

Mental Health Care Planning

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Question

What is the best available evidence regarding mental health care planning in hospital settings?

Clinical Bottom Line

Mental health care planning provides an opportunity for health professionals, individuals with mental illness and their carers to all be aware of the goals, processes and illness management regarding the treatment of someone with a mental illness.¹ Care plans are ideally created with the individual with the mental illness to create an alignment between the service users, the health care providers and families working towards key goals.¹ It also can provide an opportunity to guide interdisciplinary communication ideally leading to improved care of the service user. The care plan is developed by actively involving the patient and all relevant care providers, that is, multidisciplinary healthcare teams, with careful considerations given to the patient's needs, values, and preferences that can be facilitated with the resources and capacity of the hospital setting and context.¹

- A clinical practice guideline from the National Institute for Health Care and Excellence (NICE) suggests that care plans should be co-created between the individual with the mental illness and health care professionals. This care plan is based on an assessment of the individual and may include a crisis plan for advance decision-making during periods of severe illness if deemed appropriate. Care plans should include the following: support service details and treating clinical team members; fee and payment options if appropriate; details regarding current or future services; risk management strategies and activities that promote meaning, occupation and inclusion (education, employment, leisure activities, volunteering and caring for dependents); a list of self-chosen coping strategies and incorporate plans to maintain self-efficacy and maintain independence where possible. A copy of the care plan should be given to the individual and all staff members involved in the care. All staff involved with the care of the service user should have a copy of the mental health care plan, including electronic if available. All plans are required to have an agreed review date. A mental health care plan with a crisis plan should include warning signs and coping strategies and supports to prevent hospitalization. If hospitalization is required then the crisis plan has details of where the service user would prefer treatment, what must happen to any dependents, details of advanced decisions, information to 24-hour support and named next of kin contacts with contact details.¹ (Level 3)
- A qualitative study explored the influence of shared decision-making on implementation at individual with mental illness, carer, mental health professional and health care organizational levels. Three overarching themes were identified, which included: the sense and sense-making of care planning training; the absence of the required relational work to enact the principles of shared decision-making and the failure of organizational readiness to support the workability of the shared decision-making care plans.

Stakeholders perceived that recovery workers, support workers and occupational therapists may be best placed to undertake care planning, as other health professionals did not have time or the capacity to get to know the individual with mental illness sufficiently to conduct appropriate care planning. Healthcare professionals may need training or improved capacity to effectively create a mental health care plan. The authors highlighted the need for shared decision-making to be an integral component of mental health care planning.² (Level 3)

- An American Substance Abuse and Mental Health Service Administration guideline described the importance of a co-created care or crisis plan, also known as a psychiatric advanced care plan. This is a plan which outlines care approaches created with an individual and the care team in anticipation of future mental health crises when the individual will no longer be able to make sound decisions during times of severe illness. The action of co-creating the plan also assists in fostering an alliance between the individual with mental illness, family/caregivers and the service providers/clinician teams. The plan goes into effect when the treating medical team has determined that the individual is in an acute episode (e.g., delirium, unconsciousness, catatonia, acute psychosis or mania). This plan can then be followed by health care professionals to identify a list of preferred treatments, values and as well as access to key support contact information.³ (Level 5)
- A systematic review assessed the use of carers' involvement during the creation of care plans for individuals with mental illnesses. The authors identified interventions for discharge planning and transition to community care. Carer involvement was identified in one or more of the following areas: education, moving towards hospital discharge, and planning when back into the community. Overall, it was found that carer involvement in more aspects of the care plan resulted in fewer future hospitalizations of the individual. More research is required to assess the cost-effectiveness of the different carer involvement models in care planning.⁴ (Level 3)
- A qualitative interview study aimed to understand the process of multidisciplinary created mental health care plans and assess the experiences of the meetings during the care planning process. The care planning meetings were supported by the hospital to be driven by the individual with the mental illness. The agenda and meeting based on a care plan template contained personal goals. Carers, family members or other health care professionals were allowed to attend if asked by the individual with mental illness to promote autonomy over their health and recovery. Overall, the individuals with mental illness found these care meetings a positive experience and felt that they were able to safely communicate their needs and that they were the center of the conversation about their own care. Staff would look at the goals outlined by the individual and prompted them to ask what it might look like to meet this goal, and what might be possible within the hospital system. Care planning meetings occurred at admission, and then every 3-4 weeks during long-term psychiatric ward stay, booked 2 weeks in advance. Issues raised about barriers or facilitators towards goal attainment were able to be utilized by health care staff. Overall, this model of care planning was considered a positive method of engagement by service users.⁵ (Level 3)
- A systematic review including low-moderate quality randomized controlled trials (RCTs), cohort studies and time series aimed to assess the impact of care planning on clinical outcomes, costs, service utilization and service user satisfaction on those with severe mental illness. The mean age of patients was 40 years, 55% were male, and 75% of the sample had a schizophrenia diagnosis. Overall, the studies indicated that care plans had a small but significant impact on reducing hospital stay (though this did not decrease hospital readmissions), reduced psychiatric symptoms and improved quality of life. Most care plan studies were delivered and facilitated by a care plan manager (nurse or social worker) who coordinated and directed service provision (psychoeducation, social worker, counseling and coping skills training). Care plans reported an overall positive effect on patient satisfaction. Cost effectiveness and satisfaction were not able to be obtained due to a lack of reporting by the available studies.⁶ (Level 1)

Characteristics of the Evidence

This evidence summary is based on a structured search of the literature and selected evidence-based health care databases. The evidence in this summary comes from:

- A United Kingdom clinical practice guideline for adults in mental health service settings.¹
- A qualitative study including in-depth interviews with 54 participants (21 health professionals, 29 service users and 4 carers).²
- An American clinical practice guideline.³
- A systematic review with 14 included studies, 2 of which were controlled studies.⁴
- A qualitative study with 10 individuals who were inpatients of a mental health ward.⁵
- A systematic review of 34 articles with 12,783 participants, 14 RCTs, 2 non-RCTs, four prospective cohort studies, 5 time series, and 3 retrospective cohort studies. The meta-analysis included 12 RCTs and cohort outcome data including 3,960 participants.⁶

Best Practice Recommendations

1. Care planning should be based on the patient's needs assessment and goals. (Grade A)
2. The care planning process should start at the admission of the patient or at the time the healthcare organization accepts the responsibility for the patient. (Grade A)
3. Healthcare providers should educate patients on the purpose and scope of a care plan. The patient and carer/s should be told that they can request to discuss the care plan if they have questions. (Grade A)
4. The care plan should be developed with the patient's consent, jointly with the patient and all the relevant professionals (healthcare, social care etc.) involved in the care of the patient, and if possible and appropriate, with the participation of the patient's carer. (Grade A)
5. The care plan should include all required details according to the organizations' standards and policies (such as, the date the care plan was developed, the details about those participating in the process of developing the care plan, the agreed care goals and actions and their timeframes, etc.) as well as the agreed planned date for the review of the care plan. (Grade A)
6. All members involved in the care plan including any relevant staff and the patient are given a copy of the care plan, including electronic if possible. (Grade A)
7. Care plans should include detailed information regarding patient and next of kin details; support service and treating clinical team members; fee and payment options if appropriate; details regarding current or future services; risk management strategies and activities that promote meaning, occupation and inclusion (education, employment, leisure activities, volunteering and caring for dependents); a list of self-chosen coping strategies and incorporate plans to maintain self-efficacy and maintain independence where possible. It is recommended that crisis plans within the care plan should only be made with an individual when they are of sound mind and include and be signed by a witness. (Grade A)
8. Healthcare professionals should receive education and training about care planning. (Grade A)
9. Care plans should be reviewed by a care plan coordinator regarding their impact (effectiveness), comprehensiveness and multidisciplinary involvement and ensure they meet the policies and

procedures of the health care setting. (Grade A)

10. For long-term inpatients in mental health ward settings, care planning should be regularly re-assessed every couple of weeks driven by service user goals. (Grade B)

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Supported JBI Recommended Practices

- JBI-RP-4624-2-Mental Health Care Planning

Archived Publications

1. JBI-ES-115-5 (Published at 21 February 2022)
2. JBI-ES-115-4 (Published at 13 August 2021)
3. JBI-ES-115-3 (Published at 2 June 2021)
4. JBI-ES-115-2 (Published at 17 March 2021)
5. JBI-ES-115-1 (Published at 14 December 2020)

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For details on the method for development see Munn Z, Lockwood C, Moola S. The development and use of evidence summaries for point of care information systems: A streamlined rapid review approach. *Worldviews Evid Based Nurs.* 2015;12(3):131-8.

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