.

(a) Discussion, negotiation and agreement on goals.

All goals are treated as sincere aspirations of the person even if the goals appear unrealistic to the mental health worker.

For example the client may express the desire to become an astronaut.

The mental health worker may start by saying 'what would you need to do to become an astronaut'? If the client has not already done so he/she is helped to find out more about the way of become an astronaut. In this way the client discovers for himself/herself what is expected and arrive at his/her own conclusion as to the cost and benefits of pursuing this ambition.

(b) Statements of goals are not reframed into professional language.

A client's goal of 'making more friends' should not be translated as 'improve socialisation skills'. The client may consider identifying past and current friends, identifying opportunities to re-establish contact or to make new friends.

(c) Some clients may be reluctant to consider what can be done. In these situations a skill of the mental health worker is to encourage clients to free themselves from reality constraints of the "Yes, but...." perspective.

**Desirable for the client and the mental health worker** (Success of the process is dependent on high levels of motivation in both parties).

Goals that are not owned by a person are rarely achieved.

Some attitudes may lead to undesirable goal, for example;

- Desire for quick result
- Setting of high goals
- Failing to revise initial statements of goals
- Feeling I must always be liked by the other partner (client by mental health worker, mental health worker by the client)

Where differences arise both client and the mental health worker should **negotiate** and not simply accept the goals the other has proposed.

### **Achievable**

It is recommended that the goals are modest.

There is a danger of either or both partners to miscalculate the match between the client's ability and the goals set. However this gap may be reduced through discussion between partners. In addition, misjudging the person's motivation such as their perception of the rewards and their perception of the cost of trying to achieve the goals may result in failure.

A goal that is ambitious requires time and resources. Sometimes too many goals are established at the same time leading to a diffusion of effort.

Conversely, if a goal is set too low, feelings of personal excitement or interest may be insufficient to fuel efforts designed to achieve the goals. Establishing a balance between the goal and the clients resources is a skill based on thorough knowledge of these factors and the person's motivation.

Failure to identify small incremental steps to achieve a goal may send the message of incompetence to the client. The tendency to attribute shortcomings in achieving the goal to the presence of a mental illness may result in seeing the disability as a state rather than being a shortcoming frequently experienced by others unaffected by mental health concerns.

### **Ownership**

Ideally goals should belong to both the mental health worker and the client.

It is one thing for the mental health worker to state the goals, another is for the client to agree and yet another for both to work on implementing them. When the going gets difficult the mental health worker may revert to the traditional role and either overtly or covertly assume responsibility for the creation of goals. The chances of success in achieving goals set are likely to be minimal without the active involvement of the client.

### **Specific and able to be Evaluated**

Vague and ill- defined goals are rarely achieved.

Goals may lack a clear and concrete set of behaviour reference, e.g. goals related to "feeling better about myself", "having meaning in my life", "feeling more connected" or "getting a job that makes me happy". Clients should be encouraged to restate their goals in terms of more concrete

specific behaviour that can be seen as being accomplished or not. Instead of saying "George will do more things with friends" it is more useful to state "George will go to the movies with John next week" as it is more specific and able to be evaluated.

### **Clearly stated goals**

Writing goals in a way that is clearly understandable by the client is likely to have more positive outcome. Some mental health workers and clients find it more useful for the user to write the goals (as well as the other parts of the documentation).

Regardless of which of the partners records the decisions taken it is important that both have a clear understanding in order to progress to the next step.

There is a danger that the mental health worker may not realise that many of the kinds of activities that they take for granted may represent significant steps or obstacles for the client. The process of writing goals in a way that is clearly understandable by both partners is likely to have a more positive outcome.

Clients should be presented with a range of options in making goals more specific.

Should the rare occasion occur when it is difficult for the partners to agree on appropriate goals advice from a respected third person may be sought.

## **Modification of goals**

The process of modification of goals includes clear documentation as to reasons for changing the goals and justification for the adoption of the replacement goal.

## **Looking at Things Afresh**

Where there is agreement that the previous coping strategies were effective, similar coping strategies may be adopted. Where they were not considered to be appropriate for the present situation discussions take place on ways of modifying these strategies. If neither of these options is feasible a third option (looking at things afresh) is considered following a **similar** line of questioning as previously namely.

- What can you do to achieve this goal?
- What can your family do to assist you in achieving this goal?
- What can your friends do to help you in achieving this goal?
- What can non-mental health agencies/facilities do to assist you in achieving this goal?
- What can mental health services do to assist you in achieving this goal?

## **(b) Means of achieving goals i.e. 'by....' (actions taken)**

The action to be taken is based on the coping strategy identified at an earlier stage of PinC system. For example, if a client's mental health concern was about feeling lonely and helpless she might identify her previous coping strategy in dealing with this experience as visiting her sister twice a week and her involvement in a local church. Now that she has moved away from that area she misses these contacts and feels lonely and helpless. Her goal of keeping existing friends and making new

ones is to be achieved by the following action - arranging to ring her sister at an agreed time twice a week and by contacting the vicar in the local church.

As stated earlier the processes involved in the phases of the PinC system are not linear. Constant references are made to earlier decisions and monitoring the progress of actions taken to achieve the goals set.

## **Phase Seven - Application of coping strategies**

### **Aim**

- To help the client to apply his/her coping strategies

### **Prerequisites**

Establishment of working alliance (bond tasks and goal)

Identification of experiential threats (optional)

Identification of concerns

Prioritisation of concerns written in the PinC Process Records

Identification of existing coping strategies

Setting of goals i.e. completion of sections on 'goals' in PinC Process document and signed by both partners.

### **Action**

The agreement between the partners in the application of the coping strategies may be understood as a contract. The contract involves maintaining the agreed plan of action and not changing things until after

the agreed date of review unless the action is detrimental to the person's interest.

Progress of the action agreed upon is entered in the appropriate sheet following each meeting with the client.

### **Notes**

Depending on how thorough the ground work is in determining the goal, the practicalities of attaining the goals should be without any major problems. This is dependent on the fact that the action is within the client's capacity and on the motivation of the client. The role of the mental health worker during this activity is to be accessible to the client and provide encouragement without over-stepping the level of support mutually agreed upon.

Here there is a danger. The maintenance of the bond or partnership relationship throughout the guided steps involves mental health workers relinquishing much of their responsibility for the wellbeing of the client. In turn clients are expected to take up the major responsibility for their wellbeing. In so doing, the client is more likely to become more motivated and committed to implementing the action agreed upon.

While the greater sharing of responsibility may be welcomed by some clients and mental health workers it may be difficult for others to accept this change of roles.

## Phase Eight - Review of Outcome

### Aim

- To identify the degree to which the goals have been achieved.
- To review the process and determine the action to be taken eg. whether to activate the process again.

### Prerequisites

Establishment of working alliance (bonds, tasks and goal)

Identification of experiential threats (optional)

Identification of concerns formulated

Prioritisation of concerns written in the PinC Process Records.

Identification of existing coping strategies

Setting of goals i.e. completion of sections on 'goals' in PinC Process document and signed by both partners.

Application of coping strategies

### Action

Decisions re taken by both the partners of whether the goals were achieved, partially achieved or not achieved. A review of the process and discussion on further action if any is to be taken.

This review may include the systematic examination of each step of the PinC process.

### Figure 4

(This section is to be completed jointly by the client and the mental health worker)

<b>Goal No:</b>
Please tick in the appropriate box.
<b>Achieved</b> <input type="checkbox"/>
If achieved indicate factors that facilitated the achievement of the goal.

<p><b>Not Achieved</b></p> <p>If not achieved indicate factors that prevented the goal from being achieved.</p>
<p><b>Partially Achieved</b></p> <p>Indicate the stage reached and outline reason/s for the goal <i>being/not being</i> fully achieved.</p>
<p><b>If you (Mental health worker and client) were to address this concern again what would you have done differently?</b></p>
<p><b>What do we need to do about this situation, eg. re-commence goal setting?</b></p>

**Client's signature** \_\_\_\_\_

**Mental Health Worker's signature** \_\_\_\_\_

**Notes**

The outcome may not be the terminal stage of the process. It may be part of a continuous cycle. Both the mental health worker and client determine whether the goal has been achieved, not achieved or partially achieved.

If the goals have not been achieved or partially achieved a number of factors may be responsible. Goals set may be too ambitious. The expected resources or support may not be available or provided or used. Either or both partners may not be motivated. There may be a lack of understanding of task or problems.

Examination of successful outcomes should be as thoroughly investigated as factors that are associated with lack of success with organisational factors such as protocols contributing to success clearly identified and

acknowledged. In addition personal factors such as motivation and overcoming of obstacles are also acknowledged.

The reasons for the success or otherwise of the outcomes are discussed and, regardless of what they are, care is needed to avoid giving a message of blame to either partners.

The system of evaluating outcome is an integral part of the PinC process in that it measures the unique goals formulated by the individual client. Other measures of outcome such as HoNOS and LSP offer standardised criteria against which clients characteristics are measured. While they may be useful in providing data relevant to groups of clients (aggregate data), they do not play as integral a part in the individual's recovery process as the client-centred outcomes in the PinC system. This way of evaluating outcome is also useful both in reformulating goals, partially or not achieved, and modifying the subsequent steps of PinC, and, when the goal is achieved, in using the experience to address the next concern on the list of priorities.

Following the review a decision is made as to how to proceed with the situation. A preferred option is to recommence the guided steps of PinC and change the aspects of the goals setting process that both partners feel will achieve a better outcome.

## PART THREE

**Below are extra notes describing interpersonal relationship skills that facilitate the development of the working alliance.**

### **Interpersonal Relationship Skills**

The development from the first contact and maintenance of the working alliance to the end of their partnership requires the skilful use of interpersonal skills. The process of 'getting to know you' will first of all depend on getting beyond the stereotype possessed by each about the group the other belongs to. Information previously acquired about the individual and the information acquired during their conversations takes time and the speed in which the relationship is driven by one or the other person can greatly affect the outcome of the encounter.

The skills used have been classified for convenience as beginning, attending and listening and using non-verbal communications. These skills involve pacing and handling silence, reflection on what has been said, being empathetic, being accepting, and the use of questions, focussing, summarising and moving forward.

### **Beginning**

When the partners first encounter each other the conversation is likely to focus on 'safe' factual topics such as aspects of their surroundings eg weather recently events eg football games, films, television program, and are non personal or anxiety producing. These exchanges give both partners a chance to know something about the other and are a

fundamental feature of most social interactions. Progress through this stage may vary from 10 minutes to one or two interviews/encounters. Failure to navigate through this state and ensure that the client is comfortable with the mental health worker can have a negative effect on the development of the working alliance. As soon as possible the mental health worker should become aware of the positive aspects of the client such as his interests (likes, dislikes), strengths, talents, goals and support systems available to the client.

### **Attending and listening**

The ability to really concentrate on the person giving him your full attention and listening carefully is central to developing a working alliance, that is, to leave the concerns you, as a mental health worker, had previously been thinking about 'at the door'. One way is to disengage your thoughts from your previous concerns by have a break from your routine work before seeing the client, disconnecting phones, and having time to review the person's file before the meeting.

Non-verbal communication is a particularly important way of demonstrating attention and that you are listening. For example, by making appropriate use of eye contact, seating and posture is important along with making sure your verbal and non-verbal behaviour is consistent. Saying 'I'm pleased to meet you' while looking bored is inconsistent and may result in the client seeing the mental health worker as being disingenuous and really not caring about the client. 'Reading' the client's non-verbals and responding appropriately is another way of demonstrating your attention and sensitivity.

### **Pacing and handling silence.**

Pacing, i.e., the rate at which the interaction moves on, is largely based on the client's degree of responsiveness. It gives him/her the opportunity to pursue or initiate new issues. Silence can also help the person think more about what has been said and what he/she may say. The person may be much less aware of silences than the mental health worker as he/she may be concentrating on their thoughts and emotions. In addition silence can be right when words seem an inadequate response for the feelings that the person has expressed.

The skilful use of silences by the mental health worker allows the client the opportunity to exercise greater control over the exchanges. Alternatively failure of the mental health worker to facilitate silences may be the mental health worker's conscious or unconscious way of asserting control over the interactions. This may result in the client behaving in a passive manner and failing to volunteer or contribute actively to the process.

### **Reflection.**

Reflection is when you mirror back in reflective tones to the person what he has said. This can be done simply by restating back to the person what he has said or by highlighting the key points made by the person in your own words. The purpose of reflection is to encourage the person to go on talking by letting him/her know you have heard him and understood him. Reflection also punctuates the session giving you both space to establish shared understanding and opportunity for greater focus..

'It sound as if you felt annoyed about ...' 'You said that ...'

### **Being empathetic**

Being empathetic occurs when the mental health worker really listens for the core message in what the person is saying and then responds with understanding. In responding empathically you convey you are standing alongside the person appreciating the situation from his point of view. Early in the system of 'Partnership in Coping' the mental health worker will focus on understanding the client's position through the negotiation towards identifying the client's concerns and his self-defined goals. For example, a woman depressed after having a baby with Down's Syndrome says, 'It's terrible, I feel as if I have produced faulty goods', the mental health worker says, 'You feel wretched because you haven't delivered a perfect baby'. The formula, 'You feel ... because ...' can help develop this skill when starting out.

### **Being accepting**

The skill in demonstrating acceptance also makes use of reflection. This response tells the client that you are not judging him that he can go on talking about his concern. Once you start listening for accepting and non-accepting responses you can see how easy it is to respond in the way that is not accepting. The client may say, 'I'm really fed up with this. Nobody here seems to care or listen to what I have to say'. The mental health worker, in a non-accepting response might say 'Complaining doesn't help. We simply haven't enough staff to give individual care. Why don't you complain to the doctor'. An accepting response could be, 'It sounds as if you are pretty fed up with being here and you say there is nobody here to listen to you. What is it that you would like to say?' Accepting responses can begin with phrases such as: 'It sounds like', 'It seems as if', 'It must be' or 'It looks like'.

## **Use of questions**

The kind of questions you ask as well as the frequency with which you ask them are important in developing a working alliance. Excessive use of open questions particularly in the early stages of the encounter may make the person uncomfortable or vulnerable. However used appropriately they tend to help people to express themselves more expansively than closed questions. The use of many closed questions can make the person feel grilled. However closed questions may make the client feel safe in that there is an expectation that there is a limited response, e.g. 'yes, 'no'. Closed questions have a danger of being leading and in restricting the response options available to the client. A classical example is asking the person to answer yes or no to "Are you still beating your wife?" when the person may not, in fact, have hit his wife. Another more relevant example of an inappropriate closed question might be 'Are you worried about being here in the hospital?' whereas the client may have different feelings about being in hospital. An appropriate open question might be 'How are you feeling about being here in hospital?'

## **Focussing**

The skill of focussing can be used to help the person to clarify and define his concerns or his goals further. When clients make very general statements you can help them to be specific by making certain focussing statements or asking certain focussing questions. For example, 'when are the voices at their most upsetting?' 'can you give me an example of what you would like to change?' 'could you describe a typically bad day for you?'

## **Summarising**

Summarising is where you try to pull together the key points or parts or all of the session stating as simply and clearly as you can and asking the client for his reaction to the summary's accuracy. For example, 'Lets see if I understand this correctly... ' can I make sure that I've got this right....?' 'can we make sure that we both have the same understanding of what you've said....'?

### **Moving the session forward**

At various points during the session it will be necessary to move on to discuss another issue in order to help the person better define his concerns. Focussing and summarising are skills that help do this. Where the client expresses a whole web of worries and concerns all tangled up together you can respond by combining, summarising and focussing together with empathy to help him move forward. You can do this by first making an empathetic open remark and then summarising the concerns the client has mentioned. For example, 'It sounds as if you're feeling worried about going home. You mentioned a few things you are anxious about - nobody to talk to, facing the next door neighbour, not having a girl-friend, feeling frightened at night and not sleeping.' Once this is done the focus can end by asking the person to pick out a concern that he wants to look at first, that is, focussing by choice, eg. 'which of these do you feel that we should look at first?' Alternatively you can identify what stands out to you in the picture of the client's situation, eg 'By the way you are talking, one of the things you seem unhappy about is not having friends'. Would you like to discuss this issue?

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