# Collaborative Care Planning –
## Recovery-oriented Care Planning in Mental Health


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# Why Individual Care Planning?
## Difficulties with current practice

- Expert-led ("medical model")
- Initial assessment by trainee (junior) doctor
- Very limited MDT input in most cases.
- MDT input often reactive rather than proactive
- Service user is 'recipient' of care rather than a 'participant'
- Families/supporters feel excluded from process
- Copy not provided to Service user
- Discharge planning not built into process of care

# Individual Care Planning - ICP

- *"Care plans provide a participatory framework for agreeing and reviewing the benefits of a given programme of treatment and care with an individual in the context of his or her recovery…. "*
- Care: addressing a broad range of Care needs,
- Treatment: focused on specific interventions
- Recovery: addressing service-user defined priorities and recovery goals.

# Best practice principles in ICP

- Needs/goals assessed in consultation with service user and family/supporters:
  ***"No decisions about me, without me"***
- Multidisciplinary perspective
- Interventions identified according to best practice
- Necessary resources identified
- ICP developed, implemented and reviewed in a timely manner, with **key worker** coordination
- Signed by the key worker and service user
- A copy kept by the service user

***(Quality Framework, 2007; Guidance Document 2012 - Mental Health Commission)***

# COLLABORATIVE CARE PLANNING

## The North Kildare '9-step' approach

1. Initial Triage of referrals
2. Assessment and identifying needs and goals
3. Advanced triage of cases
4. Biopsychosocial assessment of needs and goals
5. Complete Case Review by Consultant Psychiatrist.
6. Biopsychosocial formulation of case by MDT ("5-P model")
7. Feedback of formulation and draft Recovery Plan with service user
8. Support to engage with Therapy/Community support services and other Care Plan actions
9. Discharge to care of G.P. and Primary Care services

# Benefits of CCP approach

- Service user and family/supporter engagement throughout the process
- MDT based
- Key worker based
- Structured approach to assessment of need → planning/delivery of care → discharge
- Improved team working
- Cost-effective
- Transparent – documents copied to service user

# Future of Individual Care Planning

- Change from above ('Value for Money', MHC) and below (MHR, Service User leaders)
- Bottom up as well as top-down involvement in services
- Process is more important than form
- Resistance to change: cultural, philosophical, structural, resources
- Service Reform Fund?

**Thank you!!**