

Individual program planning as an exemplar of best practice in the delivery of consumer-oriented mental health care

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Abstract

Individual Program Planning is an action research tool that facilitates consumer-oriented service provision. It is based on four guiding principles to promote constructive interaction between consumers, significant others and services. Agreements for action are cooperatively developed in relation to the identification of issues. These are documented and monitored in the form of ongoing meetings. The process supports coordination and accountability of activity between those significant to treatment outcome across the continuum of care.

Introduction

The Second National Mental Health Plan (Australian Health Ministers 1998) represents a de facto challenge to Australian mental health service providers to develop innovative conceptualisations of service delivery, which can embrace standards of excellence as articulated in the National Standards for Mental Health Services (AHMAC National Mental Health Working Group 1996). Central to these documents is respect for the consumer voice in the collaborative development and enactment of service delivery.

Quality services should have at their core, principles of constructive interaction such as

- respectful collaboration between consumers, carers, government and non-government organisations, and the broader community
- coordination between people and services throughout the continuum care
- greater transparency in the negotiation of provision of services
- flexibility of service delivery to respond to local and individual cultural needs
- accountability for provision of services
- excellence as evidenced through outcome measurement
- documentation that demonstrates that the goals of the above have been addressed.

The provision of democratic, transparent and consumer oriented mental health services, in response to the national challenge, requires appropriate strategies and tools that facilitate successful treatment as defined by both providers and consumers. Examples of these include collaboratively developed treatment plans, the identification of clinical pathways, and other action research methodologies in order to “predict the unpredictable” (Faulkner, Tobin & Weir 1994), which make information about sometimes very complex issues more accessible.

Individual program planning

Individual Program Planning (IPP) has been developed and implemented as a flexible framework that can assist in facilitating principles of best practice as articulated in the Second National Mental Health Plan (1998). It is an action research methodology enabling the identification of a diverse range of outcomes to be monitored across the continuum of care.

The IPP process is best described as a series of structured and principle-based communications between the consumer, the mental health team and anyone else significant to treatment outcome in the form of regular meetings. The meetings are conducted in order to negotiate and coordinate therapeutic activity, and are primarily intended to identify areas of cooperation between participants for action toward the achievement of those outcomes that are relevant and sensitive to the consumer's needs.

IPP acknowledges that the consumer lives in a unique world into which mental health professionals may either intrude, or at best should be invited in a limited capacity. To this end, the consumer's world is assumed to comprise a complex system of relationships, which has the ability to support the person toward the best therapeutic outcome for him/herself. The adoption of such an approach requires that mental health personnel respect the reality that if plans for treatment do not fit with the real-world context of the consumer they are of little value, since outcomes will lack personal relevance.

In addition, the consumer's relationship with services may have a long history, perhaps comprising conflictual interactions with mental health professional value systems that may be alien to the consumer, thereby constraining how the consumer and significant others will relate to treatment recommendations as defined by the service provider. Therefore the quality of the relationship with service providers may be significantly influential to treatment outcome, and in the IPP model this is regarded as an important variable in treatment.

IPP provides the framework for guiding mental health professionals in the collaborative enactment of negotiated clinical pathways. It is based on four central principles reflective of the assumptions of constructive interaction. The principles represent a constant theme in all stages of treatment negotiation and represent the integrity of the process. They will be outlined below with an explanation of how they are enacted in practice.

1. Cooperation

Cooperation and goodwill between various components of the consumer's world facilitate positive outcomes. The social world of people who come to the attention of Mental Health Services is often in disarray, generally providing a direct analogy to their internal worlds. At the heart of the IPP process is the assumption that if the consumer's extra-psycho world can be more ordered and stable through assisted negotiation, this will reduce the demands on the consumer's intra-psycho world. The IPP process is designed to identify and foster areas of cooperation around any issues where this is possible, and to use this influence to gain further cooperation. The process also recognises constraints in the system where cooperation will not occur, and the potential impact on outcome is then defined.

In practice, the key mental health worker discusses the purpose and mechanisms of the IPP with the consumer. A list of people to be included is developed cooperatively, and they are then invited to the meeting and the process is outlined. The composition of the meeting changes according to the needs of the consumer and those considered to have meaningful input into decision-making. In the case of participants from rural and remote communities, teleconference methodology is used.

2. Requests around issues

A request is a statement of what a person wants (ie, personal definition of an outcome) in relation to a particular issue. In a treatment setting, complex requests (both explicit and implicit) are made reciprocally between people. The consumer may make requests of Mental Health Services, as well as the consumer's family and friends, and other services within the mental health care delivery system, which are in themselves considered to be consumers.

In turn, Mental Health Services make requests of these people. Additionally, within each identified grouping of people such as a family or an agency, complex requests are made between the members of the grouping. It must also be acknowledged that requests may be generated from third parties such as the Guardianship Board, courts and other services. These must be made explicit. Some requests from absent parties, such as family members, may be less readily apparent. Requests are generally made in relatively predictable arenas, generally comprising issues such as interpersonal relationships, work, leisure, education, housing, money and medication. However, the content of requests may have areas of conflict.

Given the complexity of the relationships around the consumer, there are often multiple requests that may be contradictory or unable to be fulfilled, or which unbalance the demands of treatment. There is the danger of different parties assuming the nature of the content of requests. The IPP process attempts to make this more explicit. It is considered that the more the mental health system or professional deviates from the true meaning of the request, the more difficulty there will be in eliciting cooperation with any therapeutic action relative to the request.

The identification and definition of requests is a dynamic process. Requests change over time as the consumer's world changes, and as more information is introduced into the system. Therefore, requests need to be made explicit, and to be redefined and shaped over time.

In practice, prior to the meeting consumers are encouraged to identify and discuss potential requests in relation to issues with the key mental health worker. Tools such as the Behaviour and Symptom Identification Scale-32 (a consumer rating scale assessing difficulty in a number of arenas of day-to-day life) may be drawn on as a guide to identify areas for consideration and may additionally be used as outcome measures. Those issues not for open discussion are identified and a confidentiality agreement signed between the consumer and mental health worker. The consumer may be assisted in a coaching framework to develop skills to speak to issues to achieve a desired outcome. Other members of the meeting are informed through their invitation of the purpose of the meetings and asked to consider issues for discussion.

A member of the mental health team chairs the IPP meetings. Each person is introduced in relation to their role in the consumer's life. Issues are identified and listed on a white board without deliberation in order to form an agenda. The chair determines the sequence of dealing with agenda items.

3. Negotiation and fairness: democracy and transparency

Agreements between people to take action are developed on the basis of negotiation of requests. Fairness in negotiation is the fundamental principle of this interaction. In situations where the outcome is not as each person has wished it to be, the democratisation of this process often alleviates anxiety and distrust of others.

In reality, some requests or issues have more scope for negotiation than others, especially when considering potential treatment imperatives relating to the duty of care. Any constraints around negotiation must be acknowledged and respected in an open way. For example, if a consumer wishes to cease medication whilst under a treatment order, this is minimally negotiable. However, within this issue are areas of negotiation possible. For example, the consumer may have flexibility in negotiating the type of medication, dosage, establishment of trial periods for monitoring its effects and potential side effects, and reviews of medication.

The degree of negotiability changes over time. It is anticipated that there is more flexibility in negotiation as more options are cooperatively generated and as greater cooperation is fostered. Therefore, the process is evolutionary and shaped across time. Agreements identify action in relation to issues, but are limited in time to what can be achieved in the near future, rather than assuming or forcing negotiation around larger goals and longer time-frames, which may be unrealistic or too complex to have immediate meaning.

In practice, the chairperson structures the agenda and is responsible for the fairness of negotiation, particularly for the consumer. The chair manages the meeting by inviting comment, framing issues neutrally and being open in the identification of constraints and identifying the responsibility of participants. Suitable timetables and appropriate activity to be undertaken within this time are identified collaboratively.

In issues where there is little cooperation, action may be postponed or the relevant people asked to continue their discussions until there is a workable agreement for action. The chair person is then to be notified of any decision. Service providers are therefore often encouraged to develop more creative ways of working cooperatively with consumers and others.

4. Accountability: documentation and monitoring

Carrying out negotiated tasks in a cooperative context is central to the ongoing achievement of outcome. Agreements are documented and monitored, and in turn used as the foundation for further action. They are seen as a binding contract between those identified to carry out action. However, it is acknowledged that the process or content may change and renegotiation can occur within the group away from the meeting. Those people identified to undertake action on an issue report to the next meeting and outcomes are documented and monitored.

In practice, agreements are recorded in writing as an action plan using a simple format of three headings - issue, who, and what. The next meeting time is determined at the end of the meeting reflecting the nature of the action statements to provide the time frame for reporting on activity.

The next meeting time does not imply that the activity needs to have been completed. Generally, meeting times are frequent early in the process, at times of major activity and prior to discharge. Each person is provided with the statement of agreements, which are hand-written during the meeting. These documents represent an ongoing and accountable goal-setting process, whilst maintaining flexibility within a context of the principles of the process.

The process encourages constant review and modification, enabling more possibilities to be generated by the consumer and those who have a stake in the outcome. This also creates a continuous reworking of documentation, which at discharge from any care setting provides easily accessible details of the clinical pathway for that consumer. This is central to the provision of coordinated service delivery across the continuum of care.

Summary

IPP represents a democratisation of the process of creating a clinical pathway, and facilitates transparency and accountability of the treatment program, allowing for consumer oriented psychiatric rehabilitation in which consumer needs are balanced with treatment constraints. Treatment is goal-driven, and focuses on outcome management via monitored feedback that is relevant and negotiated, without expensive changes to existing structures.

IPP enhances the principles of interdisciplinary teamwork and the inclusion of consumer services such as housing, financial management, community and other agencies in the very early stages of collaborative planning, allowing for the effective flow of information to these agencies ahead of discharge, and facilitating the continuity of care.

The enhancement of the interdisciplinary team encourages the devolution of specialist skills across the team, with the implementation of staff training programs central to each consumer, in response to the specificity of individual consumer issues/goals. Each new consumer therefore challenges the system to respond with the training of staff around novel treatment issues. A rehabilitation model that defines the roles of the treatment and people involved is thus encompassed in the IPP application.

An integrated approach to psychiatric care is formulated through the IPP. The requirements of the Second National Health Plan (1998) are managed with regard to expectations of democracy, transparency, monitoring, outcome management and continuity of care across disciplines and agencies in the delivery of mental health services.

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