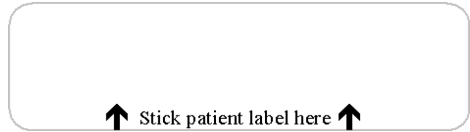
Te Whatu Ora
Health New Zealand

Treatment Plan MHSOP Otago



Preferred Name: ______________________________

Treatment Goals (including time frame)
Consider including: safety/risk, physical, mental, emotional, social, lifestyle, spiritual, cultural, health promotion, activities for wellness, education planning for discharge/transition, establishing links, care/safety of dependants
Risk assessment and formulation: (Refer to Risk Sheet)

Interventions (including location and frequency)	**Who is responsible**

How will progress towards the goals be monitored/first review date?
How was the client (whānau) involved in developing the treatment plan?

Treatment plan completed by:
Name: Designation: Signature:

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Consumer Treatment / Review Form [Manual Completion] MHAID Service (District)

Surname:		NHI:
Preferred name:	DOB:	Age:
Ward:	Consultant:	
Address:	Phone number:	

Date:	☐ Community	Team ☐	Psychiatrist:	Case manager / Key worker:
Last review date:	☐ Inpatient & length of stay	Reason for review ☐ Initial ☐ Routine ☐ Clinical concern ☐ Discharge		MHA/section:

Meeting attended by: (name and designation):
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Psychiatric Diagnosis/es Diagnosis recorded in iPM ☐
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Brief summary/vignette from admission (include any physical aspects of note)
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....
....Trauma History: Yes ☐ No ☐

Risk management reviewed ☐Yes ☐ No ☐ Refer to Risk Assessment Toolkit
Additional risk factors and comments: ....
....
....

Family violence screen Positive ☐ Negative ☐ Date: If not reviewed give reason: ....
....

Treatment goals: *(long- and short-term goals) discussed with consumer* ☐Yes ☐ No
(Linked to comprehensive assessment / assessed needs, Integration of primary and secondary services, effective community links, use recovery/resiliency focused, SMART goals, & include outcome measures e.g. HoNOS Items 2-4.)
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Consumer's goals
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Summary of progress. *Review previous consumer treatment goals from the last clinical review – note any outcomes, those achieved*

	Date/sign
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Name: ______________________________ NHI #: ______________

Interventions/plans for monitoring current and ongoing treatment goals	Frequency/date & location	Person(s) responsible
………………	………………	………………
De-escalation strategies to reduce seclusion and restraint ………………	………………	………………
Coexisting problem interventions ………………	………………	………………
Safety / risk issues – Plan in place? ………………	………………	………………
Medication/reviews/changes/consumer informed? ………………	………………	………………
Physical /dental health checks; metabolic monitoring; blood tests due? ………………	………………	………………
Other: ………………	………………	………………
Discharge planning: ………………	………………	………………

Shared transition/Wellness Plan completed: Yes ☐ No ☐

How were family/whānau/significant others involved in developing or reviewing this plan?
(Any risk issues discussed?)
………………
………………
………………

Consumer signature		(*if not signed by consumer, please state reason)	
Completed by:	Signature:	Designation:	Date:

Copies to ☐ Consumer ☐ GP ☐ Family (Who) ☐ Other (Who) ☐ DAC (Southland)

☐ Outcome measure completed ☐ Clinical review updated in iPM	Next consumer review date: ☐ Weekly (inpatient) ☐ 3 – 6 months ☐ N/A ☐ Other
Referral sent Yes ☐ N/A ☐ Signature:	

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Continuation Treatment Plan
Inpatient Mental Health Unit (Southland)

Surname:		NHI:
Preferred name:	DOB:	Age:
Ward:	Consultant:	
Address:	Phone number:	

Problem / Need:		
Objective:		
Interventions:		
Review Frequency:		
Outcomes / Review:		
Signature & Designation:	Date Commenced:	

Problem / Need:		
Objective:		
Interventions:		
Review Frequency:		
Outcomes / Review:		
Signature & Designation:	Date Commenced:	

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Te Whatu Ora
Health New Zealand

Continuation Treatment Plan
Inpatient Mental Health Unit (Southland)

Surname:		NHI:
Preferred name:	DOB:	Age:
Ward:	Consultant:	
Address:	Phone number:	

Problem / Need:		
Objective:		
Interventions:		
Review Frequency:		
Outcomes / Review:		
Signature & Designation:	Date Commenced:	

Problem / Need:		
Objective:		
Interventions:		
Review Frequency:		
Outcomes / Review:		
Signature & Designation:	Date Commenced:	

Continuation Treatment Plan – Inpatient Mental Health Unit (Southland) MR1194 V2

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Treatment Plan

Forensic Service
MHAID Service (District)

Surname:		NHI:
Preferred name:	DOB:	Age:
Ward:	Consultant:	
Address:	Phone number:	

Current location:	Court dates:	GP:
DOB:	Age:	Legal status:
Lawyer:		Current leave status:
Index offence:		
MHA review due:		
Consent to treatment date:		
Clinical risk management system:	☐ Yes	☐ No
Date of treatment plan:		
Current medication:		
Current diagnosis:		

Brief psychiatric history and history of index offence:

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Current contextual risk formation:

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Current clinical presentation:

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Culture, religious and social values are to be recognised within all goals and interventions throughout this document. All consumers identifying as Māori will be referred to Māori Mental Health Services, all other consumers may request an assessment from Māori Mental Health Services.

Name:______________________________________ NHI:____________________

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Therapeutic Issue: Mental Health
Issues:
Goals:
Interventions, timescales, responsibilities:

Therapeutic Issue: Addiction Issue
Issues:
Goals:
Interventions, timescales, responsibilities:

Therapeutic Issue: Risk to self
Issues:
Goals:
Interventions, timescales, responsibilities:

Therapeutic Issue: Risk to others
Issues:
Goals:
Interventions, timescales, responsibilities:

Therapeutic Issue: Leave
Issues:
Goals:
Interventions, timescales, responsibilities:

Therapeutic Issue: Physical health
Issues:
Goals:
Interventions, timescales, responsibilities:

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Name:_________________________________ NHI: ______________________

Therapeutic Issue: Relationships / Family
Issues:
Goals:
Interventions, timescales, responsibilities:

Therapeutic Issue: Self-care
Issues:
Goals:
Interventions, timescales, responsibilities:

Therapeutic Issue: Finances
Issues:
Goals:
Interventions, timescales, responsibilities:

Therapeutic Issue: Occupational / Education / Leisure
Issues:
Goals:
Interventions, timescales, responsibilities:

Therapeutic Issue: Accommodation / Discharge Planning
Issues:
Goals:
Interventions, timescales, responsibilities:

Therapeutic Issue: Admission location when unwell
Issues:
Goals:
Interventions, timescales, responsibilities:

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Name: ______________________________ NHI: ____________________

Legal Issues: Reports pursuant to s.38, 23, 34 P (MIP) Act 2003, parole reports, report writer, timeframes / court dates
Issues:
Interventions, timescales, responsibilities:

Completed by:
Signature:

Patient / Client comments / involvement / family (whānau) involvement:

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Patient / Client name:
Signature:

Please note if patient / clients declines to sign then include reasons, if known.

People present at MDT	

Date sent to EPS / SMHET:
Date iPM updated (transition plan etc.):

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Ward 9A Contingency Plan MHAID Service (Otago)

Name: NHI #

Ward 9A DOB:

Date of Plan: Expected review date:

Contingency Plan / Risk Management			
DASA Scores: 0-1 Green; 2-3 Orange; 4-7 Red			
Category	**Relapse Indicator / EWS / DASA**		**Contingency Actions**
Symptoms of Mental Illness	GREEN	Compliant with Rx meds, stable or no symptoms of psychosis/mood disorder	Continue with current plan
	ORANGE	Some –ve Sx, EWS present, poor engagement, brittle, poor motivation , poor self-care	Need to increase supervision and monitor, inform RC next working day, utilise PRN meds, reduce leave
	RED	Non-compliance, significant change in mood and MS, poor symptom control, evidence of relapse	Increase supervision, RC and treatment team to review plan esp leave, medications, movement about the ward, association with others, suspend ALL leave

Category	Relapse Indicator / EWS / DASA		Contingency Actions
Substance Misuse	GREEN	No AOD evidence, compliant with testing, testing –ve, engagement with treatment	Continue with current plan
	ORANGE	Suspicion of substance use, reluctance to comply with testing, no firm evidence of AOD use, substance seeking/interest behaviour	Monitor, review plan and limit access to opportunities for AOD access esp leave off ward.
	RED	Evidence of AOD use, intoxication, non-compliant with testing, impact on MS, potential for violence increased	Urgent review of treatment and care, increased monitoring, suspend ALL leave

Category	Relapse Indicator / EWS / DASA		Contingency Actions
Engagement with Treatment	GREEN	Fully attending and engaged with treatment and program including appointments	Continue with current plan
	ORANGE	Occasionally misses appointments, slow to respond to prompts, complains and attempts to negotiate plans and interventions	Review current treatment Explore issues with particular staff/situations
	RED	Disengages, evidence of MS deterioration, open suspiciousness and avoidance of staff	Urgent review of treatment and care, increased monitoring,
	BLUE	Unauthorised leave / AWOL	On location: UDS, urgent immediate medical assessment, review of treatment and care, increased monitoring, limitation of movement about ward and engagement with others. Suspend ALL leave. Consider increased risk to self

Category	Relapse Indicator / EWS / DASA		Contingency Actions
Violence / aggression	GREEN	MS stable, engaged, verbal responses appropriate for given situation	Continue with current plan
	ORANGE	Suspiciousness and feelings of being persecuted, minor verbal hostility not in keeping with situation, minor escalation in physical signs of agitation threatening in manner	Assess for relevant PRN medications, limit leave, increase supervision, offer distraction, sensory modulation and resolution where possible
	RED	Actual violence, direct threats or verbal hostility of a serious nature. Conversely, sudden withdrawal, sullenness, suspicious when interacting with others	Urgent review of treatment and care, increased monitoring, limitation of movement about ward and engagement with others. Suspend ALL leave Consider increased risk to self

(*if not signed by consumer, please state reason) *Consumer signature:

Completed by:

Name: Date: / / Signature:

Designation: RN

Copies to: ☐ Consumer ☐ EPS ☐ Family ( ) (state who) ☐ Other ( ) (state who)

Ward 9A Contingency Plan

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What have I achieved since I first came to CAFS

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What else do I want to work on

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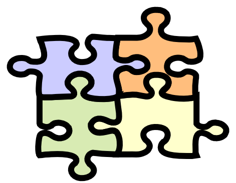
Date:……………………………………………

I also achieved



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Transition from CAFS:
My plans for follow-up support with other services

Service name:

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Key contact person/number:

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What will I need from these other services?

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My medication……………………………

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My signature……………………………

CAFS worker……………………………

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Southern DHB 87540 V1
Released 20/07/2021

Child Adolescent and Family Service
0800 443366

My Plan

(Wrap, Strengths & Transition)

Name……………………………

Child Adolescent and Family Service

Goals: Things I want to work on or changes I want to make

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....
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Date...

Just in case plan

When things seem to be getting worse what action needs to be taken by family (whānau) / caregivers

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I have shared this plan with:

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I will know I am doing well when:

Describe what you do when you are feeling okay

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The alarm bells that tell me I need some help

Such as over-reacting, withdrawing, crying, being grumpy, lack of motivation or concentration, avoiding people or things, getting stressed

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What sets off a change

What are the things that effect me being healthy or having a good life: school stress, being bullied, getting tired, rejection, criticism, particular worries?

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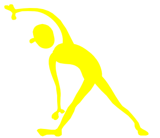

Strengths toolbox to keep me on track

Personal qualities or skills. Community resources. Family and friends. Hobbies or activities such as exercise, eating well. What helps or has helped in the past?

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My Shared Wellbeing Plan

This is a great opportunity for you to share what's important to you and your wellbeing, your hopes and dreams, your support people, your whanau, your goals and aspirations.

This template is for you to take away and take time with. Once completed, your Mental Health support team will put this information in your clinical file – and can give you a copy. This is your plan, you are the author of your own wellbeing. You are welcome to update the plan at any time – just let your Mental Health support team know.

Like all your health-related information, this is confidential and it is only shared with your General Practitioner and the District Health Board people directly involved in your care.

My name and date of birth (and your NHI number if you know it)

My iwi (if you identify)

My Journey

What's important to know about me, where I've come from, where I'm at currently, and where I want to be.

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Who's important to me and involved in my care

e.g. Family/whanau; GP; other healthcare people; community support agencies and organisations; cultural and spiritual supports

Name	How they support me	Phone Number	Share this Plan with them ?

Things I can keep doing to support my recovery, wellbeing and to stay well

e.g. Eating and sleeping well; working; social contacts; taking my medications; seeing my support people; learning new things; exercising; spending time with my friends/whanau etc

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What I am good at and what I would like to do (strengths)

e.g. Work; school; art; taking care of my whanau; keeping appointments with support people; exercise; blogging/social media; supporting my friends/whanau; looking after my pet(s) etc

Things that challenge my wellbeing

e.g. Alcohol and drugs; relationship issues; socialisation issues; worries about kids/family; functional problems; physical or cognitive challenges; loneliness; poor sleep; stress; boredom; issues with accommodation and/or other support needs; financial issues etc

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My early warning signs & coping plan

Things I know happen when I am not feeling well e.g. Sleeping poorly; eating pattern is different; energy levels are higher or lower; not communicating with friends/whanau/support people; stopping medication; dark/negative thoughts; whanau is worried; not enjoying things, etc	What I can do, and who can support me e.g. Distraction; activities; call my support people; medications; exercise; music, etc.

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Additional information

e.g. Family/Whanau responsibilities, children, grandchildren, parental responsibilities, comments or needs; pets; legal status; physical conditions / treatments; allergies, etc

Other Relevant Documents

For example, Mental Health Advance Preference, Safety Plan

Document	Details (including where the document is located)

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My Goals and Aspirations

Actions I am taking to fulfil my Goals and Aspirations

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