

Treatment plans: Can we do better?

Feedback from Chief Psychiatrist's forum

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Introduction

In July 2006, the Chief Psychiatrist hosted a forum to discuss treatment plans under the *Mental Health Act 1986*. The objective of the forum was to promote improved practice in the preparation, implementation, review and revision of treatment plans. Speakers and participants discussed their experiences of implementing plans over the 18 months since their introduction in December 2004. The following is an outline of their responses.

Primary purposes of a treatment plan

Speakers and participants recognised that treatment planning is a process, and identified the following as the primary purposes of the process.

Joint approach	To provide an opportunity for all involved to work together to develop a joint approach to recovery.
Facilitate treatment	To identify the issues to be addressed, clarify the established goals of treatment and outline the immediate action necessary to achieve the outlined objectives.
Communication	To communicate an outline of treatment and the reasons for treatment, to the consumer and carers (as agreed), thereby achieving openness, transparency and accountability.
Incorporate consumer views	To allow for identification of any conflicting goals, and incorporate the thoughts and feelings of the consumer.
Other purposes	It was recognised that a treatment plan also acts as a tool to: <ul style="list-style-type: none">• Define the boundaries of treatment• Focus on and work towards wellness and discharge• Achieve best practice in treatment• Engage the consumer and carers• Demonstrate that the treating team have communicated with, and consulted with, the consumer and carers

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Other purposes continued	<ul style="list-style-type: none"> • Promote trust between the treating team, consumer and carers • Encourage a constructive dialogue between the treating team and consumer • Inform the consumer of the benefits and risks of treatment and any alternatives • Detail all those involved in treatment and set out their roles and responsibilities • Focus the consumer when in crisis, and set out information to be accessed by the consumer and carers in a crisis • Communicate to the consumer their responsibilities under the plan • Assist the consumer to reflect upon his or her own health • Build relationships between the consumer and carers • Achieve continuity in treatment (between services and case managers) • Provide a framework for clinicians
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Key standards and principles that should always apply

Speakers and participants identified the key standards and principles that should always apply to treatment plans. The following list is a collation of responses, in no particular order.

Clarity	The language used throughout the plan should be clear, appropriate, and easily understandable for all involved, particularly the consumer and carer. Jargon and abbreviations should be avoided.
Coherent	The content of the plan must be accurate and not open to misinterpretation. On a first reading, the information should be easily understood. Any handwriting should be legible, and any electronic system should provide for a spell check function.
Concise	The plan should be comprehensive yet as brief as possible, to ensure that it is easily understandable by the consumer when unwell. The plan should not be over-inclusive, and should not be so detailed as to be overwhelming and/or confusing for the consumer.
Empowering	The language used should be caring and empowering. There should be capacity within the plan for the consumer to record his or her thoughts and feelings about the plan, and the extent to which family should be involved.
Individualised	The plan should be individualised to the unique needs of the consumer, including any cultural sensitivities. Any electronic system should be culturally sensitive, individualised, and facilitate collaboration.
Value statement	The plan should include a value statement at the beginning, spelling out the guiding principles for consumer care. There should also be capacity for the consumer to indicate the agreed overall treatment goal. For example: 'To get off CTO'.
Supportive	The plan should support the consumer, be protective of consumer rights, and not be seen as punitive.
Dynamic	The plan should not be a static document, but instead should be an evolving document, regularly reviewed and revised based on clinical need. The plan should be purposeful and achievable and should recognise the dynamic and continuing process of treatment and recovery. The plan should acknowledge change and reviews should be recognised as a learning process for all. The plan should provide for better continuity in treatment. Any electronic system should facilitate appropriate review and document integration via automatic prompting to assist and support clinical practice.

Purposeful	The plan should incorporate goals that are meaningful, measurable, realistic and achievable, accompanied by defined responsibilities, actions and timelines. The goals must be relevant to the consumer, and address current priorities for the consumer and the treating team. There should be a shared understanding and acknowledgement of the common goals, and the plan should be expressly clear about what is required by the consumer for discharge to occur. The focus of the plan should be on recovery, the end of the episode of care.
Meaningful holistic	The consumer should be provided with information about what to expect. The plan should address the immediate action necessary to achieve long-term objectives, and should not be restricted to medical treatment options. The plan should refer to any alternative treatments and promote discussion of their efficacy with the consumer. The plan should also incorporate social and physical recovery.
Collaborative	All health professionals and others involved in caring for the consumer should participate in formulating the plan. Any involvement in implementing the plan needs to be agreed upon by the participant. This collaboration should continue throughout the various stages of treatment, and should be evidenced on the plan.
Co-ordination of responsibilities	There is a need for co-ordination of responsibilities between all health professionals involved in caring for the consumer. The person who has the greatest involvement with the consumer should be responsible for managing (writing, reviewing and revising) the plan, and should be identified within the plan. The treating team should also be named within the plan. Allocated roles and responsibilities should be defined and prioritised.
Inclusive	The plan should start a dialogue between the treating team and the consumer. The treating team should consult regularly with, and seek input from the consumer and carers. Consumer views should be respected and included in the plan. The plan should allow for documentation of any disagreement. Any changes in treatment should prompt consultation with the consumer. When consumers are unable to participate, carers may be useful as a potential source of knowledge and resources.
Compliant with legislation	Legislative requirements of planning and review should be adhered to. Compliance with the <i>Mental Health Act 1986</i> (the Act) is important. Creativity is required in order to achieve a balance between achieving legislative compliance and producing a plan that is meaningful for the consumer. Within the plan, mandatory components of treatment and the consequences of failure to comply should be made expressly clear for the consumer. Any electronic system should be accompanied by sound policies to ensure compliance with confidentiality obligations.
Contextual	The content of the plan should be informed by clinical documentation, and should reflect the focus of care and the setting. There is a need to incorporate plans within a culture of best practice such that they promote best practice. This may involve integrating treatment plans with other plans, including the Individual Service Plan (ISP), and with other review processes.
Integrated	The plan should be integrated into the larger context of delivering high quality care to the consumer and carers.
Adequately resourced	A complement of qualified staff is essential, supported by guidelines and training. An adequate IT infrastructure is needed, comprising of hardware, training, resources, and support. Ideally, the technology should be accessible across teams and networks. Possibly, a standardised state-wide format is appropriate.
Timely	A consumer should be provided with a plan within reasonable time-frames.
Accessible	The plan should be readily accessible at any point of service contact.