Care and Treatment Planning

A step-by-step guide for secondary mental health service users
This guide to care and treatment planning is based on the experiences of over 1500 people with a serious mental illness and their families and carers. We developed our approach over many years by asking: what is the most effective way to achieve recovery from serious mental illness?

Our experience tells us that everyone can make significant steps to regain or improve mental health and achieve a better quality of life. We have found that people have the best chance of achieving recovery from a mental illness if these three components are in place:

1. You take control of your own recovery
2. You take all areas of life into consideration in planning recovery
3. You act on a step-by-step plan towards recovery

The good news for users of secondary mental health services in Wales is that after years of campaigning we now have a legal right to a holistic Care and Treatment Plan under the Mental Health (Wales) Measure. This gives you the opportunity to set goals in all areas of your life, create a plan and, in the process, to take more control of your own recovery.

How can this guide help you?

The guide is for users of secondary mental health services. However, if you find it difficult to engage with the process of care planning the guide can also assist your carer, family, friends, professional advocate or your Care Coordinator.

In the guide we take you step-by-step through the Care and Treatment Plan so that you can get the most out of it. We also provide many examples of outcomes and actions you can include in your Plan based on suggestions from hundreds of service users and carers across Wales.

About mental health law in Wales

The Care and Treatment Plan is one of a number of new rights delivered by the Mental Health (Wales) Measure. The Measure also gives people who have been discharged from secondary mental health services the right to refer themselves back for assessment and it extends the right to an Independent Mental Health Advocate to all in-patients.

For more information on mental health law please get in touch! See our contact details on the centre page.
Who is the Care and Treatment Plan for?

The Care and Treatment Plan is for people receiving secondary mental health services – for example from a psychiatrist, community psychiatric nurse, social worker or other member of the Community Mental Health Team. If you are receiving secondary mental health services you have a legal right to a Plan. You will also be allocated a Care Coordinator – a professional who will complete the Plan with you and oversee the care and treatment process.

If you are not yet receiving secondary mental health services but may have a serious mental illness you should be referred for assessment (usually by your GP). The referral is then screened by mental health services who decide if you might need specialist help, or if you can be referred back to the service which referred you (such as your GP).

If you are assessed as needing secondary mental health services a risk assessment will also be completed: this will identify any risks that you may be exposed to and any risks you may present to yourself or others.

If you have been discharged from secondary mental health services within the last three years you have the right to refer yourself back for assessment without needing to first go to your GP or elsewhere for a referral.

When you are accepted into secondary mental health services your Care Coordinator should be appointed within 14 days and your Care and Treatment Plan should be written with your full involvement within six weeks of this appointment.

If you are a secondary mental health service user and you have not got a Care and Treatment Plan, ask for one. You can also get a family member or carer to ask for one on your behalf – or contact your local Hafal project and we will help.

What happens next?

You will meet with your Care Coordinator to fill in the Plan. Guidelines say that patients and their carers should be involved in the planning, development and delivery of care and treatment to the fullest extent possible and that Care Coordinators should attempt to write outcomes in the service user's own words. So you should expect to have a full say on what goes in the Plan at every opportunity.

In the following pages we work through each part of the Care and Treatment Plan and provide you with suggestions for what you could include in your yours.

A word about carers...

Your carer is a key source of support and we advise that they get fully involved in care and treatment planning. Your carer will receive a copy of your Plan (unless you do not want them to). Carers can also use this guide if you are too ill or unable to give attention to it.

Hafal has produced a useful ‘Ten Point Plan’ for carers which provides key tips on how they can best provide care and look after themselves: find out more at www.hafal.org or by getting in touch (our details are on the centre page).
Your Care and Treatment Plan: a page-by-page guide

You can complete your Care and Treatment Plan in Welsh or English. In the Plan you are referred to as the “relevant patient”. The first page of your Plan will record your details and the details of your Care Coordinator.

First the Plan records your name and address.

Next the Plan records the name and contact details of your Care Coordinator. The Care Coordinator will complete the Care Plan with you and review it with you, and will oversee the whole care and treatment planning process. They will be the point of contact and information for you, your carer/s and all professionals involved in the delivery of your Plan. If you go into hospital, the Care Coordinator will remain in regular contact.

The Care Coordinator will be a health or social care professional who has the appropriate experience, skills or training to oversee your care. For example, it could be a social worker, community nurse or occupational therapist.

The care coordinator will remain in regular contact.

Make sure you are comfortable with your Care Coordinator as you will work closely with this person on your Plan. For instance, you might prefer someone who can respond to your specific cultural or gender needs. Guidelines say that it is good practice for consideration to be given to the preference and choice of the patient as to who their Care Coordinator may be.

Next the Plan will record the name of the Local Health Board or local Council who the Care Coordinator was appointed by.

Finally there is a space to date the plan and put in a review date. Plans are supposed to be reviewed at least once every 12 months but we recommend that you ask for regular reviews. Guidance states that reviews should be needs-led, and should be held as frequently as required. Reviews are essential: for one thing they provide an opportunity for you to set short steps towards long-term goals and monitor them regularly. It is important that these short steps are timetabled and that you have regular reviews to assess your progress towards them, or else to modify them.

You or your carer can request a review at any time. Any member of the care and treatment planning team can also request a review.
The most important part of your Care and Treatment Plan comes in the following pages which provide space to identify the outcomes you want to achieve in each area of your life.

Outcomes are the results and goals you want to achieve in your life. They can be about changing your life (“I want to be employed”) or about maintaining the good things in your life (“I want to stay in my job”).

This part of the Plan gives you the opportunity to set outcomes in eight key areas of your life:

- What services need to be provided, or actions taken, to achieve the outcomes. The actions should be simple, short-term steps towards your outcome. A good Plan needs to hold its focus on long-term outcomes but also the less intimidating steps which allow you to move forward.
- When the outcomes/actions/services should be achieved or delivered.
- Who should provide the services or take the actions. This section gives you the opportunity to identify any supporters who can help you achieve your outcomes. We recommend that where possible you name the individual supporters (e.g. ‘Claire Jones, Occupational Therapist’).

Guidance also says that needs, risks and personal strengths should be identified in the process.

Remember to recognise what you are doing for yourself in the Plan. Don’t simply record what mental health services, or other people, are doing. Many of the outcomes you identify are likely to be achieved mainly by you.

In the next few pages we examine each of the life areas in turn, giving suggestions for what outcomes, services, actions and supporters you can identify in each of the boxes. If you can, work through each of these pages and make notes before you meet with your Care Coordinator to complete the Plan.
### a. Accommodation

<table>
<thead>
<tr>
<th>Outcome to be achieved</th>
<th>What services are to be provided, or actions taken</th>
<th>When</th>
<th>Who by</th>
</tr>
</thead>
<tbody>
<tr>
<td>Be ambitious and look a long way ahead when you come to set your outcomes for Accommodation. Also make sure any of your unmet needs in this area are identified. For many people the main long-term outcome will be to live in your own suitable home in the community of your choice. This may involve staying where you are if you are comfortable or finding a better place to live if your accommodation has a negative impact on your mental health.</td>
<td>Services could include:  - Supported accommodation service  - Debt advice service  - Home repair services  - Information service  - Advocacy service.  Actions could include:  - Finding out about all the available housing options  - Registering with the housing office at your local Council or with your local Housing Association  - Looking for accommodation in local newspapers, estate agents and on the internet  - Arranging how you are going to pay for your accommodation, e.g. housing benefit/mortgage  - Getting support to manage your mortgage/rent payments  - Getting debt advice from the Citizens Advice Bureau  - Finding out what supported housing is available locally, particularly if you are coming out of hospital (housing options should be discussed at discharge meetings)  - Finding tradespeople to make necessary repairs to your home and getting quotes  - Making arrangements for your home to be looked after if you are in hospital.</td>
<td>Put in precise dates here. Your long-term outcome (such as ‘to live independently in my own accommodation close to town’) may be achievable in two years; your immediate short-term actions (such as ‘registering with the Council’) could be achieved within two months.</td>
<td>Your local Council has a legal duty to advise you on housing if you are unable to find your own accommodation and a duty to get you housing if you are vulnerable. Other people who can support you include:  - Housing associations  - Housing charities  - Hospital manager  - Shelter Cymru  - Citizens Advice Bureau  - Care and Repair Cymru  - Independent mental health advocate and/or  - A family member and/or other carer  - Care Coordinator  - You!</td>
</tr>
<tr>
<td>There are a number of accommodation options. You can choose to manage your own accommodation without support, get support to live in your own home, live in supported accommodation, live in shared accommodation or live with family/friends. You may also choose to buy a place on your own or with family/friends, or to rent from a private landlord, your local Council, a Housing Association or other Registered Social Landlord, or a housing charity.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you are in hospital long-term then an outcome may be to stay in a suitable ward with the maximum amount of comfort, safety and independence.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Another goal may be to maintain, repair or improve your home ensuring that your accommodation is warm, weatherproof, equipped with modern facilities, in a good state of repair, safe and secure. Are you close enough to family, friends, green spaces or the services you use? You may also want to ensure that your accommodation meets your physical requirements (e.g. if you have poor mobility or eyesight).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Finally, your outcome may be to deal with financial issues such as managing mortgage payments or rent.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hafal has published a guide to supported accommodation options for people with serious mental illness called “My Own Home”. Visit <a href="http://www.hafal.org">www.hafal.org</a> to download a copy or contact us (see the centre page for details).</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Education and Training can play a key part in your recovery: this is the area of life in which you can explore your interests, catch up on basic skills like literacy and numeracy, or achieve goals which will help you get the job you want.

As with every life area, you should be ambitious with your long-term outcomes and identify any unmet needs. For many people the goal may be to achieve general or career-related education and training goals, whether or not resulting in a formal qualification.

If you are already on a course of study (e.g., in school or college), your aim may be to continue with your study or to re-engage with it. You may want to explore different ways of learning: you can choose to study full-time or part-time; to get specialist support; to use long-distance learning packages (such as through the Open University); or to access adult education and training opportunities in your community.

Your main aim may be to achieve a specific qualification which will support your interests or getting a job. If you are already employed you could discuss with your employer what training will support you in your role, and whether they will fund it or provide you with the time to do it. There are also courses available which will enable you to gain life skills, social skills or skills in managing your recovery.

You don't have to attend a structured course to start learning: if a qualification is not your goal then you can take up self-study through reading, the internet, using your local library, etc.

Your Local Education Authority is a key source of support and can advise you on what education/training opportunities are available locally. Your Careers Adviser can also discuss training options with you. Other supporters may include the following:

- Teacher
- Local college/university
- Open University
- Student Finance Wales
- Hafal National Learning Centre
- Careers Wales
- A family member and/or other carer
- Care Coordinator
- You!

Put in precise dates here. Your long-term outcome (such as ‘to get a GCSE in Maths’) may be achievable in three years; your immediate short-term actions (such as ‘finding a local college which teaches GCSE Maths’) could be achieved within a month.

Hafal’s National Learning Centre specialises in accredited training programmes in managing your mental illness and life skills. For more information visit www.hafal.org or contact us (see the centre page for details).
Managing your finances is another key aspect of recovery, especially as having enough money to be comfortable and free from financial worries contributes greatly to your quality of life.

Your long-term outcome may be to be able to afford a reasonable standard of living with a reliable income from employment and/or appropriate benefits; you may even want to specify a target income.

For some the aim may be to begin or continue to earn a salary or wage. For others the objective may be to maximise your social security, disability or other benefits and ensure you receive all monies you are entitled to. Getting a benefits check is often the best way to achieve this.

Keeping in control of your finances can contribute significantly to your sense of being in control of your own life. Your goal may be to better manage your income and expenditure. For others the aim will be to keep in control of their finances when they are in hospital and to plan ahead for when they are not well.

Many people with a mental illness have difficulties not only with unlicensed lenders (“loan sharks”) but with licensed banking and financial service industry sales people who may not understand your mental illness; others get into difficulty by inappropriately lending or giving money to friends and sometimes their own family when they are unwell: you can use this section of your Plan to get help to address problems or to avoid them in the future.

The Citizens Advice Bureau is a very useful source of financial advice and support, especially when it comes to issues such as debt management. Other supporters may include:

- Benefits advisor
- Bank manager
- Debt counsellor
- Welfare Rights Office
- Student Finance Wales
- Money Advice Service
- A family member and/or other carer
- Care Coordinator
- You!

Services could include:
- Benefits check (e.g. from the Citizens Advice Bureau)
- Debt advice service
- Banking service.

Actions could include:
- Accessing information and advice on debt or savings management
- Opening a new bank account
- Learning to bank online
- Getting advice, information or training in budgeting
- Creating a contingency plan for managing finances when you are in hospital
- Identifying someone to take control of your finances when you are not well
- Researching whether there are cheaper service suppliers for electricity, gas, etc.
- Researching which mortgage, pension or other financial product is best for you
- Applying for a student loan by setting up a student finance account
- Shopping around for better deals on groceries, petrol, insurance, etc.

Put in precise dates here. Your long-term outcome (such as 'to sort out my debts') may be achievable in a year; your immediate short-term actions (such as 'getting debt advice') could be achieved within three months.
Getting the right treatment can have a big impact on your recovery. For many people the goal may be to achieve a full recovery where no medication or other forms of treatment are needed. For others the long-term goal will be to find the minimum level of treatment that is effective.

Because both medication and other therapies are combined in this one ‘life area’ of the Plan you need to take extra care that any non-medical treatment – including psychological therapy – is covered.

Psychological therapies can be very important for many people with a serious mental illness, but they can be difficult to access. Our advice is that you ensure that any need for psychological therapies is recorded in the Care and Treatment Plan – and that psychological therapies are kept on the agenda in case any need arises in the future.

If you require medication our advice is that you should take account of its effectiveness, side-effects and any management issues when you discuss options with your doctor. If you are taking older antipsychotic medication the side-effects of your medication may be a significant issue. An example outcome might be to reduce the side-effects of your medication by trying a new medication or reducing dosage levels. We recommend that it is well worth some extra effort to manage a medication if it gives you the best results (for example, some medications may require you to take blood tests).

At www.hafal.org you’ll find two useful guides to treatments for mental illness: “Your Choice” and “Treatments for Serious Mental Illness: A Practical Guide”. For hard copies please get in touch (see centre page for details).
### e. Parenting or Caring Responsibilities

<table>
<thead>
<tr>
<th>Outcome to be achieved</th>
<th>What services are to be provided, or actions taken</th>
<th>When</th>
<th>Who by</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**For many people the long-term Parenting and Caring Responsibilities outcome will be to remain an effective and reliable parent or carer and as independent as possible in this role.**

Use this opportunity to recognise any parental or caring relationship you are maintaining or managing well as well as to seek help if you are having difficulty. Your outcome may be to get the support you need to maintain or improve your ability to carry out your parenting/caring role. This may include getting financial support (including the appropriate benefits) or finding opportunities to take breaks from your caring role.

You could discuss parenting/caring issues with your GP, health visitor or mental health professional, or you can seek advice from a local or national advice organisation such as the Citizens Advice Bureau. They can signpost you to various sources of support, as can your local Council. If you think your child is in distress because of your mental illness you can ask the local Council to make an assessment of their needs. They may also be able to provide you with support services.

If you are in hospital your outcome may be to improve your contact with home, or to renew your parenting/caring role when you are back in the community.

We recommend that you routinely consider this area when you come to review your Plan as people's caring/parenting responsibilities often change.

**Services could include:**
- Benefits check
- Guidance and support on parenting from an advice organisation
- Child support services from your local Council
- Specialist support service from a voluntary sector organisation.

**Actions could include:**
- Joining a carers’ support group
- Joining a local “Parent and Child” club
- Writing an Advance Directive contingencies plan outlining caring arrangements for when you go into hospital
- Providing the person you care for with information on your illness
- Providing information on your situation to your child’s school/playgroup
- Creating an informal support network of relatives, friends, neighbours or colleagues
- Asking your GP or mental health professional about specialist help and support for families
- Setting aside time each day to play or take part in activities with your children
- Establishing regular contact with home when you are in hospital, e.g. by phone call, text or email
- Asking for a dedicated room for family visits so that your children don’t have to enter the hospital ward.

**Put in precise dates here. Your long-term outcome (such as ‘joining a carers’ support group’) may be achievable in six months; your immediate short-term actions (such as ‘contacting my local Council’) could be achieved within two months.**

**The main people taking a lead in providing services may be your GP, Health Visitor or (if you are in hospital) your Named Nurse. Your local Council will be able to provide you with advice and may provide support services.**

**Other supporters include the following:**
- Teacher
- Child Social Worker
- Citizens Advice Bureau
- Voluntary organisations
  - A family member and/or other carer
  - Care Coordinator
  - You!
This part of your Plan addresses your overall physical health and wellbeing. For many people the long-term goal will be to be fully fit and healthy, to be physically active, to have a good diet, to avoid smoking and excessive alcohol consumption, and to have control of body weight.

It is important not to neglect your physical health when you are receiving care and treatment for a mental illness. Maintaining and improving your physical health is an essential part of your recovery and can also counter the side-effects of antipsychotic medication (such as weight gain, increased risk of diabetes and heart problems).

Your specific outcomes may be to have an improved diet, give up smoking, exercise regularly and reduce your alcohol consumption or use of illegal drugs. If you are very ill there may be some basic issues to address such as keeping clean, eating properly and generally taking proper care of yourself. Also think about goals which will minimise the impact of physical issues such as disability, mobility and pain management on your mental health.

**Services could include:**
- Advice and treatment from your GP/Practice Nurse
- Well-woman or well man clinics at your local surgery
- Support services for giving up smoking, reducing alcohol intake, etc.
- Dental/optical check-ups.

**Actions could include:**
- Registering with a GP
- Preparing for your GP appointment by making a list of the things you want to discuss such as stopping smoking, exercise and the management of physical conditions
- Getting advice and information on healthy living
- Writing an exercise and diet plan
- Taking steps to improve your personal care by eating and washing regularly, etc.
- Joining a local gym
- Joining a stop-smoking support group
- Registering and making an appointment with a dentist/optician
- Getting support to reduce your alcohol/drugs intake
- Getting advice on sexual health
- Discussing the physical side-effects of anti-psychotic medication with your GP.

Put in precise dates here. Your long-term outcome (such as ‘giving up smoking’) may be achievable in one year; your immediate short-term actions (such as ‘talking to my GP’) could be achieved within one month.

Your GP and Practice Nurse are the main health professionals who can support you in achieving your personal care and physical wellbeing outcomes. Other supporters may include:
- NHS Direct
- Alcohol and drug (substance misuse) services
- Stop Smoking Wales
- Health promotion service
- Gym instructor and/or
- A family member and/or other carer
- Care Coordinator
- You!

Put in precise dates here. Your long-term outcome (such as ‘giving up smoking’) may be achievable in one year; your immediate short-term actions (such as ‘talking to my GP’) could be achieved within one month.

Your GP and Practice Nurse are the main health professionals who can support you in achieving your personal care and physical wellbeing outcomes. Other supporters may include:
- NHS Direct
- Alcohol and drug (substance misuse) services
- Stop Smoking Wales
- Health promotion service
- Gym instructor and/or
- A family member and/or other carer
- Care Coordinator
- You!

Put in precise dates here. Your long-term outcome (such as ‘giving up smoking’) may be achievable in one year; your immediate short-term actions (such as ‘talking to my GP’) could be achieved within one month.

Your GP and Practice Nurse are the main health professionals who can support you in achieving your personal care and physical wellbeing outcomes. Other supporters may include:
- NHS Direct
- Alcohol and drug (substance misuse) services
- Stop Smoking Wales
- Health promotion service
- Gym instructor and/or
- A family member and/or other carer
- Care Coordinator
- You!
For many people the main outcome in this area of life will be to enjoy a full social life, good personal relationships with family and friends, and full engagement with community and leisure facilities. A major problem faced by many people with a mental illness is loneliness. Hafal recently conducted a survey which found that 50% of service users had been lonely in the past month.

If you have been very ill then establishing networks with fellow patients is a good place to start before moving on and making contacts in the wider community. You may choose to focus on maintaining or improving relationships with your family, colleagues, friends or partner. You can engage or re-engage with a religion of your choice or tradition or follow your hobbies or interests individually or in a group. Another outcome may be to access general leisure facilities.

You should be clear about your cultural and spiritual needs and ensure that in all aspects of your Plan these needs are addressed. Guidance says that your preferred language should be a consideration when you think about your cultural needs.

<table>
<thead>
<tr>
<th>Outcome to be achieved</th>
<th>What services are to be provided, or actions taken</th>
<th>When</th>
<th>Who by</th>
</tr>
</thead>
<tbody>
<tr>
<td>g) social, cultural and spiritual</td>
<td>Patient group/social club for people with a mental illness</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Marriage counselling/relationship support service</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Family therapy service</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>General leisure facilities.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Services could include:</strong></td>
<td>Organising to spend time with your family</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Contacting and meeting up with friends</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Establishing and maintaining a network of friends and contacts</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ensuring your language needs are met (e.g. by engaging with Welsh-language activities/services)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pursuing a hobby on your own by joining a class or interest group</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Joining a religious group</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Engaging with local leisure facilities such as the leisure centre, libraries, museums, etc.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Attending events, concerts, plays, etc.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Identifying a friend to accompany you as you access local leisure facilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Joining Facebook, Twitter and other social networking sites</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Joining a dating service</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Identifying and pursuing volunteering activities.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Put in precise dates here. Your long-term outcome (such as ‘having an active social life’) may be achievable in a year; your immediate short-term actions (such as ‘finding local groups for people with a mental illness’) could be achieved within a month.

Supporters in this area may include your family, friends and other service users. Other people who can support you may include:

- Work colleagues
- Local college
- Voluntary services
- Relate
- Religious group and/or
- A family member and/or other carer
- Care Coordinator
- You!
Being in work can have a huge impact on your quality of life. Employment affords dignity and respect as well as financial independence.

If you are of working age the long-term goal may be to enter into – or remain in – full or part-time employment. Alternatively your goal may be to take part in work-related activities such as volunteering.

There are a number of options open to you if you would like to return to work. You could choose to work full or part-time, and to get specialist support to sustain you in employment. You could also use a specialist employment service such as an employment project or supported work scheme, or make use of occupational therapy services.

If you are already employed you could set outcomes for returning to or remaining in work with your current employer. You can request reasonable adjustments from your employer using your rights under equality law.

Other goals may include becoming a trainee or apprentice or setting up your own business.

Put in precise dates here. Your long-term outcome (such as ‘getting a job’) may be achievable in a year; your immediate short-term actions (such as ‘finding an IT training course’) could be achieved within two weeks.

Your local Jobcentre Plus can provide a range of support to help you find a job. Other supporters may include:
- Employer
- Specialist employment service
- Occupational Therapist
- Work colleagues
- Citizens Advice Bureau
- Volunteering Wales
- Business Connect Wales
- Careers Wales
- Shaw Trust
- Remploy
- A family member and/or other carer
- Care Coordinator
- You!

Hafal runs an employment project dedicated to supporting people with a serious mental illness to get into work. Visit www.hafal.org to find out more or contact us (see the centre page for details).
Now that you have identified the outcomes you want to achieve the Plan provides space to make plans for periods of illness or crisis.

This section records any signs that you are becoming unwell. This is a good idea as it means the early symptoms of an episode can be recognised as soon as possible and timely treatment provided. Record any signs of illness such as difficulty thinking, hearing voices, paranoid thoughts, decreased appetite, excessive energy, etc.

Next comes a section which sets out plans for if you become unwell. Crisis planning is essential as it means that everyone involved can agree beforehand what should happen when a crisis arises. This is the opportunity to draw up an advance agreement between you, your Care Coordinator and others involved so that if a crisis happens, it is dealt with in the way that you want. For example, you may choose to list the names and contacts of the services/people who you feel can best support you, treatments which have worked in the past and preferred places to be treated.

Next the Plan asks if you have any language or communication requirements. Record in this section whether you want your services provided in English or Welsh, or if you have another first language. Guidance states that all possible steps should be taken to ensure that bilingual (Welsh and English) services are available and that, where required, access to interpreters and/or persons with specialist skills in communication should be considered.

If you have poor literacy skills, make sure the Care Plan is provided to you in a way that you can understand fully. Guidance says that technical language and jargon should be avoided in the planning process.
Now you come to the final page of your Plan.

First you are asked to record your views on what is recorded in the Plan, the mental health services to be provided, and any future arrangements. This is your opportunity to have your say on the Plan. Is it meeting your needs? Does more need to be done?

Next you are asked to agree the Plan. You do not have to agree the Plan but our advice is to lead on writing the Plan as much as possible and ensure that your own words are used so that you have a positive Plan which you can agree with.

The Plan then has a space to record the name of the Local Health Board and/or local Council responsible for providing you with mental health services.

At the bottom of the page you are asked to sign the Plan (though again, you do not have to agree to this). The Care Coordinator also has a space to sign and agree the Plan and it is dated at the bottom.

After completing the Plan you should receive a copy. A copy will also be kept by your Care Coordinator and further copies will normally go to your carer, your GP, parents/guardians, and all other agencies/supporters who will help you achieve your outcomes. Guidance says that the Care Coordinator must take account of your views about whether or not copies should be provided to these people. We strongly recommend that they do get a copy – unless you have a particular reason to withhold it – because it will help them to give you support.
What happens next?

Once you have a copy of your Plan, keep hold of it. It’s your Plan and it’s about your life! We suggest that you keep your Plan in a safe but handy place so that you can refer to it whenever you need. It’s important to keep your attention on the Plan, including those actions which you have said you will take yourself. And do not hesitate to go back to your Care Coordinator to ask questions about the Plan.

While it is the Care Coordinator’s duty to coordinate the delivery of the Plan, this is no substitute for you taking control. We advise that you ask for an early review of the Plan and read through it regularly to make sure the outcomes are being met.

About reviews

Formal reviews of the Care and Treatment Plan must take place at least once in any twelve month period. However, you can request a review at any time.

We advise that you definitely ask for a review if there is a significant change in your circumstances or things are not going to plan. You may have new difficulties to deal with – or you may have achieved goals earlier than you thought – and the Plan needs to reflect this. We also strongly advise that you always have your Plan to hand when you meet your Care Coordinator or other people who are providing support to you.

What else can you do?

Get active! Talk to other service users. Get support from them and offer them your support!

One way of doing this is by joining Hafal. We are a Member-led charity providing services in all 22 counties of Wales and campaigning for the rights of people with serious mental illness and their carers. For more information go to www.hafal.org, call 01792 816600 or follow us on Facebook and Twitter!

Or you can get in touch with our friends at Bipolar UK and the Mental Health Foundation.

Bipolar UK is a national charity dedicated to supporting individuals with bipolar, their families and carers. For more information go to www.bipolaruk.org.uk or call 01633 244 244.

The Mental Health Foundation is the UK’s leading mental health research, policy and service improvement charity. Find out more by visiting www.mentalhealth.org.uk.