PURPOSE

It is the Bay of Plenty District Health Board (BOPDHB) Mental Health & Addiction Service's (MH&AS) aim that Tāngata Whaiora (service users / consumers / seeking wellness) will have a current individual treatment plan that is based on comprehensive assessment and identified need, and is specific to that individual's stage in the recovery / person-centred care process.

OBJECTIVE

- To provide a framework for treatment planning that involves tāngata whaiora participation and their family or whānau, with consent, in the formulation and review of their current treatment, care and support.
- To provide a framework that enables all members of the multidisciplinary team to participate in and have knowledge of the current goals of treatment and the treatment, care and support that the MH&AS team will provide for tāngata whaiora.
- To ensure clear and accessible information on the current goals of treatment and plan of care, treatment and support, is available to all members of the multidisciplinary team.
- To meet requirements of the Health and Disability Services Standards.

STANDARDS TO BE MET

1. **Tāngata Whaiora involved with the MH&AS will have an individual treatment plan (service delivery plan).**
   1.1. The individual treatment plan will be based on comprehensive assessment and identified need, as per CPM.M5.10 Assessment.
   1.2. The individual treatment plan will be specific to the person's stage in the recovery / person centred care process.
   1.3. The treatment plan will include (but is not limited to):
      a) Management of risk
      b) Treatment/intervention goals, actions and responsible persons
      c) Goals to address HoNOS outcomes indicators scoring 3 or 4
      d) Wellness and Transition, early detection and early intervention management
      e) Discharge plans
      f) Timeframes
      g) Consent or documentation of diminished capacity.
      h) Identification of person responsible for co-ordination of care
      i) Involvement of the tangata whaiora and their nominated family / whānau
   1.4. The individual's treatment plan will be shared with tangata whaiora, their family / whānau member(s) with consent and other treatment providers as specified in 2.5.1 P2 Privacy and Information Sharing
   1.5. Adult tāngata whaiora who receive residential or home based support from a Non-Government Organisation [NGO] provider simultaneously with MH&AS secondary services will have a Shared Support Plan.
   1.6. The Shared Support Plan will be a collaborative process that guides all interventions and actions to achieve the person's recovery goals in the partnership between consumer, family / whānau, care providers and the secondary MH&AS services.
   1.7. A single current shared support plan will be identifiable in the patient file and the electronic system and all previous plans will be cancelled and replaced to achieve a standard of one person one plan document to guide both provider arm and NGO sector service providers.

2. The individual treatment plan is developed collaboratively with Tāngata whaiora.

2.1 Tāngata Whaiora are encouraged to fully participate in the development and evaluation of their individual treatment plan.

2.2 Family, whānau or nominated significant others are involved in the treatment planning and evaluation process with consent. This may involve a family or whānau group meeting.

2.3 A copy of the individual treatment plan is provided to the person receiving the service where appropriate, or their specified representative.

2.4 Each individual treatment plan should be signed by the person receiving the service as an indicator of consent.

2.5 In the event that tangata whaiora does not or cannot agree with the treatment plan due to diminished capacity, or is subject to the provisions of the Mental Health (Compulsory Assessment and Treatment) Act 1992, this will be noted and signed on the plan by the staff member allocated to treatment planning.

3. The treatment plan will be completed and reviewed at defined intervals

3.1 To ensure the treatment plan:

a) Ensures risks are managed
b) Remains relevant
c) Is accurate
d) Reflects current needs
e) Evaluates progress towards goals
f) Redefines goals as necessary
g) To meet standards of practice

3.2 The treatment plan will be completed within the following timeframes

a) Acute Response – an initial plan will be developed immediately following assessment and documentation completed within 24 hours of assessment.
b) Inpatient – an initial plan will be made in a timely manner following entry to the unit and admission assessment. A comprehensive plan will be completed as clinically appropriate and in time for the next multidisciplinary team (MDT) meeting.
c) Shared Support Plans – a first collaborative meeting will occur within 1 month after the tangata whaiora entered the community support service.
d) All other areas – an initial plan will be developed as clinically appropriate following assessment and the comprehensive treatment plan completed following completion of a comprehensive assessment and MDT meeting.

3.3 The review process is conducted at intervals defined when the treatment plan is developed or based on risk assessment reviews and will include input from the MDT. Timeframes are identified as:

a) In the IPC environment treatment plans are required to reviewed on a daily basis and if being cared for in seclusion on a shift by shift basis.
b) When clinically appropriate, taking into consideration such events as; changes in the patient's health status, legal status; risk assessment, MDT review meeting outcomes etc.
c) Every three (3) months for community tāngata whaiora.
d) Every six (6) months for stable Older adults (+65) being monitored with disorders of cognitive impairment.

3.4 The treatment plan review will include input from the tāngata whaiora where appropriate.

3.5 The treatment plan review will include input from the tangata whaiora family, whānau or significant others as consented to by the tangata whaiora, where possible.

3.6 The review will be recorded and included in the health record. A copy of the review and updated care plan will be given to the tangata whaiora.

3.7 The treatment plan will also be reviewed when significant changes occur for that person, for example (but not limited to):

a) The tangata whaiora requests a review
b) The tangata whaiora has a decline or improvement in his / her health status
c) The tangata whaiora self-injures or injures another person
d) The legal status of the tangata whaiora changes
e) The tangata whaiora declines treatment and / or support
f) The tangata whaiora is going to exit the service
g) Monitoring of outcomes indicates a sustained decline for the client

4. Inpatient specific standards

4.1 All tangata whaiora receiving inpatient services will have an initial treatment plan developed in collaboration with the admitting medical officer, the tangata whaiora and their family / whānau (where appropriate), in a timely manner following entry to the unit and admission assessment.

4.2 The initial treatment plan will include a risk management plan and attention to any urgent needs.

4.3 A comprehensive treatment plan will be completed as clinically appropriate and in time for the next MDT meeting.

4.4 The primary nurse and nominated medical practitioner will review the treatment plan each 48 hours.

4.5 A full MDT review, including community case manager, will occur at least once per week.

5. Service Transitions

Individual treatment plans will include a transition plan, which is commenced during entry to the service, to ensure ongoing continuity of care. (Refer CPM.M5.17 Discharge)

6. Risk Management

An individualised risk management plan will be identified as part of the treatment plan. This will be developed collaboratively with tāngata whaiora and their family / whānau with consent. (Refer CPM.M5.10 Risk Assessment)

7. Wellness and Transition Plan

7.1 An individualised Wellness and Transition plan will be identified as part of the treatment plan. This will be developed collaboratively with the tāngata whaiora and their family / whānau with consent. (Refer CPM.M5.17 Discharge From MHAS).

7.2 Tāngata whaiora with degenerative cognitive conditions (e.g. Dementia's) and those with a terminal illness will have a person centred care plan in place of a Wellness and Transition plan.

REFERENCES

- Blueprint for Mental Health Services in NZ, Mental Health Commission, November 1998.
- Health & Disability Services Standards NZS 8134:2008

ASSOCIATED DOCUMENTS

- Bay of Plenty District Health Board policy 1.1.1 Informed Consent
- Bay of Plenty District Health Board policy 2.5.1 Protocol 2 Health Information Privacy And Information Sharing - Mental Health & Addiction Services
- Bay of Plenty District Health Board Clinical Practice Manual protocol CPM.M5.9 Admission to Acute Inpatient Mental Health
- Bay of Plenty District Health Board Clinical Practice Manual protocol CPM.M5.10 Assessment
- Bay of Plenty District Health Board Clinical Practice Manual protocol CPM.M5.17 Discharge from MHAS
- Bay of Plenty District Health Board Clinical Practice Manual protocol CPM.M5.26 Risk Assessment - MHAS
- Bay of Plenty District Health Board Clinical Practice Manual protocol CPM.M5.36 Wellness and Transition Plans
- Bay of Plenty District Health Board Mental Health and Addiction Services Best Practice Guidelines and flowchart for Shared Support Plans
- Bay of Plenty District Health Board Mental Health and Addiction Services NGO Provider Referral Form
- Bay of Plenty District Health Board Mental Health and Addiction Services Shared Support Plan Form