ABILITY TO UNDERTAKE A COLLABORATIVE COMPREHENSIVE ASSESSMENT

The focus of this section is on working with patients who are presenting with an acute mental health crisis. Clinical judgment will be needed about the scope of a specific assessment but is likely that it should focus on the presenting crisis and reasons for admission. These competences are for those with a core profession and/or those with sufficient and appropriate training.

Assessments need to be comprehensive, identifying biological, psychological, and societal factors that may be contributing to the patient's presenting strengths and difficulties – usually referred to as a 'biopsychosocial' assessment. The aim is to develop an understanding of the whole person, placing them in the context of their community.

Knowledge of assessment

An ability to draw on knowledge that a patient should be assessed by a team member promptly following admission
An ability to draw on knowledge that the assessment process aims to create a formulation that guides the care plan, and improves the quality of life of the patient and their family and carers
An ability to draw on knowledge that assessment should prioritise engaging the patient and their family and carers in a meaningful dialogue about their current presenting difficulties
An ability to draw on knowledge that talking about risk does not increase the likelihood of harmful behaviour being carried out and that it is helpful to maintain an upfront and direct approach to the assessment
An ability to draw on knowledge that by building hope and identifying specific ways forward in collaborative assessment can be a powerful intervention in its own right
An ability to draw on knowledge that because it is difficult to predict future risk behaviours, even a comprehensive risk assessment may have limited predictive value
An ability to draw on knowledge that assessment should not be limited to one source of information and that a comprehensive assessment will draw upon multiple sources of information (for example, a clinical assessment, clinical notes and reports, information from the patient's family and carers, staff, other clinical teams), but prioritise the patient's perspective

Engagement

An ability to conduct an assessment in a flexible, compassionate, and collaborative manner that aims to:	
	actively engage the patient and their family and carers in the assessment process
	help the patient identify the factors generating and maintaining crisis
	identify treatments/interventions that will help manage the crisis
	balances problem-focused questions with eliciting areas of strength and resilience
An ability to help the patient and their family and carers manage the potential distress associated with discussing difficult topics by ensuring that they understand the rationale for the questions, and discussing how they might like to manage distress during and after the assessment	
An ability to draw on knowledge that the process of assessment needs to be responsive to any interpersonal issues that threaten the integrity of the assessment, for example where there is evidence that the patient and their family and carers:	

have negative expectations based on prior adverse and/or traumatising experiences with the mental health system, including experiences resulting from the current admission
perceives the assessor as an authority figure who is judging them or keep them detained
expects the assessor to misunderstand them or let them down
An ability to identify and engage other relevant people and agencies in the patient's network in the assessment process
An ability to ensure that the assessment process is coordinated with the wider team to minimise repetition, overlap and patient burden

An ability to undertake a multidimensional biopsychosocial assessment

An ability to assess key triggers or reasons for the admission, for example:
stopping medication
drug and alcohol use
social isolation
bereavement or breakdown in relationships
experience of trauma or abuse
social difficulties such as housing instability or financial problems
An ability to assess the presenting mental health symptoms (for example, experiences of psychosis) and their characteristics
An ability to assess behaviours that may cause harm (for example, self-harming behaviours, restrictive eating), their characteristics (for example, severity, frequency, intent to die, the function of the behaviour) and the motivations behind them
An ability to assess coping strategies that the patient has used to manage their difficulties
An ability to assess key cognitions which relate to their presenting difficulties (including their content, duration, frequency and intensity of thinking, and intent)
An ability to assess any cognitive difficulties which may be transient (i.e., due to the crisis) or more permanent (such as issues with memory and concentration)
An ability to assess emotional difficulties (for example, hopelessness, fear, anxiety)
An ability to assess related physiology and comorbid physical health difficulties (for example, chronic pain)
An ability to assess impacts of difficulties on current functioning and quality of life
An ability to assess any current forensic needs
An ability to help the patient identify protective factors such as:
attitudes, beliefs, and values (for example, hopefulness, reasons for living, a wish to live)
a sense that it may be possible to manage their difficulties
interpersonal networks and social support
other relevant strengths and resources

An ability to assess the patients cultural and social content

An ability to ask about any potential stressors in the patient's physical or social environmen example, overcrowding, poor housing, neighbourhood harassment, problems with gangs)
An ability to draw on knowledge of the patient's and family/ carers cultural, racial, and religi background when carrying out an assessment of their behaviours, beliefs, and the potentia impact of this perspective on their views of problems
An ability to understand cultural influences on gender roles and gender identity, relationshi and family values

An ability to assess a patient's history

An ability to assess the patient's history to help inform their current care, including:
mental health history, including admission history

developmental history (for example, developmental delay, social skills)
trauma history (for example, experiences of abuse and neglect)
medical history (for example, contact with specialist services, head injury, prescribed medication)
family history (for example, family mental health diagnoses, family relationships and dynamics, current family stress)
social history (for example, education, work, housing)
forensic history (for example, previous convictions or index offence)

An ability to assess cognitive function

An ability to assess cognitive functioning, and to:
assess level of consciousness
assess the patient's orientation to time, place, and person
carry out basic memory tests
estimate the patient's intellectual level, based on their level of vocabulary and comprehension in the interview, and their educational achievements
conduct or refer for formal cognitive assessment if there are indications of a learning disability

An ability to assess risk

An ability to conduct a risk assessment that explores and understands the specific functions of risk behaviours for the patient and offers personalised risk management and intervention opportunities
An ability to identify and utilise historical information in a way that mitigates the impact of repeated assessments (for example, by summarising what is already known), while recognising that information may change and need updating

An ability to assess potential factors relating to current risk behaviours that are threatening the patient's or others safety, including:
severity, method, and potential reasons/motivations for this behaviour
links between risk behaviours (for example, self-harm and suicide)
presenting mental health difficulties which relate to the risk behaviour
psychological factors (for example, commanding voices and hopelessness)
psychosocial factors (for example, a recent bereavement and relationship breakdown)
the specific characteristics of the risk behaviours, such as the frequency, duration, context, and function of the behaviour
protective factors such as their family, supportive social network, attitudes, and beliefs (for example, hopefulness and reasons for living)
cognitions relating to the risk behaviour (for example, suicidal ideation) including their content, duration, frequency, and intensity
experience of bereavement by suicide in their social network, including fellow patients on the ward

An ability to work with people to identify behaviours (both current and in the past) that relate to the risk behaviour (for example, saying goodbye to others)
An ability to discuss with people the specific characteristics of a risk behaviour (for example, the function of the behaviour, level of intent) and use this to estimate the likelihood of future behaviours

An ability to assess interpersonal factors associated with risk behaviours

An ability to identify a sense of social isolation, for example, the perceived absence of caring, meaningful connections to others, recent losses through death or relationship breakdown, conflict with peers or bullying
An ability to identify a sense of being a burden on others, for example, expressing the view that others would be better off if they were gone or that they are a burden
An ability to assess 'markers' that indicate the development of a capability to carry out the risk behaviour, for example, current markers, such as:

fearlessness about undertaking the behaviour
prolonged preoccupation with the behaviour
if the behaviour has taken place, the intent behind the behaviour
current and past experiences of the behaviour
frequent exposure to or participation in violence (including conflict and military service)
exposure to childhood physical and/or sexual violence participation in painful and provocative activities (for example, jumping from high places, engaging in physical fights)
patterns of risk behaviour associated with substance use
evidence of clear plans (for example, a written suicide note, having affairs in order, taking out life insurance)

ABILITY TO MAKE USE OF OUTCOME MEASURES

Knowledge

An ability to draw on knowledge that an outcome measure is a tool that examines the impact of a treatment or intervention on the health, well-being, and values of the patient
An ability to draw on knowledge of recommended standardised measures for this setting that demonstrate reliability and validity
An ability to draw on knowledge that measures may be more challenging to administer when patients are experiencing an acute mental health crisis due to:
difficulties in memory and concentration
experiences of acute emotional distress
very changeable or labile presentations
practical problems such as finding an appropriate time and place to undertake the measure
An ability to draw on knowledge that measures should not be used as the basis for predicting future crisis or risk behaviours because there no clear evidence that they are suited to this purpose
An ability to draw on knowledge that in comparison to outpatient/community samples, there are fewer validated measures for use with inpatient populations (as quite a number have not been appropriately validated with acute samples)
an ability to draw on knowledge of the types of measures that are validated and used in assessments in inpatient settings

Ability to administer measures

An ability to administer a measure in line with its administration instructions, and, if applicable, not administering a measure without the appropriate training
An ability to choose a measure that is suitable for examining experiences of acute mental health crisis and appropriate for the patient's presenting needs
An ability to administer a variety of self-report and clinician-administered measures that are relevant to inpatients and can detect appropriate change
An ability to judge when the patient may need assistance when completing a measure and offer appropriate support to enable them to complete it
An ability to consider the patient's attitude, memory, and concentration (and their behaviours while completing it) when interpreting the results of the scale
An ability to administer measures at appropriate time points, including pre- and post-intervention, which may involve active planning to ensure they can be administered prior to discharge
An ability to score and interpret the results of the measure using the manual guidelines
An ability to interpret information obtained from the measure in the context of assessment and evaluation information obtained by other means

ABILITY TO UNDERTAKE AN ASSESSMENT OF THE FUNCTION OF BEHAVIOURS

This section outlines competences required to assess the function of behaviours. These competences are for those with a core profession and/or those with sufficient and appropriate training.

Knowledge

An ability to draw on knowledge that an assessment of the function of behaviours aims to:
understand behaviours that challenge or pose risk of harm
generate hypotheses regarding the factors that are causing and maintaining the behaviour of concern
inform the development of a positive behaviour support management plan*

An ability to draw on knowledge that an assessment of the function of behaviours aims to identify the 'ABC's, i.e.:
the antecedents (A) of the behaviour such as key triggers, causes, location, time, and context
the characteristics of the behaviour (B) such as the type, frequency, duration, and severity
the consequences (C) of the behaviour such as responses from others which may act to reinforce the behaviour
An ability to draw on knowledge that the assessment should draw on several sources of information, including a collaborative assessment with the patient and their family and carers, systematic observations and completion of ABC charts, and reports from relevant staff

Planning

An ability to identify a specific focus for the assessment (for example, a particular behaviour, interaction, or event)
An ability to draw on information from the assessment to establish when, where and for how long observations should take place (for example, drawing on information about the settings or circumstances are most likely to elicit particular behaviours, or the frequency of a specific behaviour)
An ability to reflect on one's own perceptual or attitudinal biases and maintain an objective, open-minded stance
Where possible, an ability to obtain consent from the patient to carry any assessment of their behaviour

Ability to gather data

An ability to draw on knowledge that the main strategies to gather data for a functional assessment are naturalistic behavioural observation (including their strengths and weaknesses)
An ability to explain the rationale for, and procedures used in, behavioural observation (i.e. the need to gather accurate information about a behaviour to plan an intervention)
An ability to complete ABC charts of behaviour either in collaboration with the patient and their family and carers or by observation of the patient (if it is not possible to complete them collaboratively)
An ability accurately to record:
the frequency of target behaviours
the content of target behaviours
environmental factors that may be temporally related to target behaviours

An ability to select the contexts and situations to be monitored, guided by knowledge of the contexts and people associated with a greater likelihood of the target behaviour occurring
An ability to engage other people in completing the chart, where required, offering appropriate training, and checking inter-rater reliability

Ability to integrate systematic ABC charts into assessment and intervention

An ability to explain the function of structured ABC charts to the patient and to help them use the charts to monitor their behaviour, for example by explaining and demonstrating the use of:	
	self-completed frequency charts (designed to record the frequency of target behaviours)
	self-completed behavioural diaries (designed to record problematic or desired behaviours and their antecedents and consequences)
An ability to review completed frequency charts and behaviour diaries with the patient to:	
	understand their interpretation of the data
	understand how easy (or difficult) it was for them to record information
	motivate them to carry out any further data collection
An ability to use diary and chart information to help assess the frequency of problems, degree of distress caused, antecedents and patterns of behaviour, and consequences	
An ability to use gathered ‘ABC’ data to develop a formulation and inform a care plan/positive behaviour support plan	

ABILITY TO DEVELOP A FORMULATION OF THE ACUTE MENTAL HEALTH CRISIS

The section focuses on developing a formulation of the acute mental health crisis with patients. These competences are for those with a core profession and/or those with sufficient and appropriate training.

Knowledge

An ability to draw on knowledge that a formulation aims to understand the development and maintenance of the patient's current crisis and reasons for admission, and that formulations:
are tailored to the patient and their family and carers
comprise a set of hypotheses or plausible explanations that draw on theory and research to understand the details of the patient's presentation (as identified through assessment)
inform their care plan

An ability to draw on knowledge that models of formulation include:
generic formulations, which draw on biological, psychological, and social theory and research
model-specific formulations, which conceptualise a presentation in relation to a specific model, and usually overlap with the generic formulation
An ability to draw on knowledge that the formulation should usually be explicitly shared and co-constructed with the patient and their family and carers
An ability to draw on knowledge that formulations should be reviewed and revised as further information emerges (for example, through ongoing collaboration with the patient and their family and carers)
An ability to draw on knowledge that best practice is for formulations to be multidisciplinary and 'owned' by everyone in the team
An ability to draw on knowledge that one of the main functions of a formulation is to help guide interventions to reduce the crisis and promote safety
An ability to draw on knowledge of models of crisis and risk behaviours that can help to guide the content of a formulation
An ability to draw on knowledge of generic formulation factors (such as, predisposing factors, precipitating factors, maintaining factors, and protective factors)
An ability to draw on knowledge that the formulation should be culturally sensitive and incorporate culturally relevant protective factors (for example, spirituality and religion)

Ability to develop a formulation

An ability to generate a comprehensive list of all the presenting problems
An ability to integrate assessment information into an understanding of the presenting problems, drawing on sources of information such as:
the patient and their family and carers' perception of the presenting problems
associations between the onset, intensity and frequency of the presenting problems and the patient's psychosocial environment (for example, relationship breakdowns or trauma)
the results of a functional analysis which records the antecedents and consequences of a particular behaviour
theory and research that identifies biological, developmental, psychological, and social factors associated with an increased risk of mental health difficulties
theory and research that identifies biological, psychological, and social factors associated with mental wellbeing

An ability to identify a care plan that accommodates and addresses the issues identified by the assessment and formulation particularly those that relate to the current crisis and risk behaviours
An ability to revise the formulation in the light of feedback, new information or changing circumstance
An ability to use team reflections and responses, alongside evidence, to make sense of the maintenance of difficulties and identify team-level changes that might need to be made to address these

An ability to construct a comprehensive formulation that draws on a specific model and:	
	identify issues relating to the presenting problems and risk behaviours
	addresses any contradictory reports of a problem (for example, where the patient's account differs from that of their family and carers or mental health staff)
	demonstrates an understanding of the patient's inner world (cognitive, behavioural, emotional, and physiological experiences) and interpersonal experiences

ABILITY TO FEEDBACK THE ASSESSMENT AND FORMULATION

This section focuses on a practitioner's ability to feed back the assessment and formulation, which may be presented as a care plan, to the patient and their family and carers. An important part of this process may also be feeding back the psychiatric diagnosis. These competences are for those with a core profession and/or those with sufficient and appropriate training.

Knowledge

- An ability to draw on knowledge that an inpatient care plan should draw on the assessment and formulation of the presenting crisis

Ability to provide information and feedback on the assessment and formulation

- An ability to maintain an empathic, neutral, non-blaming and non-judgmental stance when presenting information about the assessment and formulation to the patient and their family and carers
- An ability to collaboratively outline presenting, predisposing, precipitating, maintaining, and protective factors for the current crisis, explicitly linking this description to information gathered during the assessment
- An ability to discuss with the patient and their family and carers the importance of sharing the assessment and formulation with the inpatient multidisciplinary team
- An ability to discuss with the patient and their family and carers how they would like information about the assessment and formulation to be conveyed, including how they would like this information shared with the wider multidisciplinary team
- An ability to recognise when the patient requires more specialist assessment (for example, for a coexisting mental and/or physical health condition) and to ensure appropriate plans are made for this to occur
- An ability to appropriately discuss the formulation with patients and their family and carers, check whether they agree with the information being conveyed, and encourage their questions
    - an ability to discuss any disagreements or concerns about the assessment and formulation

Ability to work towards a collaboratively agreed formulation

- An ability to consider the reasons for any significant differences between the patient's and the practitioner's view of the formulation considering whether:
    - the information has been clearly explained in a sensitive non-blaming manner that highlights the patient's strengths as well as difficulties
    - an understanding of the patient's presenting problems has been clearly described
    - the patient's reaction to an aspect of a formulation is a normal reaction to difficult or upsetting news
    - there are factors in the patient's presentation that may make it hard for them to accept specific aspects of the formulation
    - the assessment fully explored their concerns and/or beliefs
    - the assessment and formulation have taken into account their personal, social, and cultural context

ABILITY TO COLLABORATIVELY DELIVER AN INPATIENT CARE PLAN

The competences in this section relate to the collaborative delivery of an inpatient care plan. These competences are for those with a core profession and/or those with sufficient and appropriate training.

Knowledge

An ability to draw on knowledge that while patients are admitted to an inpatient ward the key priority of a care plan (treatment and intervention) is to reduce the intensity and frequency of the crisis including related harmful thoughts and behaviours, as well as increase the patient's safety and ability to cope

Delivering an inpatient care plan

An ability to work collaboratively working with the patient and their family and carers whilst delivering their care plan	
An ability to be honest about the limitations that the Mental Health Act (MHA) may have on the ability for the patient and their family and carers to have full control and choice over the treatments and interventions they receive	
An ability to promote informed choice regarding treatments or interventions, which comprise an inpatient care plan, by working collaboratively with patients and their family and carers	
An ability to gauge motivation and preference for a particular treatment or intervention option, considering the impact of any treatment or intervention strategies that have already been tried	
An ability to discuss any differences in treatment or intervention preferences with patients and their family and carers, and make clear, if required, the reasons why it may be important to focus on treatments or interventions which are less appealing	
An ability to provide the patient and their family and carers with sufficient information about the treatment or intervention options, such that they are:	
	aware of the range of options available in the inpatient service
	in a position to make an informed choice from the options available to them
An ability to ensure that the patient and their family and carers have a clear understanding of the treatments or interventions being offered (for example, their broad content and the way they usually progress)	
While maintaining a positive stance, an ability to convey a realistic sense of:	
	the effectiveness and scope of each treatment or intervention
	any challenges associated with each treatment or intervention
An ability to use clinical judgement to determine whether the patient's agreement to a treatment or intervention is based on a collaborative choice or appears to be a passive agreement resulting from the inherent power imbalance present in inpatient care, particularly when they are under section of the MHA (and if so, an ability to address this)	
An ability to discuss issues empathically, but also to move the situation forward by working with the patient to develop a concrete care plan of appropriate treatments and interventions that aim to contain the current crisis and increase their safety	
When a treatment or intervention has to be offered against the patient's will as part of their MHA section, an ability to ensure that the rationale for the treatment has been clearly explained, all options to collaboratively deliver the treatment or intervention are exhausted, and they have had several opportunities to ask questions	
An ability to ensure that the treatments and interventions communicated with the appropriate parties and is collaboratively agreed, whenever possible	
An ability to help the patient mobilise their social family and carers and promote the inclusion of their family and carers in the care plan whenever possible	

An ability to ensure that the treatments and interventions offered as part of an inpatient care plan are documented in their clinical notes

ABILITY TO UNDERTAKE OBSERVATIONS

Knowledge

An ability to draw on knowledge that the aim of observations is to maintain patient safety	
An ability to draw on knowledge that the use of observations should be care planned	
An ability to draw on knowledge of local policies on carrying out observations, and the different levels/types of observation	
An ability to draw on knowledge that observation of patients is an intervention in its own right	
An ability to draw on knowledge that the integrity of continuous or intermittent scheduled observation can be compromised:	
	when carried out by practitioners who are untrained or lack direct experience of patients who are very distressed and actively at risk (for example, of harming themselves or ending their lives)
	when carried out by practitioners who are not familiar with the patient and their history
	when carried out as a 'tick-box' exercise (for example, when involving a very brief 'check in')
	when there is a crisis on the ward
	when staffing issues are leading to a prolonged time on observation
	when they are acting to reinforce a challenging or risky behaviour
An ability to draw on knowledge that the effectiveness of observation can be compromised if the practitioner is unclear about their remit and so restricts the extent of observation for example by:	
	not checking when the patient is in their bedroom because of concerns about invading a 'private' space
	feeling unable to check that the patient is safe when they are for example, in bed and under covers (and observation would involve disturbing them)
An ability to draw on knowledge that observation can be distressing and experienced as punishing, shaming, or degrading for the patient (for example, if continuous monitoring means that they have no or very limited privacy when carrying out activities, particularly those related to patient's hygiene)	

Conducting observations

An ability to explain to the patient the rationale for why an observation is being undertaken and the processes involved	
An ability to use observation as a constructive opportunity to:	
	interact with and engage the patient and gain their trust
	engage in purposeful activities with the patient
	understand the sources of their distress and help them to express themselves
	help assess the patient's mental state
	encourage and motivate them to undertake day to day activities
An ability to draw on a range of clinical skills to respond to distress with the aim of helping the patient express their feelings and make use of basic coping skills	
An ability to adapt observation to the moment-to-moment needs of the patient, for example by:	
	interacting and/or engaging in activities if they are open to this
	being silent or reducing proximity to the patient where appropriate if they are uncomfortable or distressed by contact
An ability to detect indications of potential aggression or violence and to respond appropriately (for example, by withdrawing to a safer distance, using de-escalation techniques, or asking for support from others)	
An ability to conduct observations so they are done in a way to minimise disruption, for example, trying not to interrupt sleep when undertaking observations at night	

An ability to regularly review the need for observations and reduce/stop them at the earliest and safest opportunity

TRANSITION PLANNING (DISCHARGE AND TRANSFER OF CARE)

This section outlines the competences required to transition patients from inpatient care to other services. The most common transition is discharge from inpatient to community services. However, a patient may experience other transitions, for example, transfer from acute inpatient care to inpatient rehabilitation or psychiatric intensive care. This section refers to all types of service transitions. These competences are for those with a core profession and/or those with sufficient and appropriate training.

Knowledge of transition planning

An ability to draw on knowledge that transitions of care from inpatient settings can be potentially destabilising and provoke strong feelings, and so constitutes a time of greater risk and reduced safety
An ability to draw on knowledge that transitions from inpatient care should be well planned even when the transition is last minute or unexpected (for example, due to bed pressures)
An ability to draw on knowledge of national and local guidelines on transition planning
An ability to draw on knowledge that because most inpatient services are very fast paced, transitions (for example, discharge) can occur quickly and should be explicitly discussed with the patient and their family and carers from admission
An ability to draw on knowledge that a personal transition plan should be devised, prioritising patient needs and incorporating strategies such as a graded approach to the transition (for example, trial leave at home before discharge)
An ability to draw on knowledge that transitions are also interpersonal endings and should be thought about accordingly, bearing in mind many patients have a history of traumatic interpersonal relationships
An ability to draw on knowledge that a transition may be experienced a loss if the patient is being discharged back to a care home or supported accommodation when previously they were living independently

Helping the patient and their social network prepare for a transition

An ability to advise the patient and their family and carers of the date and time of any proposed transition, and to ensure that this is done with as much advance notice as possible
An ability to recognise that a transition can be a very difficult and distressing time for the patient and that emotional support, care, and reassurance may be required

Considerations for transition planning

An ability to discuss the patient's feelings about the transition and to work with them to identify barriers that make it less likely that they will maintain contact with the new service or engage with their new accommodation
An ability to discuss the plan for follow up support with the patient, and their family and carers, in collaboration with the receiving services/accommodation, prior to the transition
An ability to ensure that a transition between inpatient and community services is carried out in a timely manner and is communicated effectively to the patient's family and carers and relevant services
An ability to work in partnership with the transitioning service to collaboratively develop a safe discharge plan, in collaboration with the patient and their family and carers
An ability to discuss the patient's, and their family and carers, concerns about the transition, and troubleshoot any potential problems
An ability to consider what information is appropriate to share with the patient's family and carers about the transition (keeping in mind that their involvement is likely to support a more successful transition)

An ability to understand that the patient's family and carers may find particular transitions (for example, discharge) a challenge (for example, by having a loved one return home after a hospital admission) and that they may need support managing this
Where there are indications that transitions of care will present significant challenges to the patient, an ability to implement appropriate strategies, such as:
identifying a care plan which aims to maintain continuity of support during the transition
where appropriate, helping the patient to develop skills in independence, assertiveness, and self-advocacy
An ability to assure effective communication with professionals within and between services by providing written communication that identifies:
the relevant clinical issues, the current care plan, and any identified risks
the rationale for referral or transfer of care
expectations regarding feedback from the service
An ability to utilise trusted assessments, where possible, to reduce repeated and unhelpful re-assessment at points of transition

Care planning

An ability to undertake a thorough assessment of the patient's personal, social, practical, and safety needs before considering transition of care. It should:
be collaboratively undertaken with the patient and their family and carers, and understand their hopes and concerns
be underpinned by a formulation of the patient's needs including psychological, social and cultural aspects
based on the principles of personal recovery, prioritising aspects such as interpersonal relationships, self-identity, and self-esteem, living well despite symptoms
prioritise the patient's safety and ensure strategies are put in place to manage any risk behaviours

Recognising and managing challenges to transition

An ability to monitor the progress of a transition (for example, undertaking follow-ups calls)
An ability to identify when a transition has been compromised and to identify the reasons for this, for example:
institutional/systemic factors (such as long waiting lists or organisational change)
miscommunication between services
lack of cooperation or trust between services
lack of clarity about who is responsible for acting on a transfer request leading to failure to act
the patient's locality falling within another trust's remit
difficulties or issues with accommodation (if they are being discharged)
An ability to address concerns about a compromised transition, for example, through further verbal and/or written communication
Where possible and appropriate, an ability to offer bridging support if this increases the probability that the patient will engage with the new service

Knowledge of Community Treatment Orders (CTOs)

An ability to draw on knowledge that a CTO is a treatment order which outlines conditions that the patient has to adhere to following discharge from a Mental Health Act (MHA) section
An ability to draw on knowledge that CTOs have been demonstrated to have limited efficacy in improving treatment adherence and recovery outcomes for patients
An ability to draw on knowledge that a CTO is a form of restriction and should only be considered when:

a thorough assessment and formulation of the patient's presenting crisis and needs is undertaken
the costs and benefits for the patient have been carefully considered and the advantages outweigh the disadvantages
that all other care strategies have been exhausted

Implementing CTOs

An ability to consider whether a CTO is needed based on the benefit to the patient, the purpose of its use, and the conditions required for it to be used
An ability to ensure that the patient and their family and carers have had the opportunity to discuss the details of the CTO, its implications, why it is being imposed, and how to appeal
An ability to communicate the CTO plan to relevant parties, including the patient, their family and carers, and other involved services, offering the opportunity for discussion and to ask questions

Working with endings in relationships due to transitions

An ability to help the patient reflect on their experience of inpatient care, making connections between their feelings about endings and other losses or separations as a result of a transition
An ability to help the patient explore any feelings of anxiety about managing without inpatient care
An ability to help the patient reflect on the process of inpatient care as well as what they have learned and gained from it
An ability to help the patient express any feelings of hostility and disappointment with the limitations of the inpatient service
An ability to actively discuss with the patient what they have found unhelpful or could be improved about their inpatient stay and support the process of honest feedback and complaints, where appropriate.