After-Care

Potentially Mr Cordell care/treatment would be delivered via the Care Programme Approach. I am the allocated Care Coordinator and he will have a responsible clinician in the community.

My role would be first of all to build a relationship with Mr Cordell as I have only met him on 2 occasions. I will try to motivate him to engage with myself and the multidisciplinary team. As his Care Coordinator I will review Mr Cordell regularly independently and with the Community RC.

We have a Team Clinical Psychologist and it would be vital for Mr Cordell to have some form of talking therapy. This is on the basis of the stress and anxiety that his mother states he suffers from.

We have a Dual Diagnosis Worker in the team who could offer drug counselling if necessary.

We have an organisation called 'Remploy' which is funded by the Local Authority. Potentially they could support Mr Cordell to find work. They meet regularly with clients whilst they are in work and also liaise with employers.

I could support Mr Cordell in making an application for PIP. Alternatively he could get that support from 'Enfield Well-Being Connect'

The Mental Health Enablement Team could provide support in tenancy management as well as support to access education/training and work.

Opinion and recommendations

I have met Mr Cordell on two occasions only and I have not had the opportunity to assess him in the community. A rapport needs to be established with him.

On the basis of recent events, history of risks to self and alleged risks towards others, and taking into account the views of the MDT on the ward I think that he would benefit from a longer stay in hospital. This is in-order for the MDT to assess him comprehensively to determine if he has a severe and enduring mental illness such as schizophrenia/psychosis. If it is determined that he has a severe mental illness then this should be treated accordingly whilst he is in hospital.

Signed: Soobah Appadoo, CPN

Dated: 07/11/2018