Guideline Three

An assessment plan and collaborative assessment of needs should be drawn up which is both comprehensive and collaborative, and driven by the needs and preferences of the client and their relatives and friends.

Background

The needs and preferences of clients embrace areas that are not always consistent with the needs identified by care professionals, yet the meeting of such needs holds the key to engagement (Sainsbury Centre For Mental Health, 1997).

Requirements

1. A full assessment will incorporate mental state, vulnerability, psychosocial factors involving both the client and their family (see Tool Kit).

2. The client's expressed needs should be given priority in the formulation of an intervention plan.

3. Mental state assessment during the acute and recovery phase should follow normal clinical practice. The recovery phase is a high risk period for early relapse, and suicidal thinking should be carefully monitored.

4. Assessment and action plans are likely to need review more frequently than statutory requirements. We would suggest assessment at six weekly intervals initially.

Getting it right....

An 18 year old young man living alone accessed services via his college tutor who was concerned about his general well being, self-care, vagueness and social isolation. He ensured that the GP, social services and mental health professionals were informed. The concerns were discussed with his family. A professional assessed and collaborated on a needs plan to promote his well being. The plan was devised with him to meet his health, social and occupational needs as well as those of his family.

Where things can go wrong....

John had a history of criminal behaviour with some risk of violence and was known to probation services. He also had a learning disability. He

was admitted to hospital in crisis with psychosis under the Mental Health Act via the police station after a disturbance at home. His mother, who had physical health problems, was frightened of him. Some professionals felt that his parents were disinterested owing to non-attendance at ward rounds (at a hospital 10 miles away). No advice was sought from the learning disabilities team. He was discharged home whilst follow up was still being negotiated.

Ask Yourself.....

- Is there a care plan available to the client and family and friends (and shared by professionals)?
- Does the plan reflect needs other than those met by health resources, eg, financial concerns?...
  If not, it probably should!

National Service Framework Links: Standard 4 requires a comprehensive care plan to be available within the Framework of the Core Programme Approach, to involve all players: client, carer, professional