Care Planning Processes:
From Managed Care to Self Directed Care.

General Processes

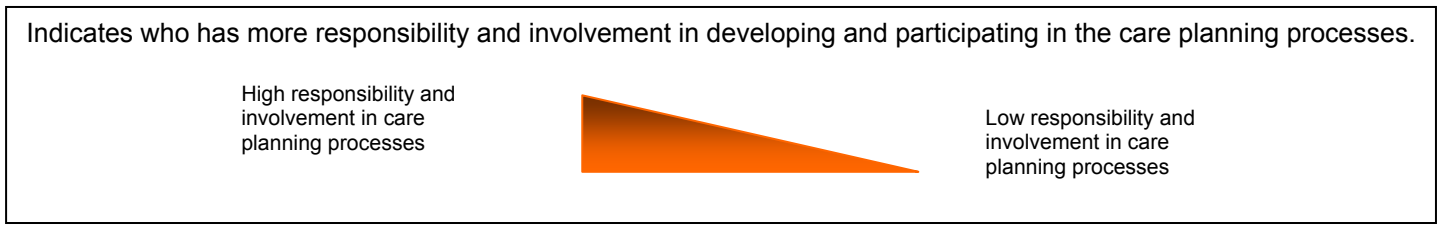
Care planning plays an important role in providing comprehensive, accountable and client centred care within mental health services. Care plans come in a range of shapes and sizes: from very formal templates to informal plans that rely on the skill and direction of those involved in formulating plans

Care plans are used to:

- encourage involvement and ownership of planning processes by the person, their family and friends
- create opportunities towards person centred and self directed planning
- document the goals and direction of care and treatment
- describe how the intervention/s contribute to the wellness of the person
- differentiate the actions required by each person (including the person, their family and friends)
- assist the communication between people involved in providing support
- track and account for the support and care provided
- establish clear outcomes
- assist in review processes

…and the list could go on.

The processes involved in planning are as important as the template that you choose to use. Many services and providers rely on templates to guide their practice, and to seek conformity amongst clinicians. Whilst templates may act as a guide to care planning, using them without the intended processes may divert the focus away from the uniqueness of the person, limit the scope of options, limit the involvement of the person, limit the involvement of family and friends, and limit the creativity that is needed to support an individual's recovery. A perfectly written care plan that appears to have all the boxes completed, may have been completed without any of the processes that support a recovery direction, whilst a plan that is completed by the parties involved on a blank sheet of paper may be fully inclusive and responsive to meet the person's expressed needs. A move from managed care to self-directed care is desired within a recovery oriented service framework.



Self Directed / Self Managed Care

(We acknowledge that you are in the best position to understand your unique experiences of distress, ultimately contributing to your ability to self direct your care and self manage)[1]

Person's Responsibility & Involvement in Care Planning — **Clinician's Responsibility & Involvement in Care Planning**

Person(s) involved	Principles and Processes	Examples
The person (with the illness/disability). (The person may wish to involve others of their choosing in their planning process.)	▫ Can only be completed and directed by the person. Others' involvement may be invited in supporting the person to carry out their plan. ▫ Self directed plans/recovery plans are not a substitute for service plans. ▫ This process considers planning based on life direction and not solely around the management of illness/ disability. ▫ Self directed plans address the continuum of wellness, including crisis planning and prevention planning. ▫ The process utilises personal resources, friends, family and community resources and (if needed) service resources. Relies heavily on the person's ability to self manage and seek support when and as required. ▫ Recovery oriented service providers may provide support where this is identified by the person within their plan. ▫ Recovery oriented services will seek to enhance the control and choices a person has in: their planning; services they receive; how funds are spent on their care and treatment; and allocation of service providers. ▫ Self directed workbooks are a common way of developing self directed plans.	▫ **The Crisis Plan (WRAP)**, Copeland, M, Copeland Center for Wellness and Recovery, Arizona. http://www.mentalhealthrecovery.com/crisis.html ▫ **Post Crisis Planning (WRAP)**, Copeland, M, Copeland Center for Wellness and Recovery, Arizona. http://www.mentalhealthrecovery.com/postcrisis.html ▫ **Mental Health Recovery Including Wellness Recovery Action Planning** (article), Copeland, M, Copeland Center for Wellness and Recovery, Arizona. http://www.mentalhealthrecovery.com/art_wrap.html **Recovery Plans** ▫ **MH-OAT Care Plans: CoRe Consumer Recovery Plan,** NSW Health, (updated 2002), Sydney http://www.health.nsw.gov.au/policy/cmh/mhoat/protocols.html **Self Directed Workbooks** ▫ **Express Yourself: Assessing self determination in your life,** Cook J & Peterson, C. (2004), University of Illinois at Chicago. http://www.psych.uic.edu/uicnrtc/sd-self-assessment.pdf ▫ **Wellness Recovery Action Plan,** Copeland, M. (1997) Peach Press, Vermont. ▫ **Direct Power**, Leader, A. (1995), Pavilion Publishing, Brighton. ▫ **This is Your Life! Creating Your Self-Directed Life Plan**. Jonikas, J. & Cook, J (2004), University of Illinois at Chicago, http://www.psych.uic.edu/uicnrtc/sdlifeplan.pdf ▫ **Pathways to Recovery: A Strengths Recovery Self-Help Workbook**, Ridgway, P, McDiarmid, D. & Davidson, L. (2002) University of Kansas School of Social Welfare, Kansas. ▫ **The Recovery Workbook II: Connectedness:** Spaniol, L, Bellingham, R, Cohen, B. & Spaniol, S. (2003), Center for Psychiatric Rehabilitation Boston.

[1] Glover, H, & Kalyanasundaram, V. (2005) Queensland Health's Recovery Education Training Programme: Day Three - Doing Things Differently (awaiting publication).

Person Centred Care

(We acknowledge your individual needs, goals and aspirations as central in providing care)

Person's Responsibility & Involvement in Care Planning  **Clinician's Responsibility & Involvement in Care Planning**

Person(s) involved	Principles and Processes	Examples
The person as well as others who are significant to that person's life and direction (i.e. family members, friends, community providers, mental health service providers). Usually coordinated by 'others'.	▫ Values the inclusion of the person. The person is central to all planning processes. The person's knowledge of their situation is equal if not greater than professionals'. [2] ▫ The focus is on 'the person' and not the person's disability/illness/deficits. Planning is based on the knowledge of the person, and not what others think may be required to manage the illness and/or disability. ▫ The person's expressed and unique needs and future direction are central to the planning. Focuses on the person's goals, aspirations and preferences. Affirms the gifts, talents, capacities of the person. ▫ Others to be involved in the process are personally invited by the individual. Planning can occur anywhere and is not time limited. ▫ The plan is owned by the person and not the service. It is considered as 'Mary's plan' rather than 'the service plan for Mary'. ▫ Uses the person's language and not service language. ▫ The process is a shared responsibility rather than a total service responsibility. ▫ Invites participation and commitment to action from all people involved in the planning processes. Others are accountable to the individual for their involvement in the plan and not to the service. ▫ Generates ideas and responses beyond a service framework and its resources. ▫ Processes that manipulate a person into compliance with others or service systems are not used.	▫ **P.A.T.H: A workbook for planning possible futures**, Pearpoint, J, O'Brien, J, & Forest, M. (1998), Inclusion Press, Toronto. ▫ **Mental health: Care Plans (**General information), Better Health Channel, Victoria, Aust. http://www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/pages/Mental_health_care_plans?OpenDocument ▫ **Connecticut Implementation of Person Centred Care**, Dept of Mental Health and Addiction Services, Connecticut. http://www.dmhas.state.ct.us/recovery.htm http://www.dmhas.state.ct.us/recovery/personcentered.pdf ▫ **Recovery TIPS: Key Principles and Practices of Person Centred Care** (Draft)**,** Dept of Mental Health and Addiction Services, Connecticut. http://www.dmhas.state.ct.us/recovery/pcc.pdf http://www.dmhas.state.ct.us/recovery.htm ▫ **Person Centred Planning and Person Centred Approaches** Ritchie, P. (2002). www.valuingpeople.gov.uk/documents/PCPCh2.pdf

[2] Ritchie, P. 'Person Centred Planning and Person Centred Approaches' in Bates (Ed) 2002, Working *for Inclusion: Making social inclusion a reality for people with severe mental health problems*, Sainsbury Centre for Mental Health, London.

Managed Care

(We organise your care based on our knowledge of your disease and capabilities) [3]

Person's Responsibility & Involvement in Care Planning  **Clinician's Responsibility & Involvement in Care Planning**

Person(s) involved	Principles and Processes	Examples
Mental Health Clinician, Doctor and other service providers	▫ Planning is based on the assumptions of what we think people with this illness/disability require. ▫ The treating professionals consider that the individual does not have the ability (or is unwilling) to participate in any care planning processes. The family is usually not considered in any planning processes. There is limited negotiation between treating professionals, the person, family members and other stakeholders. ▫ The organisation takes full responsibility for the person's care and treatment and does not fully utilise the resource base of the community or other individuals. ▫ Planning usually takes place within a service environment, with a set service framework. ▫ Planning options are limited within the organisation's scope of practice, service responses and resources. ▫ Planning is centred on the 'service goals' for a person and not necessarily their 'personal goals'. Planning is usually around service interventions that manage crisis/distress, limit or promote particular behaviours (eg medication focus, anger management, curbing self harm). ▫ Manipulation of the person by service systems to agree to 'service goals' may occur (use of power). ▫ Language will primarily reflect professional knowledge basis and shorthand is written to communicate between professionals (e.g. PRN, Rx). ▫ Review is undertaken primarily by professionals and based on objective criteria, with little or no involvement by the person involved. ▫ A person's signature is not usually sought when completing a 'managed care' plan. A person usually would not be given a copy of their treatment plan.	▫ Discharge processes that are not planned and discussed fully. ▫ A person's plan whilst under the order of the Mental Health Act may be considered to be a Managed Plan. ▫ Managed Plans are usually template driven. ▫ A signed care plan that is prepared and determined by professionals still constitutes 'managed care'. **MH-OAT Care Plans,** NSW Health, Sydney. ▫ **Child and Adolescent Care Plan** http://www.health.nsw.gov.au/policy/cmh/mhoat/modules/child_adolescent/cp_ca.pdf ▫ **Adult Care Plan** http://www.health.nsw.gov.au/policy/cmh/mhoat/modules/adult/cp_a.pdf

[3] Glover, H, & Kalyanasundaram, V. (2005) Queensland Health's Recovery Education Training Programme: Day Three - Doing Things Differently (awaiting publication)