Do our current approaches to care planning and the CPA enhance the experience and outcomes of a person's recovery?

Miles Rinaldi and Flippa Watkeys

Miles Rinaldi is Head of Recovery and Social Inclusion, based at Service Development, South West London, UK and St George's Mental Health NHS Trust, London, UK. Flippa Watkeys is Recovery and Involvement Lead/ Professional Lead Occupational Therapy (Local Services), based at West London Mental Health NHS Trust, London, UK.

Abstract

Purpose – *Increasingly mental health services are attempting to become recovery focused which demands changing the nature of day-to-day interactions and the quality of the experience in services. Care planning is the daily work of mental health services and within this context, care planning that enhances both the experience and the outcomes of a person's recovery is a key element for effective services. However, care plans, the care planning process and the Care Programme Approach (CPA) continue to pose a challenge for services. The purpose of this paper is to discuss these issues.*
Design/methodology/approach – *Conceptual paper.*
Findings – *Within recovery focused services a care plan becomes the driving force, or action plan, behind a person's recovery journey and is focused on their individual needs, strengths, aspirations and personal goals. If involving people directly in the development of their care plan is critical to creating better outcomes then supporting self-management, shared decision making and coproduction all underpin the care planning process. Based on the evidence of people's experience of care plans and the care planning process it is time to seriously debate our current conceptualisation and approach to care planning and the future of the CPA.*
Originality/value – *The paper describes aspects of the current situation with regard to the effectiveness of care planning in supporting a person's recovery. The paper raises some important questions.*
Keywords *RECOVERY, Care planning, Care plans, CPA, Self-management, Shared decision making*
Paper type *Conceptual paper*

Introduction

Recovery has become the overarching concern for people using mental health services, their families and policy makers (Shepherd *et al.*, 2008; Department of Health, 2011). Whilst there is still a lot to learn about the experience of Recovery and how best to support it, what clearly emerges from the literature, and where there is consensus, is that Recovery is a highly individualised process. The Department of Health (2011) use Anthony (1993), as a working definition of Recovery:

> A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and or roles. It is a way of living a satisfying, hopeful and contributing life even with the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness.

Recovery is about individualised approaches and, as the definition suggests, it is about having a satisfying and fulfilling life, as defined by each person. Importantly, recovery does not necessarily mean "clinical recovery" (usually defined in terms of symptoms and cure). However, it does

mean building a life beyond illness without necessarily achieving the elimination of the symptoms. A challenge for mental health services is to look beyond clinical recovery through facilitating recovery and promoting social inclusion by measuring effectiveness of treatments and interventions in terms of the impact of these on the goals and outcomes that matter to the person and their family.

It is clear that Recovery is not an intervention and it is not what professionals do to people. Within recovery-focused services professionals work with the central components of Recovery: hope, control and opportunity (Repper and Perkins, 2003). They provide people with information, skills, networks and support, and help them to get access to the resources they think they need to live their lives (Shepherd *et al.*, 2008). This way of working demands a shift in the relationship between professionals and people using services, to one with a greater emphasis on collaboration and partnership. It represents a transfer of the authority to define and recognise Recovery away from the professional to the individual.

To achieve this means changing the nature of day-to-day interactions and the quality of the experience in mental health services. Care planning is the daily work of mental health services and, within this context, care plans that enhances both the experience and the outcomes of a person's recovery are a key element for effective services.

Care planning and care plans

Conceptually, care planning describes the processes involved in proactively reviewing a person's current situation and their priorities, and planning for their forthcoming care and support. It aims to provide person-centred care and actively increase involvement in decisions and health care. When the Care Programme Approach (CPA) was refreshed (Department of Health, 2008) a care plan was defined as a plan that set out a person's assessed health and social care needs and promoted recovery by focusing on improving outcomes that mattered to the person. It is recognised that involving people directly in the development of their care plan is critical to creating better outcomes (Adams and Grieder, 2005; Schizophrenia Commission, 2012). The eighth quality indicator of mental health services (NICE, 2011) is that people jointly develop a care plan with their health and social care professionals, and are given a copy with an agreed review date.

However, despite national policy and guidance, care plans, the care planning process and the CPA framework continue to pose a challenge for mental health services. The Centre for Social Justice (2011) identified that the CPA is viewed as being excessively bureaucratic and has effectively turned skilled clinicians into administrators. They also identified that most people using mental health services and their families are not even aware what the CPA is. A national survey of people using community mental health services (Care Quality Commission, 2012) showed that 38 per cent of people either did not understand their care plan or simply did not know they had one. Of those who had a care plan and knew what was in it, just over half (54 per cent) definitely thought their views were taken in account and, less than half (43 per cent) definitely felt their care plan set out their personal goals. Recent user-led research into the experiences of people receiving mental health services through the CPA (Gould, 2013) showed care plans predominately emphasise clinical outcomes, medication and risk. Whereas the people surveyed wanted greater involvement in their care plans and for them to focus on options to help them be in control of their lives and live lives that they found meaningful. The study also highlighted differences in the meaning and understanding of Recovery between professionals and people using services.

Care plans still appear to be primarily focused on people's risk, their illnesses, the problems they experience and the care planning process does not always involve people in the decisions about their lives. If working in a recovery focused way is about supporting people to find a fulfilling life beyond illness then care plans need to focus on people's strengths, preferences, individual needs, aspirations and personal goals (Care Quality Commission, 2013). To achieve this, however, demands a change to our current conceptualisation of care plans and the care planning process. Traditionally care plans have been written by professionals based on problems, weaknesses, diagnosis and risk, and not always sought to include people in a

meaningful way. As a consequence the care planning process is often poorly understood by people who are being served and, as such, care plans are seen as being relatively meaningless to them.

Risk is a significant part of health and cannot be eliminated from the process of assessing and managing mental health conditions; it is always there and can drive risk averse care plans thereby limiting opportunities and choice discussions with the person, but there are things that professionals can do to help the person to maximise their chances of success. Central to this is the notion that professionals should be able to speak frankly with people and share their opinions about the risks associated with different courses of action, whether or not the person agrees. Managing risk effectively involves not one expert, but two: the professional, whose expertise comes from training; and the person, whose expertise comes from their own lived experience. By sharing respective information and working collaboratively to identify the best ways of maximising the chances of success, while minimising negative impacts if things do not turn out as hoped, both parties place themselves in the best position to make the best decisions and help people to make the most of their lives and do the things they want to do in life (Perkins and Goddard, 2009).

Within recovery focused services a care plan becomes the driving force, or action plan, behind a person's recovery journey and is focused on their individual needs, strengths, aspirations and personal goals. When professionals encourage people to set their own goals, jointly develop care plans which are personalised, conveying a sense of hope, it helps to move the focus from the professional "doing" to the professional "enabling". In turn, the process of care planning becomes a dynamic and collaborative process underpinned by self-management, shared decision making and coproduction[1]: not planned occasions where professionals meet with people for reviews and complete documentation to fulfil a bureaucratic process (Centre for Social Justice, 2011; Thornicroft *et al.*, 2013).

Personal recovery goals

Typically an assessment process in mental health services leads to the identification of treatment or intervention goals. However, in recovery focused mental health services the assessment process leads to the identification of two types of goal: recovery goals and treatment goals. Recovery goals are a person's own goals – their dreams and aspirations. They are based on what the person actively wants, rather than what the person wants to avoid. They are strengths based and oriented towards reinforcing a positive identity and developing valued social roles. Treatment goals on the other hand are different; they are important but they interrelate with recovery goals by addressing people's health and social care needs that interfere with a person's ability to achieve their recovery goals. Bridges *et al.* (2013) illustrate the differences in goals and outcomes between professionals and people with a diagnosis of schizophrenia. The study highlighted the differences and the need to identify both treatment goals and peoples own recovery goals – psychiatrists focused on goals to produce clinical outcomes, while people using services were more concerned with goals to improve their social functioning and living a normal life.

The ability to set recovery goals can be challenging for both people themselves and professionals involved in their care. To think about a future that encompasses goals depends, in a large part, on a person having hope. Some people cannot see anything other than a bleak future when they have tried in the past to pick up the pieces over and over again only to see them fall apart. Some people never had hope, so it must be built. Others had it at one time, necessitating restoration of hope. Whatever the case, it takes time and patience. When a person has no hope, it is important that others carry hope for that individual until such a time as the person begins to believe that his or her life can get better.

For mental health professionals recovery goals can be challenging, either because when identified they seem unrealistic, inappropriate or supporting them is outside their role. Recovery goals sometimes involve staff effort, or they may have nothing to do with mental health services. They always require the person to take personal responsibility. Recovery goals are identified by the person, and are their dreams and aspirations with actioned timelines. If the care planning process is underpinned by coproduction (see Box 1 for the guiding principles of coproduction) then the

```
┌─────────────────────────────────────────────────────────────────────┐
│                Box 1: The core principles of coproduction             │
│                                                                       │
│  The six core principles of coproduction:                             │
│                                                                       │
│  1. Recognising people as assets                                      │
│                                                                       │
│  2. Building on people's capabilities.                                │
│                                                                       │
│  3. Promoting mutuality and reciprocity.                              │
│                                                                       │
│  4. Developing peer support networks.                                 │
│                                                                       │
│  5. Breaking down barriers between professionals and users.           │
│                                                                       │
│  6. Facilitating rather than delivering.                              │
│                                                                       │
│  Source: Boyle et al. (2010).                                         │
└─────────────────────────────────────────────────────────────────────┘
```

development of both recovery goals and treatment goals becomes a transformational imperative to the care plan. Incorporating both sets of goals can provide a person with hope, a sense of the purpose and value of their care plan and enables mental health professionals to support people in achieving their goals whilst actively supporting self-management and shared decision making.

Supporting self-management and shared decision making

The third quality indicator of mental health services (NICE, 2011) is supporting self-management and shared decision making. Self-management support is viewed in two ways: as a portfolio of techniques and tools that help people problem solve, set goals, identifying triggers and warning signs and develop coping strategies; and a fundamental transformation of the person-professional relationship into a collaborative partnership (De Silva, 2011). Self-management offers the opportunity of enabling people to rebuild their lives within the context of living with a mental health condition – putting people in direct control of managing their condition. Working with the core principles of coproduction enables professionals to transform their relationships with people into collaborative partnerships. Care planning can be an example of putting self-management support into practice if the focus moves from the professional doing things to the person, to one which professionals through coproduction support people's confidence and skills enabling them to self-manage their own condition as far as possible.

Wellness Recovery Action Plans – WRAP (Copeland, 1997) and personal recovery plans (Perkins and Rinaldi, 2007) are examples of plans that people develop themselves to take control of their lives and support their self-management. Personal recovery plans are different from care plans. A personal recovery plan is where a person identifies internal and external resources for facilitating their recovery and they then use these to create their own plan for how they will take control of their life. A person does not have to consult or share their plan with anyone unless they want to but many people find it helpful to share their personal recovery plan with professionals and others who assist them in their recovery journey. If professionals are actively supporting self-management then there is an inter-relationship between a person's personal recovery plan and their care plan.

It is encouraging that a recent survey of care co-ordinators (Rinaldi and Suleman, 2012) found care co-ordinators rated self-management as an important process for people to engage with. However, when specifically asked about people on their caseloads, care co-ordinators considered just over half (54 per cent) were actually capable of engaging in the self-management of their condition. This raises important issues in terms of care co-ordinators understanding of self-management and second how they can support people in the self-management of their condition. Box 2 illustrates the reality of self-management in the lives of people with mental health conditions and highlights, simply based on the maths, the importance for professionals to support people in the self-management of their condition.

In the White paper *Equity and Excellence: Liberating the NHS* (Department of Health, 2010) the Government announced the key principle of "no decision about me, without me", the intent

being for people to be much more in control of their own care primarily through shared decision making.

Shared decision making promotes person-centred care, increases patient choice, autonomy and involvement in decision making in relation to treatments, interventions and supports. It is an interactive and collaborative process between an individual and their professional that is used to make decisions pertinent to a person's recovery. Charles *et al.* (1997) describe a set of principles for shared decision making:

1. it involves at least two participants, the professional and the person;

2. both the professional and the person take steps to participate in the process of decision making;

3. information sharing is a prerequisite to shared decision making;

4. both the professional and the person take steps to build a consensus about the preferred treatment weighted accordingly to the specific characteristics and values of the person; and

5. a treatment decision is made and both parties agree to the decision.

Woltmann *et al.* (2010) used an electronic decision support system to facilitate shared decision making within the care planning process. They found people could build their own care plans and negotiate and revise them with their care co-ordinators by using an electronic decision support system. Through using the electronic decision support system it brought to light preferences held by people that were not previously known by care co-ordinators. Both care co-ordinators and the people using the electronic decision support system appeared to be able to work together to take action on these items. People using the electronic decision support system were also more aware of the care decisions that were being made either directly by them or on their behalf. The majority of the people in the study were long-term users of mental health services and had a diagnosis of schizophrenia (60 per cent) or bipolar disorder (25 per cent).

Information, education and resources

Participating in self-management and shared decision making often requires access to information, resources and education. There is recognition that there has been far more emphasis on elaborating professionals skills in supporting self-management and shared decision making than there has been on developing these skills of people who use health services (Gigerenzer and Muir Gray, 2011). Recovery Colleges[2] are rapidly developing in mental health services in England. They use an educational approach to complement traditional

treatment approaches to mental health care. They enable people to become experts in their own self-management, build knowledge and confidence to participate in shared decision making and, to develop skills and confidence to manage their own recovery journey. Within Recovery Colleges all courses are co-produced, co-delivered and co-received by professionals, people with mental health conditions and their families to support shared learning and understanding and provide access to peer support and peer networks. Courses such as "understanding your care plan", "your care plan – getting the best out of it" are increasingly becoming available to enable people to understand the care planning process and what a care plan is, informing people they have the right to greater involvement in their care plan, tips on how to prepare for a care plan review and learning that their care plan should be focused on options to help them be in control of their lives and live lives that they want to lead.

A recent survey of people using mental health services (Rinaldi and Barrett, in press) showed that 54 per cent had accessed the internet in the past year, with the majority of those (87 per cent) accessing the internet on a regular basis at least once a week. They were asked whether they would want, if available to them, access to their care plans, medical records and to request prescriptions and appointments through the internet: 71 per cent, irrespective of whether they accessed the internet or not, responded "yes" to wanting this access. It was also interesting to find that 51 per cent of respondents who did not have access to the internet also said "yes". Greater access to information can increase knowledge and understanding, promote autonomy and informed choice and transform the person-professional relationship into a collaborative partnership. In this context, there is the expectation by March 2015 that everyone who wishes to will be able to get online access to their own health records held by their GP (Department of Health, 2012).

There are examples in England where people, including people with mental health conditions, are already managing their own personal health records – an online record owned by the person, allowing them to add and organise personal health information including their care plan, as well as to integrate health records from different providers, and share this with other individuals and institutions at will. Box 3 provides examples of online personal health records.

Time to rethink the approach?

The CPA was introduced in 1991 to provide a framework for effective mental health care and set out four main elements: systematic arrangements for assessing the health and social needs of people accepted into specialist mental health services; the formation of a care plan which

---

Box 3: Examples of online personal health records

■ Haughton Thornley Medical Centre offers people online access to their electronic medical notes and they can gain a better understanding of their health via access to trusted health information, maintained on the surgery's web site or practice web portal (www.htmc.co.uk). The portal also contains self-management tools and resources, allows people to book appointments, order repeat prescriptions and access their health records.

■ Patients Know Best (www.patientsknowbest.com) is an online patient-controlled medical records system. Each person gets all their records from all their clinicians – GP and hospital, NHS and non-NHS, UK and non-UK – and controls who gets access to these records. They can also conduct online consultations with any member of their clinical team, receive automated explanations of their results and work with clinicians on a personalised care plan. The Patient Knows Best portal is integrated into the NHS secure network.

■ Myhealthlocker (www.myhealthlockerlondon.nhs.uk), recently developed by South London and Maudsley Foundation Trust, aims to give people with mental health conditions more control over their healthcare and greater choice in their treatment. It provides secure access to health records, a person's care plan, information about their condition and medications they use. It encourages a two-way flow of information between patients and their clinicians. There are also self-management tools such as a health diary so people can monitor their own wellbeing.

identified the health and social care required from a variety of providers; the appointment of a key worker (now known as a care co-ordinator) to keep in close touch with the person and to monitor and co-ordinate care; and regular review and, where necessary, agreed changes to the care plan (Department of Health, 1990). Nine years later the CPA was modernised and aimed to achieve: integration of the CPA and care management; consistency in implementation of the CPA nationally; more streamlined process to reduce the burden of bureaucracy; and a proper focus on the needs of people using mental health services. (Department of Health, 1999). In 2008, the CPA was refocused by further updating the CPA and outlining the competences of the care co-ordinator (Department of Health, 2008).

For over 20 years care planning has been the daily work of mental health services but the evidence continues to show neither care plans nor the care planning process are enhancing the experience and the outcomes of a person's recovery. Whilst care plans were pioneered in mental health many people still report not being fully involved in making and agreeing them. With the recognition that mental health services are still a long way from "no decision about me, without me" (Care Quality Commission, 2013) and with the CPA being viewed as being excessively bureaucratic, having effectively turned skilled clinicians into administrators then surely this demands a change to our current conceptualisation and approach to care planning?

If a care plan is the driving force, or action plan, behind a person's recovery journey and is focused on improving outcomes that matter to the person then we need to recognise that mental health services only play a role, and sometimes only a small role, in a person's recovery. The Centre for Social Justice (2011) made the recommendation that the CPA framework along with care co-ordination should be taken outside of health and social services and be delivered by independent third sector organisations. Such a move would require appropriate safeguards, training and accountability currently required for employing statutory sector care co-ordinators to be put in place for independent third sector organisations. However, such a structural and system change might enable a rebalancing of the current emphasis within care plans on clinical outcomes, medication and risk. Whilst this change may provide the answer to enhancing the experience and the outcomes of a person's recovery, lessons learnt from other areas of health and social care along with forthcoming individual rights would also be helpful to consider in this context.

Personalisation in social care has shown that, where local authorities commission user-led organisations to deliver support planning and brokerage of social care personal budgets with disabled people, the process is experienced by service users as more "human" and with less bureaucracy (Campbell *et al.*, 2011). The independent evaluation of the national pilot programme for Personal Health Budgets (Forder *et al.*, 2012) showed they had a significant positive impact on care-related quality of life, physical health and wellbeing. They were also shown to be cost-effective for people with mental health conditions, reducing their use of primary and secondary care. A recent survey to find out what people with mental health conditions want from services and support, and what role personal health budgets might play (MIND, 2013) found that people identified choice of treatments and joint care planning being the most important improvement to their experience of mental health care. These ideas are central to personal health budgets.

The government's vision of choice is putting patients first and enabling them, in discussion with their GP, to make choices about the type of treatments and supports they need, and the services they will access to receive these. The NHS Mandate (Department of Health, 2012) states everyone with long-term conditions, including people with mental health conditions, will be offered a personalised care plan that reflects their preferences and agreed decisions. From April 2014, if a person needs to see a mental health professional as an outpatient they will have the legal right to choose which professional, including consultant psychiatrists, will be in charge of their treatment (Department of Health, 2013). Underpinning this is the aim that care is co-ordinated around the needs, convenience and choices of patients, their carers and families – rather than the interests of organisations that provide care.

If we are to truly put the patient first (Francis, 2013) and, if we have learnt anything from Winterbourne View and Mid Staffordshire then we know that the quality of experience and

listening to people who use services along with their carers and families is of equal importance to organisational performance data. Based on the evidence of people's experience of care plans and the care planning process, along with the introduction of a legal right to choice and potential control through personal health budgets, is it not time to seriously debate our current conceptualisation and approach to care planning and the future of the CPA?

Notes

1. Co-production requires users to be experts in their own circumstances and capable of making decisions, while professionals must move from being fixers to facilitators. To be truly transformative, co-production requires a relocation of power towards service users. This necessitates new relationships with front-line professionals (Realpe and Wallace, 2010).

2. For more information on Recovery Colleges see Perkins *et al.* (2012).

References

Adams, N. and Grieder, D.M. (2005), *Treatment Planning for Person Centred-Care: The Road to Mental Health and Addiction Recovery*, Elsevier Publishers, Burlington, MA.

Anthony, W.A. (1993), "Recovery from mental illness: the guiding vision of the mental health service system in the 1990", *Psychosocial Rehabilitation Journal*, Vol. 16 No. 4, pp. 11-23.

Boyle, D., Slay, J. and Stephens, J. (2010), *Public Services Outside In. Putting Coproduction into Practice*, NESTA, London.

Bridges, J.F.P., Slawik, L., Schmeding, A., Reimer, J., Naber, D. and Kuhnigk, O. (2013), "A test of concordance between patient and psychiatrist valuations of multiple treatment goals for schizophrenia", *Health Expectations*, Vol. 16 No. 2, pp. 164-76.

Campbell, N., Cockerell, R., Porter, S., Strong, S., Ward, L. and Williams, V. (2011), *Independent Living Strategy: Support Planning and Brokerage. Final Report from the Support Planning and Brokerage Demonstration Project*, Office for Disability Issues, London.

Care Quality Commission (2012), *National Community Mental Health Survey*, Care Quality Commission, London.

Care Quality Commission (2013), *Monitoring the Mental Health Act in 2011/12*, Care Quality Commission, London.

Centre for Social Justice (2011), *Completing the Revolution. Transforming Mental Health and Tackling Poverty. A Policy Report by the Mental Health Working Group*, The Centre for Social Justice, London.

Charles, C., Gafni, A. and Whelan, T. (1997), "Shared decision-making in the medical encounter: what does it mean? (or it takes two to tango)", *Social Science and Medicine*, Vol. 44 No. 5, pp. 681-92.

Copeland, M.E. (1997), *Wellness Recovery Action Plan*, Peach Press, Dummerston, VT.

Department of Health (1990), *Joint Health and Social Services Circular, 11 HC (90) 23/LASSL (90) 11, The Care Programme Approach for People With a Mental Illness Referred to Specialist Psychiatric Services*, Department of Health, London.

Department of Health (1999), *Effective Care Coordination in Mental Health Services: Modernising the Care Programme Approach*, Department of Health, London.

Department of Health (2008), *Refocusing the Care Programme Approach: Policy and Positive Practice Guidance*, Department of Health, The Stationary Office, London.

Department of Health (2010), *Equity and Excellence: Liberating the NHS*, Department of Health, The Stationary Office, Norwich.

Department of Health (2011), *No Health Without Mental Health. A Cross-Government Mental Health Outcomes Strategy for People of all Ages*, Department of Health, The Stationary Office, London.

Department of Health (2012), *The Mandate: A Mandate from the Government to the NHS Commissioning Board: April 2013 to March 2015*, Department of Health, The Stationary Office, London.

Department of Health (2013), *2103/14 Choice Framework*, Department of Health, London.

De Silva, D. (2011), *Helping People Help Themselves: A Review of the Evidence Considering Whether it is Worthwhile to Support Self-Management*, Health Foundation, London.

Forder, J., Jones, K., Glendinning, C., Caiels, J., Welch, E., Baxter, K., Davidson, J., Windle, K., Irvine, A., King, D. and Dolan, P. (2012), *Evaluation of the Personal Health Budget pilot programme*, PSSRU, University of Kent, Kent.

Francis, R. (2013), *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*, The Stationery Office, London.

Gigerenzer, G. and Muir Gray, J.A. (Eds) (2011), *Better Doctors, Better Patients, Better Decisions: Envisioning Health Care 2020*, MIT Press, Cambridge, MA.

Gould, D. (2013), *Service Users' Experiences of Recovery Under the 2008 Care Programme Approach.*, National Survivor User Network and the Mental Health Foundation, London.

MIND (2013), *Personal Health Budgets in England – Making them Work in Mental Health*, MIND, London.

NICE (2011), *Service User Experience in Adult Mental Health: Improving the Experience of Care for People Using Adult NHS Mental Health Services. NICE Clinical Guideline 136*, NICE, Manchester.

Perkins, R. and Goddard, K. (2009), *Sharing Responsibility for Risk and Risk-Taking – Module 5. In Realising Recovery Learning Materials*, NHS Scotland and Scottish Recovery Network, Edinburgh.

Perkins, R. and Rinaldi, M. (2007), *Taking Back Control: A Guide to Planning Your Own Recovery*, South West London and St George's Mental Health NHS Trust, London.

Perkins, R., Repper, J., Rinaldi, M. and Brown, H. (2012), *Recovery College – Implementing Recovery Through Organisational Change*, Centre for Mental Health/NHS Confederation, London.

Realpe, A. and Wallace, L.M. (2010), *What is Coproduction?*, Health Foundation, London.

Repper, J. and Perkins, R. (2003), *Recovery and Social Inclusion. A Model for Mental Health Practice*, Balliere Tindall, London.

Rinaldi, M. and Barrett, D. (in press), "After all is it is the 21st century: internet access, health related information and access to medical records on the internet", *The Psychiatrist*, in press.

Rinaldi, M. and Suleman, M. (2012), *Care Co-ordinators Attitudes to Self-Management and Their Experience of the South West London Recovery College*, South West London and St George's Mental Health NHS Trust, London.

Schizophrenia Commission (2012), *The Abandoned Illness: A Report from the Schizophrenia Commission*, Rethink Mental Illness, London.

Shepherd, G., Boardman, J. and Slade, M. (2008), *Making Recovery a Reality*, Sainsbury Centre for Mental Health, London.

Thornicroft, G., Farrelly, S., Szmukler, G., Birchwood, M., Waheed, W., Flach, C. and Barrett, B. *et al.* (2013), "Clinical outcomes of joint crisis plans to reduce compulsory treatment for people with psychosis: a randomised controlled trial", *The Lancet*, Vol. 381 No. 9878, pp. 1634-41.

Woltmann, E.M., Wilkniss, S.M. and Teachout, A., McHugo, G.J. and Drake, R.E. (2010), "Trial of an electronic decision support system to facilitate shared decision making in community mental health", *Psychiatric Services*, Vol. 62 No. 1, pp. 54-60.

Corresponding author

Miles Rinaldi can be contacted at: Miles.Rinaldi@swlstg-tr.nhs.uk