

# **1 Personalisation and mental health care planning**

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## **Learning outcomes**

After reading this chapter you will be able to:

- Develop an awareness of the law and policy that directs personalised mental health care
- Identify the four main areas of care planning
- Identify the components of a care plan
- Develop an awareness of different models of care planning

## **Introduction**

This chapter will give a brief overview of the care planning process in mental health care. The main policies will be identified in relation to their use in practice. You will be encouraged to reflect upon your own areas of practice and use the rest of this book to develop your care planning skills. This chapter therefore should be read before the other chapters to gather a basic understanding of what is required of people when they are planning personalised mental health care. Terminology and jargon will be kept to a minimum but is required in some places so that an understanding of the different possible meanings can be discussed and reflected upon.

First and foremost this book is about practice and is for those people who work every day, helping other people to recover their independence and maintain a dignified way of living. Each chapter therefore explores the care planning process in a different area of mental health care so that we can learn how to provide effective and efficient mental health care. In this chapter the focus is upon general provision of mental health care and care planning in order to prevent repetition where possible throughout the rest of the chapters and to enable the focus of the book to be on the care planning skills rather than the theory.

## **Mental health policy in practice**

Repper and Perkins (2009) identify many ways in which policy has influenced current mental health practice. National Service Frameworks and strategic policy help

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guide us towards providing a more personalised and empowering mental health care. Such strategies therefore need to be incorporated into everyday practice if they are to be effective and we should be able to demonstrate that we have done so. Many of the interventions that can be found in personalised care plans have originated from policy and evidence based practice.

One of the most important areas of policy that is becoming more widely accepted across the UK and the world is one that is now more familiarly known as the Recovery Approach (Slade 2009). This approach has developed from listening to service users about what they need to be able to manage their mental illness so that they can continue to live a meaningful life. While there are many authors of the Recovery Approach (Deegan 1996; Davidson et al. 2006; Repper and Perkins 2009), it is generally agreed that it is not a model that must be followed rigidly but more a philosophy for practice. Embedded within this philosophy are some principles that can help us to demonstrate whether our practice is recovery focused or not. Repper and Perkins (2009: 8) state that these include

- **hope** – that a person can regain their confidence and independence;
- **relationships** – that a person can maintain relationships with family and friends as well as professionals;
- **knowledge and understanding** – of what has happened and how it can be treated and managed including dealing with loss;
- **control** – and feeling empowered to do the things that a person needs to do to self-manage their symptoms;
- **opportunity and resources** – to facilitate recovery including housing, money, information and support.

Policy has become an overwhelming part of our everyday practice in health and social care and is difficult and possibly dangerous to ignore. Policy helps us to see the map of care and how what one person does in one area of practice can affect a whole group of people in another (Sainsbury Centre for Mental Health 2009; SCIE 2007). For example risk is an area of mental health care that is very prominent in policy and in law and can sometimes take up all of our time. Policy can provide this guidance so that we do not have to go looking for evidence every time we want to improve our practice (DH 2006). Policy originates from the words police and politics so it could be seen as something that is there to protect both staff and service users as long as we follow the guidance laid out. One important piece of policy influencing mental health care today is the Ten Essential Shared Capabilities (Hope 2004: 3), which can be used to guide our care planning practices.

The ten capabilities help us to become more aware of our day to day practice by

- 1 **working in partnership** with each other and with service users, carers and other agencies in order to develop an effective care plan;
- 2 **respecting diversity** by addressing the different needs of individual people and their carers including differences in culture, age, sex, religion

and race. It is not ignorant to discuss diversity with people but it can be harmful if we do not;

- 3 **practising ethically**, ensuring that every individual has a chance to express their needs and not assuming that we always know best what other people's needs might be;
- 4 **challenging inequality**; while it may be difficult at times we must always make sure that there is someone to advocate on behalf of the person if they are unable to do so for themselves;
- 5 **promoting recovery** by encouraging people to make decisions that maintain their hope and optimism in their individual needs being met;
- 6 **identifying people's needs and strengths** to encourage people along a recovery journey;
- 7 **providing service user centred care**, working in collaboration at all times to identify and address needs;
- 8 **making a difference** in helping people to identify and make choices without assuming that they know what is available to them;
- 9 **promoting safety and positive risk taking** by identifying risks and working together to address them;
- 10 **ensuring personal development and learning** by taking responsibility for our own learning and providing evidence that our practice is up to date.

The above capabilities include risk but this is put into context with other equally important areas of mental health care practice. This provides us with an holistic or whole way of looking at our practice so that we do not exclude or forget areas that are not so prominent (Lloyd 2010). Challenging inequality may not be the first thing on our minds when we think about our practice but it may be the one thing that is preventing the care plan from being effective. Consider the following scenario.

### Case study – Bob

Bob has been off work with depression for six months now. He has many practical skills and is a good driver and operator of machinery. He knows that work can help take his mind off things and you discuss with him how he might be able to return to work. Which of the above capabilities do you think you might use and what will be the main issues for Bob?

After thinking about this case study you may begin to think about what other information or evidence you will need to help people towards their recovery. This will probably include the structure and layout of the care plan that is outlined

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further below. However in exploring the above basic care plan you may be asking some very important questions of it, such as:

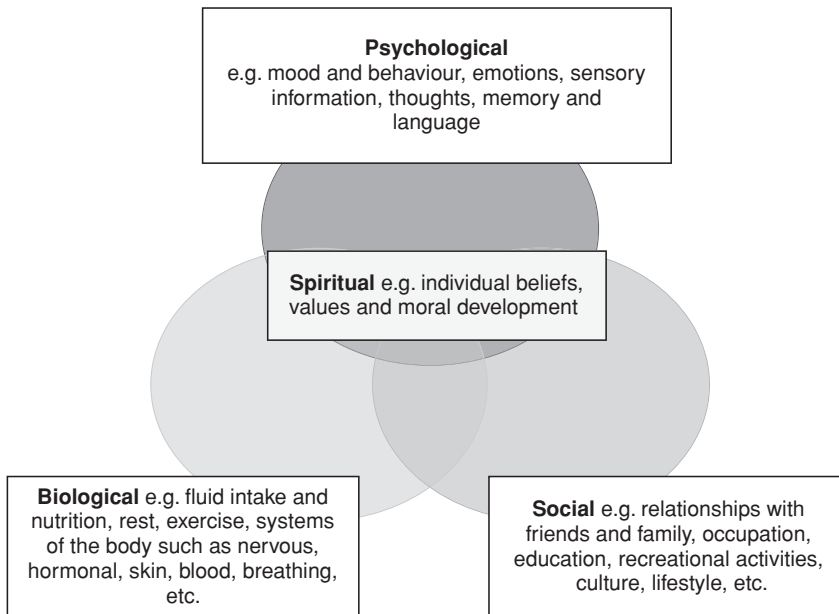
- How do I know that we have identified and addressed all of Bob's needs?
- Who else is likely to become involved in Bob's care?
- Who should I discuss Bob's care plan with?
- How will I know when it has been effective?

**Table 1.1** Care plan for Bob

<i>Assessment</i>	<i>Planning</i>	<i>Implementation</i>	<i>Evaluation</i>
Bob suffers from depressed mood and thoughts	Help Bob recover by identify coping skills/ mechanisms	1 Staff to explore treatment options with Bob 2 Review medication and side effects 3 Help Bob develop a supportive network	Weekly until returns to work
Being occupied is a strength for Bob in recovering his independence	Help Bob to find or return to work	1 Help Bob make contact with workplace 2 Discuss risks 3 Discuss strengths 4 Support Bob and employer by providing information with consent from Bob	Weekly then monthly

These questions can be answered by regularly reflecting upon practice and using resources that you have in your area of practice to develop your skills and knowledge. This can be achieved by writing down your thoughts on paper and searching for more evidence to support them; this is known as a reflective account but can also be used to begin a small research study. You might also want to discuss your thoughts with a colleague or your manager. Most professional organizations now have codes of practice or conduct that you can refer to for guidance or support. The important thing to remember in the care planning process is that it is a collaborative communication tool that can be used to ensure that a person gets the best help available. For more information on professional conduct you can visit the Nursing and Midwifery Council (NMC) website which gives a comprehensive account of what is required of registered practitioners in nursing ([www.nmc.org](http://www.nmc.org)) and there are similar guides in medicine, social work, psychology and occupational therapy. We will however consider the ethical implications of personalised mental health care planning later in this chapter.

In order to develop our care planning skills the above questions should have led to an awareness that you may need to find out more. This is where models of practice or theory can help us in searching for new or evidence based information.



**Figure 1.1** Holistic approach to personalised care planning

*Source:* Adapted from Lloyd (2010)

Figure 1.1 provides a basic outline of where we might need to look. It is based upon an empowerment model identified and discussed in a previous book (Lloyd 2010) that can remind us to develop our skills so that we can demonstrate not only effective services but also compassionate and personalised care. But before you explore Figure 1.1 attempt the activity below.

### **Activity 1.1 Critical reflection: identifying individual needs**

If you have not already been ill think about what your individual or personalised needs might be. How would you obtain help in meeting your needs?

## **Putting a personalised care plan together**

In order to begin writing a care plan we will need to make an assessment of a person's needs. This assessment should cover the four areas in Figure 1.1 in as much detail as necessary. One area is no more important than another to the individual, but they may experience more problems in one area than another.

Likewise they may also find that problems in one area of their life may influence other areas of their life. This is why we will need to explore or assess needs and strengths in all areas of a person's life. This is also known as *holistic* care planning (Lloyd 2010).

In everyday practice planning care can become a little bit like a ritual that you just carry out without thinking too much. However if we want our care plans to be effective for the people that we are helping then we do have to think carefully every time we write one. This is to make sure that we have covered everything and not missed out anything that the person feels is important. To do this properly requires both skills and knowledge. Assessing a person's needs therefore requires that we consider everything that is important to them as a whole person and not just signs and symptoms. When considering the whole person's needs Figure 1.1 will be helpful to refer back to.

Person centred care is at the heart of holistic or personalised care planning and requires us to put the person first. This may sound obvious as you read this book but in reality it can be very different and we can become so busy that the person ends up coming last. The Care Quality Commission (2010) has recently published its first report on its role in monitoring the use of the Mental Health Act and found some interesting facts about how people are cared for. One client gives an example of his involvement in care planning:

On my previous ward I would often just be invited in for ten minutes at the end of the planning meeting. To wait for two hours then go along to be told that this is what's going to happen to you, this is what we've discussed and this is how it is, I found that pretty degrading. But it does not happen on all wards and certainly not on the ward I am on at the moment.

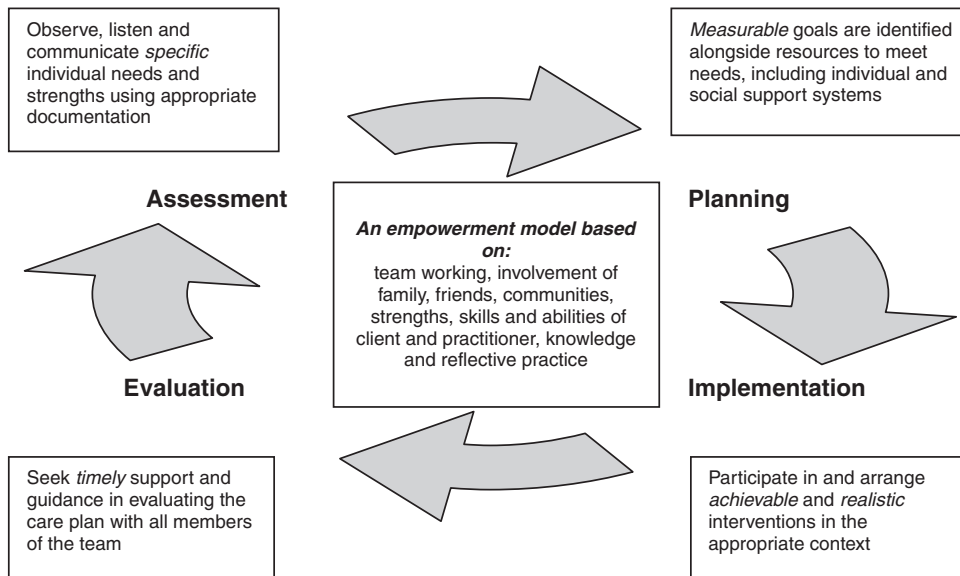
(Care Quality Commission 2010: 8)

You can also watch Mark talking about his care and other videos on the CQC website (<http://www.cqc.org.uk/mentalhealthactannualreport2009-10/videos.cfm>).

## The skills of care planning

When planning personalised mental health care we therefore need to consider the whole person and their needs alongside the theory or knowledge about mental health care that we already have. We will most probably need to find out more either from the person or from the literature and so the process of care planning becomes circular and in effect never ending (see Figure 1.2). However, the care planning process can also be empowering in that it enables a conversation to take place between the person and the practitioner who is helping them to recover their independence.

You do not need to have a lot of skills to write a care plan but the skills that you do need you have to be very good at. You cannot write a meaningful, effective care plan for someone if you have not paid attention to what they are saying or doing. A



**Figure 1.2** An empowerment model of care planning

Source: Adapted from Lloyd (2010)

recent review of communication skills within mental health nursing identified that the skills used when communicating with a person with mental illness are essential to developing a therapeutic relationship (Bowers et al. 2009). The following skills are therefore essential to good care planning in mental health care:

- **communication** – on a one to one basis and in a team, being able to communicate well means that information is shared effectively;
- **listening and attending** – actively so that your body language tells the person that you are genuinely interested in what they have to say;
- **empathy** – in developing a shared understanding of the person’s strengths and needs;
- **honesty and truthfulness** – from the beginning so that unrealistic expectations are not formed.

### Activity 1.2 Critical appraisal

Stop what you are doing from time to time and think about how you are demonstrating the above skills. Is it something that comes naturally to you or do you have to work at it? What do you need to do to improve your skills and what prevents you from doing this?

Planning care therefore can and should take up a great deal of our time whether we are gathering information from the client and others who know them or if we are monitoring its effectiveness. Care planning could therefore be seen as what we do in our everyday work and should not be viewed as simply a box to be ticked. Many reports of the quality of care provided reflect how good our care plans actually are and inform us of how we can improve our care planning skills. For example in 1997 a man who suffered from autism was detained in hospital for treatment. His carers objected and this led to a huge legal battle and reorganization of mental health care and law now known as the Bournemouth gap or Bournemouth safeguards (Mental Health Foundation 2005).

The problems identified from Bournemouth affect many people who are unable to give consent and required the existing mental health law to be updated and a new law on assessing mental capacity and depriving people of their liberty to be developed. The Mental Health Foundation (2005) provides a briefing paper on the Mental Capacity Act and how it will influence care planning in the future. Some of the main issues to arise included the following, which can now essentially be legally tried as neglect if not addressed:

- the need for appropriate treatment that will alleviate or prevent suffering;
- the need for safety and protection from harm when suffering from mental disturbance;
- the need to communicate needs as individuals and groups when planning care/services;
- the need for carers to become more involved in helping people make choices about their care;
- the need to be more involved in care planning and deciding what individual needs are addressed;
- the need to make choices from options available within health services and the wider community;
- the need to have someone advocate on our behalf when we have been detained under law;
- the need to have our care regularly reviewed and people held to account for their actions.

It is therefore an important and in many cases a legal requirement that we can demonstrate that the person who is in need of our help is at the centre of the care planning process. Care planning helps us to recognise the personal nature of people's needs and identify how we can help them recover their independence. The Department of Health (2009) website for long term conditions states that:

Personalised care planning is essentially about addressing an individual's full range of needs, taking into account their health, personal, social, economic, educational, mental health, ethnic and cultural background and circumstances. It recognises that there are other issues in addition to medical needs that can impact on a person's total health and well-being.



### Case study – Mark

Mark is a 22-year-old student at university. He is studying sociology and would like to work in social sciences and research and travel the world when he obtains his degree. Mark is experiencing frightening thoughts and beliefs that everyone is watching him. He is becoming more and more anxious about going outside and to lectures at the university because he constantly feels in danger. Mark has told no one about how he feels in case it is them who wants to harm him. He is only telling you because he knows you work in the health service and therefore he should be able to trust you. Mark wants you to help him find whoever is going to harm him so that he can continue with his studies. He has a really important exam coming up in the next month and does not want to miss it. Mark is living in student accommodation which is very noisy at night; his parents are both professionals and have busy social lives so he does not get to see them very much. Mark keeps very much to himself and has few friends; he takes his studies very seriously and does not want a university social life that will distract him.

Considering Marks needs how best do you think you can help him? What options or choices do you think Mark has and how will you communicate those to him?

The above exercise may have been difficult to do without a framework to work within. You may have identified a number of areas that Mark will need to think about but how will you document what you have done? Developing a care plan will help you to identify both what Mark thinks his needs are and how they can be addressed. Many care plans follow a similar framework to the one below and you may already be familiar with this layout. It is important to remember that the care plan is an active document constantly requiring updating if it is to be effective. Care planning practice therefore is a skill that we must all learn to develop. There are different frameworks for care planning with different abbreviations but the APIE Framework appears to be the most well recognised (Lloyd 2010). The APIE Framework covers the four areas of care planning practice which are not always given equal weighting when planning care. However if any one of the areas is neglected then the care plan may be destined to fail. The four areas of assessment, planning, intervention and evaluation (APIE) are outlined in Table 1.2.

Care planning using a framework is also known as a systematic approach, which means that each area of planning care is carefully worked through with the service user using good communication skills that were outlined above. Such communication skills also contribute to developing a therapeutic relationship with service users and carers. This relationship is intended to help the person to recover and is therefore different from a friendship or other social relationship. Professional

**Table 1.2** Outline of the care planning process

<i>APIE Framework</i>	<i>Area of care planning practice</i>
Assessment	This is an important information gathering process. Communication skills are very important in listening to and checking with the client what they have told you. You may also need to ask other people for information such as friends, carers and other professionals. Whoever you do ask you must always seek the permission of the client to share and gather information about them and act according to your professional code of practice.
Planning	Once a person's needs have been identified we can then begin to think about how they can be addressed. We can do this by discussing realistically how the person might be when they have recovered. It may be important here to discuss short and long term goals so that people have realistic targets to work towards. The case study above identified what Mark eventually wants to achieve (travel the world) and what steps he needs to do that (get his degree).
Implementation	Once the goals have been identified we can then think about how we can achieve them, who will be involved and how much time and effort will be needed. Also how we will measure improvement, which will be important in keeping people motivated in working towards the same goals. If people do not carry out their part at this stage the whole care plan can fail so it is important to be completely honest and realistic with Mark.
Evaluation	This can be a taken for granted part of the care plan but for the same reason is sometimes overlooked. It is important therefore to identify when the care plan will be evaluated and who by. If this is not clearly stated the care plan can become ineffective very quickly.

*Source:* Adapted from Lloyd (2010).

codes of practice help staff to ensure that the relationship remains therapeutic at all times but there are times when a lack of consideration of the ethics of our practice may affect the relationship developing to its full potential.

Legal and ethical guidance is often needed when assessing a person's ability to make decisions about their care and in planning the right sort of care to meet their individual needs. More recently new parts have been added to mental health law to try and accommodate the needs of individual people who may not want to go to hospital but need substantial forms of support to help them cope with their symptoms. There are now different community mental health teams who might specialise in certain disorders such as substance misuse, or provide a certain kind of help such as home treatment teams. Finding the right kind of help and support is crucial to helping Mark recover quickly and in fostering a supportive relationship between the client and the mental health service providers. Supervised Community Treatment Orders (SCTs or CTOs) have been developed to help people manage their care better but with the support of mental health services

under the amended Mental Health Act. The Code of Practice (DH 2008: 220) suggests that:

The purpose of SCT is to allow suitable patients to be safely treated in the community rather than under detention in hospital, and to provide a way to help prevent relapse and any harm – to the patient or to others – that this might cause. It is intended to help patients to maintain stable mental health outside hospital and to promote recovery . . . . SCT provides a framework for the management of patient care in the community and gives the responsible clinician the power to recall the patient to hospital for treatment if necessary.

It goes on to suggest that personalised care planning must be in place in order for supervised community treatment orders to be successful:

Good care planning, in line with the Care Programme Approach (CPA) (or its equivalent) will be essential to the success of SCT. A care co-ordinator will need to be identified. This is likely to be a different person from the responsible clinician, but need not be.

The care plan should be prepared in the light of consultation with the patient and (subject to the normal considerations of patient confidentiality):

- the nearest relative;
- any carers;
- anyone with authority under the Mental Capacity Act 2005 (MCA) to act on the patient's behalf;
- the multi-disciplinary team involved in the patient's care; and
- the patient's GP (if there is one). It is important that the patient's GP should be aware that the patient is to go onto SCT. A patient who does not have a GP should be encouraged and helped to register with a practice.

(DH 2008: 223)

The Mental Health Act (1983) was amended in 2007 following a lengthy consultation about changes that needed to be made after tragic events had taken place in the community where failure to continue treatment had occurred for some clients. Practices were also called into question that were too restrictive or were harmful to the physical health of clients and did not comply with The Human Rights Act of 1998. The Community Care Act of 1990 was considered to have failed people in the care of mental health services and so radical changes were made which included

- the development of supervised community treatment orders as outlined above;
- the development of law to assess and protect the needs of carers in 2000 and 2004;

- the development of the Mental Capacity Act in 2005;
- the development of Deprivation of Liberty Safeguards (DOLs) in 2009;
- the development of the Equality Act 2010;
- a five yearly report on the homicides and suicides in mental health services from 2001;
- national guidance on treatments including prescribing practices from NICE and SCIE (National Institute for Clinical Excellence and the Social Care Institute for Excellence).

All of the above were intended to improve practice and develop the skills of practitioners when planning care in collaboration with individual clients (King's Fund 2008). However the Mental Health Act of 1983 remains in place with the amendments added as outlined in Table 1.3.

In addition, some changes to the definition of a mental disorder were made because some people had been refused treatment even when they asked for it, because they were assessed as not having a mental illness that was treatable. Some of those people had gone on to commit fatal acts after failing to get help from the mental health services. The Department of Health (2008) Code of Practice therefore clearly lays out what the new definition means on page 19:

### **Definition of mental disorder**

Mental disorder is defined for the purposes of the Act as 'any disorder or disability of the mind'. Relevant professionals should determine whether a patient has a disorder or disability of the mind in accordance with good clinical practice and accepted standards of what constitutes such a disorder or disability.

### **Clinically recognised conditions which could fall within the Act's definition of mental disorder**

- affective disorders, such as depression and bipolar disorder
- schizophrenia and delusional disorders
- neurotic, stress-related and somatoform disorders, such as anxiety, phobic disorders, obsessive compulsive disorders, post-traumatic stress disorder and hypochondriacal disorders
- organic mental disorders such as dementia and delirium (however caused)
- personality and behavioural changes caused by brain injury or damage (however acquired)
- personality disorders
- mental and behavioural disorders caused by psychoactive substance use (but see paragraphs 3.8–3.12 Mental Health Act Code of Practice)
- eating disorders, non-organic sleep disorders and non-organic sexual disorders

**Table 1.3** Brief overview of the main sections of the Mental Health Act (1983 amended 2007)

<i>Section of the Act</i>	<i>Practice</i>	<i>Appeals</i>	<i>2007 Amendments</i>
Section 2 Admission to hospital for Assessment	Can be detained in hospital for up to 28 days for assessment – not renewable Requires two doctors and one Approved Mental Health Practitioner (AMHP)	Can appeal against the decision in writing	Definition of mental illness changed to cover all disorders – Approved Social Worker (ASW) replaced with Approved Mental Health Practitioner (AMHP)
Section 3 Admission to hospital for treatment	Can be detained in hospital for up to six months for treatment – renewable Requires two doctors and one Approved Mental Health Practitioner (AMHP)	Can appeal in writing against decision Second Opinion Approved Doctor (SOAD) may be called for treatment decisions after three months	Can now be transferred quickly to a CTO under Section 117 below SOAD required mandatory for some treatments e.g. electroconvulsive therapy (ECT)
Section 4 Admission to hospital for emergency assessment	Can be detained in hospital for up to 72 hours – not renewable Requires one doctor and one Approved Mental Health Practitioner (AMHP)	Cannot appeal and should only be used in an emergency	
Section 5.2 Detain while already in hospital for assessment	Can be detained in hospital by one doctor for up to 72 hours or transferred to another section	Cannot appeal and should only be used in an emergency	
Section 5.4 Detain while already in hospital for assessment	Can be detained in hospital by one registered mental health or learning disability nurse for up to six hours or transferred to another section	Cannot appeal and should only be used in an emergency	
Section 117 Right to aftercare following discharge from hospital	Right to aftercare if previously been detained on a Section 3 only	Not to be used for detaining a client but to ensure access to services is given as a priority – no appeal necessary	Amendments made to this section to accommodate Supervised Community Treatment Orders (SCTs or CTOs)

- learning disabilities (but see paragraphs 3.13–3.15)
- autistic spectrum disorders (including Asperger’s syndrome) (but see paragraphs 3.16–3.17)
- behavioural and emotional disorders of children and adolescents

(Note: this list is not exhaustive.)

## **Ethical considerations when planning personalised mental health care**

It is important to keep Mark’s wishes in mind at all times and in mental health care and law the person’s best interests must always be upheld. However, when making decisions with a person about their care needs, ethical conflict can arise. It is important to recognise and address such ethical conflict so that the appropriate interventions can be planned and put into place as soon as possible. Considering Mark’s case study above there are a number of ethical conflict issues that can arise and which, if not addressed, may sabotage the whole care planning process. For example:

- Mark may not think he has any symptoms as such but is aware that he is feeling frightened. The role of the person helping him is therefore to help him identify what he needs to do to feel less frightened.
- Mark is a very independent person and considers his ability to study alone a strength. In collaboration with Mark the person helping him plan his care needs will need to take this into account and not expect Mark to join lots of social groups.
- Mark is not taking any medication at present and may not understand why he should be taking medication for what he thinks is other people’s behaviour. Mark may need information on how medication can help him cope with his feelings.
- Mark is isolating himself and does not have a support network to help him cope in an emergency. Helping Mark to identify a support network will also help him to cope with distressing feelings.

It is important to identify the main areas that Mark needs help with and there could be many, but at the moment he is asking for help with how he is feeling. It would not be appropriate to begin formal admission under the Mental Health Act until all other avenues have been tried. A care plan will then document what you have discussed and how you intend to help Mark, which can also be shared with other people who will be involved, with consent from Mark. Current mental health law requires that all attempts are made to involve people in their care plan and that force, in the form of detention, should only be used as a last resort or when the risk becomes too great to a person’s mental wellbeing. For further information about interpreting mental health law in practice see the Codes of Practice for the Mental Health Act 1983 (amended 2007) and the Mental Capacity

Act 2005 but these may vary in different countries and governments. The Code of Practice for the Mental Health Act for England (Department of Health 2008; and adapted elsewhere) is based upon five main guiding principles which are:

- 1 **Purpose principle** Mental health law should only be used to enable the safety of individuals and others, to reduce distress and to support mental wellbeing and recovery.
- 2 **Least restriction principle** Any actions taken without the consent of the person should keep to a minimum the restrictions made upon the person.
- 3 **Respect principle** When taking actions with and for a person their holistic and diverse needs should be respected at all times, including their biopsychosocial and spiritual needs.
- 4 **Participation principle** People should be involved in their care plan at all times and stages and carers should be encouraged to participate where possible and agreed by the client.
- 5 **Effectiveness, efficiency and equity principle** All resources available should be used to ensure that the person receives the most appropriate help at the right time in order to ensure an effective care package is in place.

While the above are simply principles and are therefore not law in their own right, they can help as a guide when planning personalised mental health care. The care plan for Mark (see Table 1.4) therefore takes into account the above principles and his holistic care needs and focuses upon promoting mental health recovery.

## Writing SMART care plans

An effective care plan is one that can be read by any member of the healthcare team and acted upon without seeking further clarification. If the care plan is too elaborate or simple it may obscure vital information and be less efficient in meeting the goals that have been collaboratively created between the care coordinator and client. An effective personalised care plan is therefore **SMART**, which means: **S**pecific assessment of needs is identified, **M**easurable goals of planning so that we know when it has been achieved, **A**chievable goals and interventions that are **R**eliable and not dependent upon long waiting lists for further services and **T**imely interventions and evaluations to make sure everyone feels safe and comfortable with the current care plan. (See Lloyd 2010 for more indepth discussion of care planning.)

Mark's care plan is basic but can be found in the evidence discussed previously. It is important to know where the evidence for the care plan comes from and that it is not something that has been written to comply with a practice policy. The professional knowledge and support of the care coordinator is essential in helping people to access the most effective and efficient services and support as soon as possible in order to minimise risk and promote safety (DH 2008). In Mark's care

**Table 1.4** Care plan for Mark

<i>Assessment</i>	<i>Planning</i>	<i>Implementation</i>	<i>Evaluation</i>
1 Mark feels afraid that people are going to harm him	To reduce feelings of harm and help Mark cope with his feelings	1 Arrange for Mark to speak with a doctor about medication and attend any associated clinics 2 Care coordinator to discuss with Mark other ways in which he can cope with his feelings 1 Weekly meetings with care coordinator to make future management plans (Mondays free from lectures)	Weekly follow up initially by named care coordinator Review weekly Evaluate and review weekly
2 Mark is an independent person and can usually manage his daily activities very effectively	To help Mark create an advanced directive/ statement and crisis plan		
3 Mark has very little support to help him cope with how he is feeling	Help Mark identify a support network of people he can trust to help him in a crisis	1 As part of developing the crisis plan each week make a list of contact names and numbers available 2 Ensure Mark has access to a phone 3 Help Mark access support groups and services of his choice either with a peer or health/social care support worker	Review weekly  Review daily in first week Review monthly



plan you can see that his needs were addressed to help him cope with his feelings so that he can feel safe again and to provide enough support so that the risk of him feeling this way for much longer is minimised. Mental health recovery is also incorporated in ensuring that Mark develops a stronger support network around him and that he can identify and use his strengths to help him do this. The role of the care coordinator is to provide support, advice and guidance during this recovery process.

## **Adopting a recovery focused approach to personalised mental health care**

In completing this chapter, which provides an overview of the personalised care planning process, it is worth remembering that recovery should influence all personalised care plans if they are to be recovery focused. The National Institute for Mental Health in England (2005: 3) produced a *Guiding Statement on Recovery* which included the following principles:

**Principle I** The user of services decides if and when to begin the recovery process and directs it; therefore, service user direction is essential throughout the process.

**Principle II** The mental health system must be aware of its tendency to promote service user dependency. Users of service need to be aware of the negative impact of co-dependency.

**Principle III** Users of service are able to recover more quickly when their:

- Hope is encouraged, enhanced and/or maintained
- Life roles with respect to work and meaningful activities are defined
- Spirituality is considered
- Culture is understood
- Educational needs as well as those of families/significant others are identified
- Socialisation needs are identified
- They are supported to achieve their goals.

**Principle IV** Individual differences are considered and valued across the life span.

**Principle V** Recovery from mental illness is most effective when a holistic approach is considered; this includes psychological, emotional, spiritual, physical and social needs.

**Principle VI** In order to reflect current 'best practices' there is a need for an integrated approach to treatment and care that includes medical/

biological, psychological, social and values-based approaches. A recovery approach embraces all of these.

**Principle VII** Clinicians' and practitioners' initial emphasis on 'hope' and the ability to develop trusting relationships influence the recovery of users of services.

**Principle VIII** Clinicians and practitioners should operate from a strengths/assets model.

**Principle IX** Users of service with the support of clinicians, practitioners and other supporters should develop a recovery management or wellness recovery action plan. This plan focuses on wellness, the treatments and supports that will facilitate recovery, and the resources that will support the recovery process.

**Principle X** Involvement of a person's family, partner and friends may enhance the recovery process. The user of service should define whom they wish to involve.

**Principle XI** Mental health services are most effective when delivery is within the context of the service user's locality and cultural context.

**Principle XII** Community involvement as defined by the user of service is central to the recovery process.

### **Activity 1.3 Critical reflection on the principles of recovery**

Does your practice include all of the principles above? If not how could you improve it? Try writing a care plan with the above principles as a guide.

The above principles could be applied to Mark's care plan above in order to check that recovery focused interventions are in place. In helping Mark manage his symptoms we are also helping him to develop personalised self-management skills for the future. The care plan could then be developed into a crisis plan indicating for Mark how he would like to be helped in the future and/or an advanced statement which provides information on what Mark would not like to happen. Mark may also wish to develop a wellness recovery action plan (WRAP) which will be based upon his strengths and skills and not necessarily upon his symptoms. For more information on WRAP go to the website of its founder Mary Ellen Copeland (<http://www.mentalhealthrecovery.com/>) where information on the process and training can be found. You can also visit the Scottish Recovery Network for more information on recovery and WRAP training (<http://www.scottishrecovery.net/>). In all our attempts to develop evidence based practice it is important to remember

that we are working with people first and foremost. Patricia Deegan (1996), a service user herself, reminds us that each person we meet in our personal and professional life has a heart but it is a wise practitioner who remembers that it is a human heart not a mechanical one:

Wisdom would seek the form or essence of the heart. In wisdom we would see that the anatomical heart, which we have given our students to study, is nobody's heart. It is a heart that could belong to anybody and therefore it belongs to nobody. Wisdom would have us understand that there is another heart. There is a heart that we know about long before we are taught that the heart is a pump. I am speaking here of the heart that can break; the heart that grows weary; the hardened heart; the heartless one; the cold heart; the heart that aches; the heart that stands still; the heart that leaps with joy; and the one who has lost heart. Wisdom demands that we teach students of the human sciences about the essence of this heart. The human heart.

(Deegan 1996: 91)

## Conclusion

The above care plan and overview of mental health services requires a lot of information to be understood and practised if we are going to provide personalised and recovery focused mental health care. Personalised care planning however is largely an ethical endeavour in that we are all attempting to keep the person's best interests at the centre of the care planning process. Sometimes the management of risk and other resources may make practitioners feel like we are being prevented from carrying out our job to the best of our ability. It is very important in that case that we ensure the best services are available for the people who need them and that we all work in a collaborative and recovery focused way. Developing our practice towards a more recovery focused person centred approach will enable us to ensure that the person remains at the centre of the care planning process.

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## Useful websites

Care Quality Commission <http://www.cqc.org.uk/>