

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

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Feidhmeannacht na Seirbhíse Sláinte  
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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

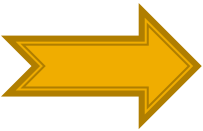
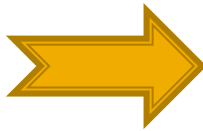
*(Quality Framework, 2007; Guidance Document 2012 - Mental Health Commission)*

# **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!!**