USERS’ MANUAL:

PARTNERSHIP IN COPING SYSTEM (PinC)

OF RECOVERY
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PART ONE

INTRODUCTION

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

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

Although the PinC system of Recovery was developed with mental health nurses in mind, the principles are equally appropriate for all workers in the mental health field.

The system consists of eight guided steps

- **Step 1** creating a working alliance that includes core conditions (empathy, unconditional positive regard and genuineness),
- **Step 2** identification of experiential threats
- **Step 3** identification of concerns
- **Step 4** prioritising concerns
- **Step 5** identification of personal strengths, i.e., coping strategies
- **Step 6** setting goals to deal with concerns
- **Step 7** achieving goals through actions based on personal strengths
- **Step 8** reviewing progress to achieving goals

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

The system is specifically designed to work in both community and in hospital settings.
The creation of PinC involved the process of building on thoughts, ideas and theories relevant to mental health and recovery. In other words, PinC was not created out of a vacuum but derived and revised from existing thoughts, ideas and theories on mental health care as well as from the experiences of the service users and mental health workers involved in its development.

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

The second observation we make is that, in *using* the PinC system, a person does not need to be a rocket scientist! Initially it involves the adherence to a clear straightforward process based on an understanding of the philosophy behind the system as described in the recovery alliance theory and skills developed in the use of PinC. It is recommended that training in the application of PinC is undertaken prior to using the system for the first time.

**Link** [Recovery Alliance Theory](#)

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

**Issues of Terminology**

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

Where reference is made to both mental health worker and service user in their working alliance the term ‘partners’ are used.
OVERVIEW OF PARTNERSHIP IN COPING (PinC) SYSTEM OF RECOVERY

Background to Partnership in Coping (PinC)

The PinC system was developed by service users, consumer representatives and mental health nurses working in inpatient, community and educational settings in Western Australia. It was designed to take into account cross cultural variations and its applicability across disciplines and organisations though it was initially developed with the practice of mental health nurses as its focus.

The PinC approach is based on the Recovery Alliance Theory (RAT) (Shanley and Jubb-Shanley (2007). This theory outlines the assumptions used and the philosophy and the methods of interactions between the mental health workers and the person with mental health concerns. A core component is that recovery can be achieved by helping the person apply their existing strengths in coping to their mental health concerns.

Mental health concerns are usually periodic occurrences in a person’s life when he or she may have such difficulties in coping with issues in their lives that, without the involvement (or increased involvement) of a mental health worker, the person may have difficulties in coping. The result is psychological distress and major disruptions to the person’s way of life.

The classification of the person’s psychological distress into a diagnostic category, while important to psychiatrists, is not seen as being as helpful to the work of other mental health workers. Acceptance of the person’s own understanding of his or her concerns (not the psychiatrist’s or the mental health worker’s) is a major plank of the PinC system.

Stated simply, the work of the mental health worker in using the PinC system is to accept the person’s understanding of their mental health concerns and to use his or her existing strengths to address those concerns.

Addressing the concerns is through the application of a problem solving approach in helping the person prioritise their concerns, setting goals and using previous coping strategies or develop new strategies to achieve these goals.
Working Alliance

In the PinC system the person with the mental health concern and the mental health worker are partners within a working alliance. The presence of the working alliance particularly early in the engagement is the best predictor of outcome in psychotherapy (more so than any particular psychotherapeutic approach). (Henry et al. 1994) Therefore it is crucial in helping the user of the service that this alliance is established as early as possible in the engagement.

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

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

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

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

The bond, tasks and goals are integrated in a systematic way within the partnership and designed to give the person with the mental health concern the major responsibility in determining and undertaking tasks towards achieving theirs goals.

Role of the mental health worker

The mental health worker’s role is to follow the eight guided steps of the PinC system which includes collaborating as team members with colleagues including psychiatrists, external agencies and family members and/or friends. The monitoring of effects of medications may constitutes part of their collaborative role with medical colleagues.
In keeping with recovery principles PinC requires the ‘normalisation’ of engagement between mental health workers and consumers (Shanley and Jubb-Shanley 2007)

The adoption of these rules of engagement requires include mental health workers to possess skills such as

1. use of everyday speech.

The use of everyday speech and narrative minimizes the inequality in the power relationship, improves communication and helps develop a helping relationship. Reclassifying what a person with mental health concerns says and does into predetermined categories creates a difference in the power relationship, inhibits communication and inhibits the development of a therapeutic relationship. The ordinariness of the relationship and the ability of the mental health worker to be friendly and approachable go some way in demonstrating a shared humanity between the partners.

2. competence in engaging with service users in variable context and times

Encounters between mental health workers consumers may be impromptu or planned. For example, they may arrange to meet at the individual’s house or at public places such as the cafe or local park. These encounters demand interpersonal skills beyond those used in engaging with consumers in more predictable setting, e.g., appointments in interview rooms etc.

3. self-disclosure

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

4. unscripted dialogue.

By the nature of their role some mental health workers deal with unpredictable behaviour and situations ranging from social exchanges to the service user’s expression of intense anger. Planned and unplanned encounters may occur in variable contexts and at variable times, e.g. inside and outside
the regular 9–5 schedule in the hospitals or in the community and require the mental health worker to ‘think on their feet’ and interact accordingly.

5. holistic perspective

*Mental health workers use a holistic perspective of the service user’s experiences. Both mental health workers and service users recognize that issues outside the remit of the traditional medical model are legitimate areas that may be addressed.*

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

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

Working Through the Phases of PinC

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

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

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

Phase One – establishment of core conditions (bond)

Aim

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

Action

The core conditions of unconditional positive regard, empathy and genuineness form the bedrock of the working alliance between the service user and the mental health worker. The following is a brief description of each condition.
Unconditional Positive regards

To establish this condition the mental health worker conveys to the service user the feeling of being viewed as a worthwhile person despite the fact that from time to time he or she may disagree, have different values or behaves or has behaved in a way that the mental health worker may see as unacceptable. In other words, the service user recognises that the mental health worker values him/her without making his or her regard dependent on the service user behaving in a way that meets with the worker’s approval.

Empathy

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

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

Genuineness

Being genuine means more than just being honest with a person. It means an internal honesty for the mental health worker who conveys it to the service user.

Rogers (1980) described genuineness or congruence thus: ‘when my experience of the moment is present in my self awareness and when what is present in my awareness is present in my communication then each of these three levels matches or is congruent’ (Rogers 1980 p 15). It is worth reflecting on this statement in order to understand it fully.

Being genuine doesn’t mean the mental health worker discloses all. The mental health worker may share with the service user feelings and sensations that are a response to the person, that are relevant to the immediate concerns of the person and are relatively persistent or particularly important.

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

The presence of these core conditions has been shown to have a powerful therapeutic effect on service users for many kinds of problems even without any
additional techniques being employed. However increasingly it is recognised that offering a structure, such as the PinC system is appropriate in helping a person with mental health concerns deal more immediately with those identified issues. A major advantage of the PinC system is that, within this approach, techniques such as cognitive behaviour therapy, mindfulness and ACT can be usefully applied.

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

- Initially the focus of conversation is likely to be on ‘safe’ factual topics, e.g. aspects of their surroundings e.g., weather, recently events e.g., football games, films, television program, and topics that are non personal or directly related to the service user’s reason for seeing the mental health worker.
- With Aboriginal people exchanging information about one’s own origins and family and where you are from may be a necessary precursor to any deeper engagement.
- The conversation progressively moves to open discussion that embraces aspects of service users’ life, common interests, likes and dislikes.
- Later the conversation moves to the narrower issue of service user’s experiences such as their subjective feelings and what they see as happening to them.
- Mental health workers provide information such as the gaps in the service users’ understanding about the organisation they have engaged with, the type and level of help they are to receive, their rights and, the service they can expect.
- The mental health worker may also obtain information about the service users’ psychological and social circumstances and enquires about general and positive aspects such as interests (likes, dislikes), strengths, talents, goals and support systems available. The mental health worker explains his/her role and how they (both service user and mental health worker) can work together using the PinC system.
Phase Two (optional) – Identification of experiential threats (at risk screening if appropriate)

**Aim**
- To determine the degree of risk presented by the service user.

**Action**
Service users’ degree of risk is best assessed by mental health workers who already have established a positive relationship with the service user. However earlier assessment may be necessary.
Standardised forms are usually provided by the individual service to help make this judgement.

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

Phase Three – Identification of concerns

**Aims**
- To identify concerns experienced by the service user

**Prerequisites**
1/ establishment of core conditions (as the initial phase of the working alliance).
2/ identification of experiential threats (risk assessment, if required, by completion of ‘at risk’ screening (optional).

**Action**
A description of the service user’s concerns is written on the PinC Head Sheet (See Figure 1) of the PinC Process Records.
A spare sheets of paper may be used on which to draft the person’s concerns prior to recording the final draft on the PinC Head Sheet.

The Range of Life Experiences document may be helpful as a checklist in helping the service users identify their concerns.

Link Range of Life Experiences

**FIGURE 1**

**PinC Head Sheet**

<table>
<thead>
<tr>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Worker:</td>
</tr>
<tr>
<td>Other Support Workers:</td>
</tr>
</tbody>
</table>

**Concerns Prioritised:**

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

**Please Note:**
Any number of concerns may be prioritized.

Documentation is in the service user’s own words written in as clear and understandable language as possible directly by the service user or transcribed by the mental health worker. Professional jargon, unless used by the service user, should not be recorded on the PinC Process Records.

**Notes**
A basic assumption of the PinC system is that the approach used is the same whether you think the person is experiencing depression, anxiety or schizophrenia.
What is important is that your understanding of the person’s concerns is based on his or her understanding of their experiences. Establishing a relationship that is genuine, that you are managing to grasp the person’s experience (empathy) and that you value him or her without it being conditional will help you both start the process of clarifying the nature of the person’s concerns and subsequently working to sort them out.

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

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

For many service users the task of describing, discussing, clarifying and recording the nature of their concerns has been shown in itself to be of considerable help e.g. identifying and challenging blind spots. Care should be taken that the discussion does not invalidate the service user’s experiences or infer that their concerns are trivial or insurmountable. Acknowledgement of the seriousness of the concerns being expressed by the service user and the encouragement of hope in their future are crucial components towards effecting recovery.

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

In their interaction with service users there is an opportunity for the mental health workers to increase the service user’s sense of control. Ways of increasing the service user’s influence over the interaction includes the Socratic method of dialogue e.g., refraining from offering a solution or an interpretation that the mental health worker might feel is very obvious solution and instead encouraging the person to explore the issue much further and help them to arrive, at their own pace, a solution or interpretation. This interpretation may or may not however be the same understanding as the mental health worker.
The process of identifying concerns may involve the service user breaking down the whole story into smaller, more manageable parts and then prioritising them. Before arriving at the final statement of each concern the service user is encouraged to discuss examples of each concern and to consider the frequency of occurrence of the problem and the severity of effects on his/her life.

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

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

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

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

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

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

**Phase Four – Prioritisation of concerns**

*Aim*
• The service user identifies concerns in order of their priority

Prerequisite
1/. Establishment of working alliance
2/. Identification of experiential threats (optional)
3/. Identification of concerns

Action
Concerns described in the record sheet are listed in order of priority. The service user may require help in determining the order of priority of their concerns. Practical issues such as the time available, degree of difficulty and resources available should be taken into consideration.

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

Phase Five – Identification of existing coping strategies

Aim
• To identify coping strategies used by the service user in addressing the concerns that have been identified as being the highest priority.

Prerequisite
1/. Establishment of core conditions (bond)
2/. Identification of experiential threats (optional)
3/. Identification of concerns

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

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

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

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

- Was there a time when the issue wasn’t a concern?
- How was the concern successfully dealt with previously?
- What did you do to deal with this concern?
- What did your family do to assist you in dealing with this concern?
- What did your friends do to help you in dealing with this concern?
- What did non-mental health agencies/facilities do to assist you in dealing with this concern?
- What did mental health services do to assist you in dealing with this concern?
- What other resources did you use in dealing with this concern?

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

It may be that the strategies the person used in the past may not be considered effective by the mental health worker e.g., self medicating with alcohol or other drugs when depressed. Negotiating with the person about the effectiveness of particular strategies may result in alternative strategies being adopted.
FIGURE 2

PinC Process Records

<table>
<thead>
<tr>
<th>CONCERN DESCRIPTION or NUMBER</th>
<th>(derived from Header Sheet).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coping Strategy/ies used previously:</td>
<td></td>
</tr>
</tbody>
</table>

Notes

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

Among coping strategies used trying to ‘think through’ the concern (cognitive approach), e.g. re-appraising the experience, and in ‘acting through’ the concern (behavioural approach), e.g. taking medication, avoiding trigger factors etc. Other coping strategies may involve cognitive avoidance (becoming resigned to the problem) and behavioural avoidance (acting out or finding distractions). See Table 1

Table 1
1. Cognitive approach strategies (logical/analysis and positive reappraisal). These strategies involve paying attention to one aspect of the situation at a time, drawing on past experiences, mentally rehearsing alternative actions and their probable consequences and accepting the reality of a situation but restructuring it to find something favourable.

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

2. Behavioural approach strategies (Seeking Guidance Support and Problem-solving) These strategies include seeking guidance and support and taking concrete action to deal directly with a situation or its consequences.

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

Other behavioural approaches that may give the person a greater sense of control over his/her concerns are to display what might be considered mental illness related behaviours such as contacting police for protection, shouting demands to be left alone or telling voices to shut up.

3. Cognitive avoidance strategies (Acceptance/Resignation). These strategies are aimed at denying or minimising the seriousness of a situation or its consequences as well as accepting the situation as it is and deciding that the basic circumstances cannot be altered.

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

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Approach strategy</th>
<th>Avoidance strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive</td>
<td>1 Logical/Analytic and positive reappraisal</td>
<td>3 Acceptance/Resignation</td>
</tr>
<tr>
<td>Behavioural</td>
<td>2 Seeking Guidance Support and Actions taken in Problem solving</td>
<td>4 Seeking alternative rewards Emotion Discharge</td>
</tr>
</tbody>
</table>
These strategies involve seeking alternative rewards by becoming involved in new activities. These strategies include openly venting one’s feelings of anger and frustration and behaviour that may temporarily reduce tension, such as acting impulsively and doing something risky.

Examples of behaviour avoidance strategies control include distraction (passive listening to radio, music or watching TV) and active distractions (playing a musical instrument, writing a diary or gardening and socialising with family and friends.

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

As a footnote, it should not be assumed that the person’s social network in always a useful resource. Sometimes negative aspects of the network whether family or friends such as conflict and criticism are harmful to the person’s recovery (Moos and Holahan 2003).

PinC and Cognitive and Behavioural strategies of coping
Despite what the mental health worker may feel are solutions to the service user’s situation the decisions as to what coping strategies are used will primarily rest with the service user. Whether the strategies have worked or not will be determined during the scheduled review by both the service user and the mental health worker. The likelihood of failure, in the eyes of the mental health worker, should not warrant overriding the desire of the person to use a particular coping strategy. Even if the goal has not been achieved the selection and use of a particular coping strategy is a learning experience for the service user and may affect the service user’s perception of dealing with that or similar concerns in the future.

Should the service user have difficulty in identifying previous coping strategies the mental health worker may consider giving examples of strategies other service users have used. (Obviously it would be more useful if the service user came up with their

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

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

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own strategies). For example contacting friends when lonely (behavioural approach) or the use of relaxation, sport, music, or meditation (behavioural avoidance) which are not aimed at addressing the concern directly but at managing or altering their emotional response to the concern. Examples of coping strategies used by service users that have been devised in collaboration with consumer representatives are recorded in the document Range of Life Experiences.

Please Note: **These examples should only be used as a prompt when the person has difficult in identifying their own strategies.**

**Phase Six- Setting of goals**

**Aim**

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

**Prerequisite**

1/. Establishment of core conditions (bond)

2/. Identification of experiential threats (optional)

3/. Identification of concerns


5/. Identification of existing coping strategies

**Action**

*The process of creating each goal is divided into two stages*

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

‘I will ………………………………..’ (service user’s goal)

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

‘………………………………by……………… ’ (actions to be taken by service user)

The complete statement will read:
‘I will…………………………………by…………………………………’

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

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

**Figure 3**

<table>
<thead>
<tr>
<th>GOAL:</th>
<th>ACTION:</th>
</tr>
</thead>
<tbody>
<tr>
<td>I will …</td>
<td>By … (state how this will be done)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date to be achieved:</th>
<th>Date when action will be taken.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Action Number</th>
<th>Dates actions are to be reviewed.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Identifying Goals

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

(a) Discussion, negotiation and agreement on goals.

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

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

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

A service user’s goal of ‘making more friends’ should not be translated as ‘increase social network’. The service user with the help of the mental health worker may then consider identifying past and/or current friends, identifying opportunities to re-establish contact or to make new friends.

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

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

Goals that are not owned by a person are rarely achieved.
Some attitudes may lead to undesirable goal, for example:

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

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

**Achievable**

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

A goal that is ambitious requires time and resources. Sometimes too many goals are established at the same time leading to a diffusion of effort. Conversely, if a goal is set too low, feelings of personal excitement or interest may be insufficient to fuel efforts designed to achieve the goals. Establishing a balance between the goal and the service users resources is a skill based on thorough knowledge of these factors and the person’s motivation.

Failure to identify small incremental steps to achieve a goal may send the message of incompetence and/or hopelessness to the service user. The tendency to attribute shortcomings in achieving the goal to the presence of a mental illness may result in seeing the disability as a state rather than being a shortcoming frequently experienced by others unaffected by mental health concerns.
Ownership
Ideally goals should belong to both the mental health worker and the service user. It is one thing for the mental health worker to state the goals, another is for the service user to agree and yet another for both to work on implementing them. When the going gets difficult the mental health worker may revert to their traditional role and either overtly or covertly assume responsibility for the creation of goals. The chances of success in achieving goals set are likely to be minimal without the active involvement of the service user.

Specific and able to be evaluated
Vague and ill-defined goals are rarely achieved. Goals may lack a clear and concrete set of behaviour reference, e.g. goals related to “feeling better about myself”, “having meaning in my life”, “feeling more connected” or “getting a job that makes me happy”. Service users should be encouraged to restate their goals in terms of more concrete specific behaviour that can be seen as being accomplished or not. Instead of saying “George will do more things with friends” it is more useful to state “George will go to the movies with John next week” as it is more specific and able to be evaluated.

Clearly stated goals
Writing goals in a way that is clearly understandable by the service user is likely to have more positive outcome. Some mental health workers and service users find it more useful for the user to write the goals (as well as the other parts of the documentation). Regardless of which of the partners records the decisions taken it is important that both have a clear understanding in order to progress to the next step.

There is a danger that the mental health worker may not realise that many of the kinds of activities that they take for granted may represent significant steps or obstacles for the service user. The process of writing goals in a way that is clearly understandable by both partners is likely to have a more positive outcome.
Service users should be presented with a range of options in making goals more specific.

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

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

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

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

(b) **Means of achieving goals** i.e. ‘by…’ (actions taken)
The action to be taken is based on the coping strategy identified at an earlier stage of PinC system. For example, if a service user’s mental health concern was about feeling lonely and helpless she might identify her previous coping strategy in dealing with this experience as visiting her sister twice a week and her involvement in a local church. Now that she has moved away from that area she misses these contacts and feels lonely and helpless. Her goal of keeping existing friends and making new ones is
to be achieved by the following action - arranging to ring her sister at an agreed time
twice a week and by contacting the vicar in the local church.

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

Phase Seven - Application of coping strategies

Aim

- To help the service user to apply his/her coping strategies

Prerequisites

1/. Establishment of working alliance (bond tasks and goal)
2/. Identification of experiential threats (optional)
3/. Identification of concerns
4/. Prioritisation of concerns written in the PinC Process Records
5/. Identification of existing coping strategies
6/. Setting of goals i.e. completion of sections on ‘goals’ in PinC Process document
   and signed by both partners.

Action

The agreement between the partners in the application of the coping strategies may
be understood as a contract. The contract involves maintaining the agreed plan of
action and not changing things until after the agreed date of review unless the action
is detrimental to the person’s interest.

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

Notes
Depending on how thorough the groundwork is in determining the goal, the practicalities of attaining the goals should be without any major problems. Success is also dependent on the action agreed upon is within the service user’s capacity and degree of motivation. The role of the mental health worker during this activity is to be accessible to the service user and provide encouragement without over-stepping the level of support mutually agreed upon.

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

While the greater sharing of responsibility may be welcomed by some service users and mental health workers it may be difficult for colleagues and family to accept this change of roles and the element of risk involved in the change of responsibility.

**Phase Eight – Review of Outcome**

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

**Prerequisites**
1/. Establishment of working alliance (bonds, tasks and goal)
2/. Identification of experiential threats (optional)
3/. Identification of concerns formulated
5/. Identification of existing coping strategies
6/. Setting of goals i.e. completion of sections on ‘goals’ in PinC Process document and signed by both partners.
7/. Application of coping strategies
**Action**

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

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

**Figure 4**

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

<table>
<thead>
<tr>
<th>Goal No:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please tick in the appropriate box.</td>
</tr>
<tr>
<td><strong>Achieved</strong></td>
</tr>
<tr>
<td>If achieved indicate factors that facilitated the achievement of the goal.</td>
</tr>
<tr>
<td><strong>Not Achieved</strong></td>
</tr>
<tr>
<td>If not achieved indicate factors that prevented the goal from being achieved.</td>
</tr>
<tr>
<td><strong>Partially Achieved</strong></td>
</tr>
<tr>
<td>Indicate the stage reached and outline reason/s for the goal being/not being fully achieved.</td>
</tr>
<tr>
<td><strong>If you (Mental health worker and service user) were to address this concern again what would you have done differently?</strong></td>
</tr>
<tr>
<td><strong>What do we need to do about this situation, eg. re-commence goal setting?</strong></td>
</tr>
</tbody>
</table>

**Service user’s signature** ____________________________

**Mental Health Worker’s signature** ____________________________

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Notes

The outcome may not be the terminal stage of the process. It may be part of a continuous cycle. If the goal has not been achieved or partially achieved a number of factors may be responsible. Goals set may be too ambitious. The expected resources or support may not be available or provided or used. Either or both partners may not be motivated. There may be a lack of understanding of task or problems. Examination of successful outcomes should be as thoroughly investigated as factors that are associated with lack of success. Organisational factors such as protocols contributing to success are clearly identified and acknowledged. In addition personal factors such as motivation and overcoming of obstacles are also acknowledged. The reasons for the success or otherwise of the outcomes are discussed. In the event of the partners deciding that the goal was not achieved, care is needed to avoid giving a message of blame to either partners.

The system of evaluating outcome is an integral part of the PinC process in that it measures the unique goals formulated by the individual service user. Other measures of outcome such as HoNOS and LSP offer standardised criteria against which service users characteristics are measured. While they may be useful in providing data relevant to groups of service users (aggregate data), they do not play as integral a part in the individual’s recovery process as the service user-centred outcomes in the PinC system. This way of evaluating outcome is also useful both in reformulating goals, partially or not achieved, and modifying the subsequent steps of PinC, and, when the goal is achieved, in using the experience to address the next concern on the list of priorities. Following the review a decision is made as to how to proceed with the situation. A preferred option is to recommence the guided steps of PinC and change the aspects of the goals setting process that both partners feel will achieve a better outcome.
PART THREE

Because of the importance of establishing a therapeutic relationship below are extra notes describing interpersonal relationship skills that facilitate the development of the working alliance.

Interpersonal Relationship Skills

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

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

Beginning

When the partners first encounter each other the conversation is likely to focus on ‘safe’ factual topics such as aspects of their surroundings eg weather recently events eg football games, films, television program, and are non personal or anxiety producing. These exchanges give both partners a chance to know something about the other and are a fundamental feature of most social interactions. Progress through this stage may vary from 10 minutes to one or two interviews/encounters. Failure to navigate through this state and ensure that the service user is comfortable with the mental health worker can have a negative effect on the development of the working alliance. As soon as possible the mental health worker should become
aware of the positive aspects of the service user such as his interests (likes, dislikes), strengths, talents, goals and support systems available to the service user.

**Attending and listening**

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

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

**Pacing and handling silence.**

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

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

**Reflection.**

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

‘It sound as if you felt annoyed about …’ ‘You said that …’

**Being empathetic**

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

**Being accepting**

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

**Use of questions**

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

**Focussing**

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

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

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


