Recovery Planning

Guideline Responsibilities and Authorisation

Department Responsible for Guideline	Mental Health and Addictions Service
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Target Audience	Mental Health and Addictions Clinical Staff
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Guideline Review History

Version	Updated by	Date Updated	Summary of Changes
02	Kylie Balzer	Oct 2022	Changed into current Te Whatu Ora Waikato Guideline template, updated health literacy resource from HQSC, updated section on external standards, change from acute care recovery plan to inpatient recovery plan, update of audit indicators and tools. Addition made to exceptions section.

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Contents

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1 Overview

1.1 Purpose

The purpose of this guideline is to provide best practice information and expectations on the recovery planning process in the Mental Health and Addictions Service by all multidisciplinary team members.

1.2 Staff group

Clinical staff in the Mental Health and Addictions Service.

1.3 Patient / client group

Mental Health and Addictions tāngata whaiora.

1.4 Exceptions / contraindications

There may be occasions when tāngata whaiora subject to the Mental Health (Compulsory Assessment and Treatment) Act where not all components of the recovery plan are agreed by the tāngata whaiora often because they lack insight into their mental illness. The care plan in these circumstances may include working with the tāngata whaiora and whānau to improve understanding of their illness and relapse plan, and acknowledge some components of the plan of care are directed by the team and not mutually agreed.

1.5 Definitions and acronyms

Collaboration	Collaboration means working together with the tāngata whaiora and whānau to provide optimal care for the tāngata whaiora or tāngata whaiora group
Health literacy	Is being able to obtain, understand and use basic health information and be able to navigate health services and make appropriate decisions.
Inpatient recovery plan	The inpatient recovery plan is a document done in a collaborative way to support any acute episode of care.
Pacific influences in healthcare	While the diversity of Pacific people needs to be acknowledged there are some general perceptions about health i.e. a holistic notion of health and health as a family concern rather than an individual matter. It is important to consider also that there are differences between the beliefs of Pacific people born in New Zealand and those who are migrants. Reference document: Improving quality of care for pacific peoples. A paper for the Pacific Health and Disability action plan review. Ministry of Health, 2008.
Person centred care	Health and social care that is respectful of the needs, values and preferences of the person / people using the health care services and recognises the person's strengths.

Recovery	Health and social care that is respectful of the needs, values and preferences of the person / people using the health care services and recognises the person's strengths.
Tāngata whaiora self-initiated plan	A plan that is designed and managed by the tāngata whaiora to support their wellness / recovery
Te Whare Tapa Whā	A Māori view of health which includes four dimensions: Te Taha Whānau (social environment and whānau), Te Taha Wairua (spiritual), Te Taha Hinengaro (mental and emotional), and Te Taha Tinana (physical). These components are viewed holistically.
Wellbeing recovery plan	The recovery plan that is documented as part of the community / rehabilitation phase of the integrated care pathway

2 Clinical management

2.1 Roles and responsibilities

Clinicians
All clinical staff are responsible for participating in best practice recovery planning processes.

Keyworkers / primary nurses are responsible for monitoring the quality and progress of recovery plans for the tāngata whaiora within their caseloads.

Managers
Managers are responsible for monitoring the standards of recovery planning within the service and providing feedback and upskilling opportunities in relation to recovery planning processes.

2.2 Competency required

Registered health professionals and social workers eligible for registration are responsible for the management of health care provision.

Staff completing recovery plans are competent in the following skills:

- Formulation of SMARTA goals (specific, measureable, achievable, realistic, time framed, and agreed)
- Coaching in the development of a person centred recovery plan
- Involvement of whānau in recovery planning processes
- Culturally supportive practice
- Linking assessment information to recovery planning
- Health literacy and the use of positive language
- Identification of health and social care needs and strengths and promoting safety and positive risk taking
- Co-ordinating care across services

Training / coaching on recovery planning will be provided as a component of the orientation and ongoing professional development for clinical staff within the Mental Health and Addictions service. Staff may also choose to discuss recovery planning within their supervision and / or with their team leader / Charge Nurse Manager.

2.3 Equipment

Recovery plan template in the clinical workstation.

2.4 Guideline

2.4.1 Recovery plans are individualised, accurate and up to date

An up to date and dynamic / lived recovery plan will be in place for tāngata whaiora across the pathway of care. This may include:

- Inpatient care planning
- Wellbeing recovery planning

Inpatient care planning: The recovery plan identified as a component of any acute period of care whether this be an inpatient, short term acute pathway, or home-based treatment. This plan will include the short-term goals developed in collaboration with the tāngata whaiora which will support the tāngata whaiora to return to either their wellbeing recovery pathway in the community / rehabilitation journey or back to primary care.

The inpatient care plan is based on the needs identified from the assessment undertaken which identified the need for acute intervention. Transfer of care back to the wellbeing recovery pathway or primary care will be a focus of the inpatient care planning process.

The inpatient care plan will be updated at any time there is a change in the condition of the tāngata whaiora or as appropriate to tāngata whaiora needs. This should include strategies that work to reduce restrictive practices such as restraint and seclusion.

The inpatient team will contact the keyworker and whānau to get their perspective on the inpatient care plan.

The inpatient care plan is to be documented in the inpatient care plan template appropriate to the context of care (e.g. adult, MHSOP, Forensic) on the clinical workstation (CWS).

Wellbeing recovery planning: The plan of care which includes both short term and longer-term goals advancing the health and social care needs of the tāngata whaiora towards recovery. This plan is collaboratively developed with the tāngata whaiora, is person centred and of which the tāngata whaiora has ownership.

The wellbeing / recovery plan will be updated based on the current context of the tāngata whaiora or as appropriate to tāngata whaiora needs and within a minimum of 91 days.

The community / rehabilitation plan will have a focus on transfer of care back to primary care.

Recovery plan dimensions:

The recovery plan is person centred and considers the following dimensions of health and social care needs:

- Te Taha Whānau – social environment and whānau needs
- Te Taha Wairua – spiritual needs
- Te Taha Hinengaro – mental or emotional needs
- Te Taha Tinana – physical needs

Note: for tāngata whaiora of diverse cultural identification the above dimensions should be considered under the most appropriate headings for their culture e.g. pacific cultures may associate with specific pacific oriented beliefs / model of care.

Recovery plans will support the cultural needs of the tāngata whaiora and whānau members of choice. At all times the recovery plan will have an emphasis on hope, support, education, self-advocacy and connectedness. The recovery plan will have personal meaning for the tāngata whaiora by including the specific cultural needs and desires and include responsibility for actions.

Goals identified as a component of the recovery plan will be person centred and whānau inclusive, measurable, and promote the tāngata whaiora to take the next steps forward in their recovery journey. A strengths-based approach will be utilised in addition to the identification of any problems / barriers / risks in the development of goals and interventions to be concentrated on. Prioritisation of one or two goals at a time may be useful. The working document needs to be both meaningful and useful for the tāngata whaiora.

Any tāngata whaiora self-initiated recovery plan and advanced directives provided by the tāngata whaiora will be considered in the process of recovery planning.

The tāngata whaiora will be encouraged to take increasing personal responsibility through self-directed care. Recovery planning is a process of collaborative understanding and shared making of choices.

The goals identified will be based on the most appropriate dimensions as above for the tāngata whaiora at any particular interval in the recovery journey and need to be based on what is a priority for the tāngata whaiora and in ICAMHS, include what is a priority for the whānau. Effective care planning involves choosing fewer interventions based on what is of the most importance for the tāngata whaiora.

The time frame for completion of goals and interventions will be appropriate to the health and social needs of the tāngata whaiora.

The recovery plan will identify who is doing what, when they are doing it, and why (the goals). Responsibilities will be clearly identifiable and may change dependent on circumstances.

If a tāngata whaiora is too unwell / not developmentally able, or not wishing to be involved in the recovery planning process this should be documented in CWS and a recovery plan based on current treatment needs formulated. Agreed whānau of choice may be able to participate in the process. Where there is an advanced directive this

should be utilised to provide information on the tāngata whaiora preferences for treatment when they are unwell.

Evaluation of recovery plan goals and interventions will be documented in the progress notes on the clinical workstation (CWS). Celebration of achievement of goals will occur on an ongoing basis.

If the recovery plan is addressing the transition of the tāngata whaiora out of the service then consideration of the tāngata whaiora risks inherent in the transition process needs to be carefully thought out and planned.

2.4.2 Recovery plans provide information on the support / interventions required to achieve desired outcomes

All recovery plans will provide measurable interventions to be implemented to achieve the desired outcomes of the tāngata whaiora and where appropriate the whānau of choice.

A recovery plan will include cultural and best practice interventions based on the tāngata whaiora identified strengths and needs. The plan will be flexible and evaluated at each point of interaction with the tāngata whaiora and more formally during multidisciplinary reviews.

2.4.3 Recovery plans link the care to be provided within the multidisciplinary team and across the health system

Recovery plans will include care provision by members of the multidisciplinary team, and be concentrated on the tāngata whaiora journey across the health care system.

All members of the multidisciplinary team will have access to the recovery plan and the plan will be shared across the continuum of care as is appropriate and with tāngata whaiora consent.

Staff will be mindful that the practice of collaboration is an important process for communication with tāngata whaiora and within the multidisciplinary team. Recovery involves developing good working relationships and a commitment to a culture of recovery-oriented practice.

Tāngata whaiora risks will inform the recovery plan.

2.4.4 Recovery plans identify early warning signs and interventions

The wellbeing recovery plan will include early warnings signs, stressors / triggers and person centred information on interventions to promote wellness and recovery. It will also include strategies for tāngata whaiora and whānau to proactively manage crises early on and that will guide clinician's responses when proactively supporting tāngata whaiora during crises.

The tāngata whaiora will be encouraged to share their early warning signs and stressors / triggers with members of their identified health care team i.e. whānau and service providers.

2.4.5 Recovery plans are developed in partnership with the tāngata whaiora, the provider of services, and the whānau as appropriate

The tāngata whaiora will be at the centre of the recovery planning process. Tāngata whaiora will be supported to lead and update their own recovery plans whenever practical, to participate in their evaluation, and be involved in multidisciplinary team meetings as appropriate to their care.

Methods of participation in the recovery planning process will be appropriate to the skills, developmental stage, needs, and wishes of the tāngata whaiora. Tāngata whaiora may choose to provide their own copy of a self-initiated recovery plan and advance directives which can contribute to the development of the recovery plan.

It is encouraged that the recovery plan will include the tāngata whaiora and whānau own words and phrases. In preparing the plan with the tangata whaiora they should be encouraged to consider any barriers / potential stumbling blocks and actions that can be taken to lessen the likelihood of these. A priority consideration is the ability of the tāngata whaiora to be able to achieve their goals. The recovery plan is continuously updated to meet the current needs / context of the tāngata whaiora.

Tāngata whaiora will have access to a copy of their recovery plan at all times. The most appropriate format and style of information on the recovery plan for the tāngata whaiora will be made available. Any recovery plan not in a CWS template will need to be uploaded to CWS.

With the consent of the tāngata whaiora, whānau will have access to the components of the recovery plan agreed by the tāngata whaiora.

2.4.6 Recovery plans are communicated in a manner that is understandable to the tāngata whaiora, the staff responsible for implementation of the plan, and with the consent of the tāngata whaiora and their whānau of choice

The following must be considered in the documentation of a recovery plan:

- The health literacy needs of the recipients of the plan. See Health Quality & Safety Commission 'Three steps to meeting health literacy needs. Ngā toru hīkoi e mōhiotia ai te hauora': https://www.hqsc.govt.nz/resources/resource-library/three-steps-to-meeting-health-literacy-needs/. Accessed 7 September 2022
- The age and developmental stage of the tāngata whaiora
- The person/s that the tāngata whaiora has consented to be involved in their recovery planning process
- The use of positive and respectful language. See document on Te Pou site: Real language, real hope https://www.tepou.co.nz/resources/real-language-real-hope. Accessed 7 September 2022

3 Patient information

A tāngata whaiora and whānau booklet will be available on recovery planning.

Posters will be displayed promoting tāngata whaiora and whānau involvement in recovery planning.

4 Audit

4.1 Indicators

National KPI on % valid recovery plans in ICAMHS

KPI measuring inpatient length of stay in adult mental health

Community Mental Health and Addictions services audit indicators:

- There is evidence that the tāngata whaiora has been involved in the recovery planning process in the clinical record (substitute whānau or career where appropriate)
- There are clearly defined goals from a person centred perspective
- The goals are in plain language and free from health jargon
- Early warning signs and stressors / triggers are identified and strategies to mitigate them
- There is evidence of whānau engagement in any part of the plan (e.g. it might be in EWS

Inpatient recovery plan audits are based on the Ngā Paerewa Health and Disability services standard (2021) criteria 3.2.1 – 3.2.7.

4.2 Tools

National KPI is monitored by the Business Analyst and information provided to the Mental Health Clinical Governance Forum monthly.

Community Mental Health and Addictions Services audit on recovery plans

Mental Health and Addictions Service Inpatient Tracer audit tool.

5 Evidence base

5.1 Summary of Evidence, Review and Recommendations

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Te Pou o Te Whakaaro Nui. Real language, real hope. Adapted by Caro Swanson, service user lead, from 'Recovery Language by Otto Wahl.

https://www.tepou.co.nz/resources/real-language-real-hope. Accessed 7 September 2022

5.3 Associated Te Whatu Ora Waikato Documents

- Mental Health and Addictions Advance Directives procedure (2181)
- Mental Health and Addictions Integrated Care Pathway policy (1703)
- Mental Health and Addictions Whānau Inclusive Practice guideline (5795)
- Mental Health and Addictions Keyworker procedure (1558)
- Mental Health and Addictions Working with Risk: Assessment and intervention for tāngata whaiora engaged with Mental Health and Addictions services who present at risk of harm to self or others procedure (5241)
- Mental Health and Addictions Clinical Workstation Recovery Plan template appropriate to the context of the service
- Clinical Records Management policy (0182)
- Informed Consent policy (1969)
- Nursing Assessment, Care Planning, Intervention and Evaluation policy (5285)

5.4 External Standards

- Health Practitioners Competence Assurance Act 2003
- Medical Council of New Zealand Standards
- New Zealand Nursing Council competencies for nurse practitioners
- New Zealand Nursing Council competencies for registered nurses
- New Zealand Nursing Council competencies for enrolled nurses
- New Zealand Nursing Council Guidelines for Cultural Safety, The Treaty of Waitangi and Māori Health in nursing, education and practice
- New Zealand Psychologists Board Competencies for Registered and Clinical Psychologists
- Ngā Paerewa Health and Disability services standards NZS8134: 2021
- Occupational Therapy Board of New Zealand Competencies of Registration and Continuing Practice
- Social Workers Registration Board New Zealand Core Competence Standards