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CONFERENCE ABSTRACT

Collaborative Care Planning: Introduction to an innovative approach to Care Planning in Adult Mental Health.

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Care Planning forms the core activity undertaken by mental health services in their work to support individuals experiencing mental health difficulties back to recovery. The Care plan provides the template for all subsequent interactions between the service user, families/supporters and the mental health team in implementing interventions and in supporting positive change.

The traditional approach to care planning in mental health is hugely problematic in being ad hoc, opaque, medically-oriented rather than multidisciplinary, directive rather than consultative, illness-focused rather than recovery-focused, and in many cases not understood or agreed by the person concerned or their family/supporters. Many service users are not provided with a record of the proposed care plan.

Collaborative Care Planning (CCP) is based on intensive multidisciplinary assessment of biopsychosocial factors underlying the person's distress, leading on to Multidisciplinary case formulation (using the '5-Ps model' of McNeil et al i.e. presenting problem, predisposing, precipitating and perpetuating factors, as well as positives and strengths.) and care planning. Family members/other supporters are intimately involved in this process, with consent. The Care plan interventions arise from and directly relate to difficulties identified using the 5-Ps model. The process is coordinated by a key worker. Once the Individual Care Plan is drafted, the key worker provides extensive feedback to the service user, (and with consent, to family members/supporters), and provides copies of all relevant Care Plan documentation and of related psycoeducational material. The Care Plan is adapted at that point depending on the wishes/preferences of the service user. CCP is labour intensive (requiring approximately 20 hours of clinical time per care plan). However, this investment of human resource is recouped from the increased capacity of the process to anticipate and manage acute crises, and the facilitation of early discharge to community/primary care services. CCP has been found to cost-effective (Gibbons et al, 2012), due to the decreased demand for expensive inpatient care.

CCP radically alters the relationship between the service user, family and mental health team so that this relationship becomes a dialogue (and often, a trialogue) leading to a shared understanding of problem areas in a person's life, and to the identification of a range of

options to address these difficulties, forming a menu of from which the person chooses to advance their recovery. This dialogue aims to engender a realistic hope for positive change, and facilitates the person to take ownership of the change process to an increasing degree as recovery progresses. Families are consulted, both as part of the assessment of need and understanding problems, and as part of the review of Care plan options (with the person's consent), thus being enabled to provide invaluable support for recovery interventions and change.

Keywords: collaboration; care planning; recovery