4As Framework: Anticipation

Anticipation and planning are what empower people who have been seriously affected by mental illness to make the decisions they choose, rather than have decisions imposed on them and lose control of their life. A sense of personal control and efficacy is essential to wellbeing, yet this is something that is often lost through current service approaches that do not operate with a focus on recovery.

Planning needs to be undertaken on several levels:

- self-management plans;
- recovery plans;
- plans for continuity of care; and
- crisis plans.

Foremost, there is a great deal that the person him/herself can undertake in terms of self-management. Self-management entails taking personal responsibility for one's health. It involves: health and medical management, which includes taking medication as required and other health actions that correspond to the risk and protective factors for mental health; role management, which means developing life roles that support ongoing mental health; and emotional management to deal with the psychological impact of coping with living with mental illness.[3] Self-management requires skills in problem solving, decision making, resource use, forming partnerships with service providers, action planning, and being able to individualise health actions and interventions to be most appropriate for oneself.

Recovery plans can be self-managed or developed in partnership with family, carers, and service providers. Recovery plans need to identify, address, and communicate all the factors that impact on relapse prevention, rehabilitation and recovery. Plans should cover early warning signs of illness, risk and protective factors for mental health, rehabilitation goals, and short and long-term goals for recovery. Such plans may be explicitly communicated through written agreements or journals, and should be reviewed and updated regularly.

For people who have been in an inpatient setting, effective discharge planning is essential to ensure continuity of care into the community. Discharge planning should start at admission with a review of any previous discharge. If, for example, a person has returned to the service within a 28-day period, a major review of the previous discharge processes should occur.

Discharge planning should progress throughout the person's inpatient stay with an increasing focus on continuing care when back in the community. Discharge plans need to be holistic, covering not only medication, but also agreed responses to early warning signs of illness and risk and protective factors for mental health, as well as goals for rehabilitation and longer-term recovery.

Plans must be developed in true partnership with the consumer, their family and carers, as well as the GP and the other service providers required for support in the community. Responsibility for coordinating the continuing care service response and ensuring access to services must be clearly assigned, and this may involve someone in

the role of ‘case manager’ or care co-ordinator. Discharge plans need to specify pathways for a step-down service approach to work towards self-management within the community and pathways for a step-up service response if the need arises.

While the importance of effective discharge planning is most evident for discharge into the community from an acute setting, discharge from *any* service is a critical transition point. Continuity of care and integrated care are based on collaborative planning and communication between services that ensure the next steps to support a person’s wellbeing are put in place and fully implemented.

Crisis planning enables consumers to specify their preferences if they become acutely unwell. Paradoxically, preparing for a crisis can prevent its occurrence or reduce its escalation if it does occur. Consumers, their family and carers, and service providers need to be able to identify the signs of an imminent crisis and agree on the step-up responses to be taken by all the relevant parties.

Anticipation and planning are enabled through trust, communication, and ongoing collaborative partnerships. They are ideally undertaken when a person is relatively well and able to make decisions, and need to encompass all the actions and supports the person may need to draw upon to support their wellbeing. Agreements need to be negotiated between all the parties identified as necessary to supporting a person’s wellbeing, and might involve any or all of the people and services identified in Figure 2 (eg, consumer, family/carer, GP, care coordinator, housing provider, employer, rehabilitation services, etc).

Major barriers to effective planning are privacy and confidentiality concerns, and protection of professional ‘expertise’. These can be overcome if plans are explicitly negotiated through written agreements, and if the wellbeing of the consumer is prioritised and recognised as the shared goal of all the service providers.

Anticipation and planning must always be undertaken in ways that are developmentally and culturally appropriate for the individual concerned. Planning has to be relevant to the life-stage of the person, and take into account their level of maturity, personal and family circumstances, and cultural background.

People require varying amounts of support for anticipation and planning, depending on factors such as their age and current health status. Some people are self-sufficient and can self-manage their mental health, and this should be supported and encouraged. Other people have complex needs and require an ongoing case management approach to coordinate the many and varied service responses, both clinical and psycho-social, they require to maximise their wellbeing. Most people will vary somewhere between these extremes.

At all times, it is important to develop the capacity of the person to self-manage their own wellness needs to the extent they are able. This means empowering people through information and support that is appropriate to their current life circumstances. Services need to adopt a ***“You can do it - We can help”*** approach. Effective communication and collaboration at all levels, frequent review, flexibility, and a personalised approach with the consumer’s wellbeing as the priority, enable this type of service approach.

Importantly, anticipation and planning have to be realistic. This means taking small steps with achievable goals to ensure success. It also means taking into account the availability of services to support mental health. At present, few communities provide

all the potentially necessary supports. Some communities are especially disadvantaged in terms of access and alternatives due to remoteness or unique cultural needs. Such realities must be acknowledged, and innovative and collaborative approaches to anticipation and planning found to eliminate barriers to access. At the same time, advocacy for increased resourcing of the mental health system, commensurate with need, must be undertaken by all those with an interest in mental health.

Outcomes

To implement the Anticipation component of the 4As Framework, the following outcomes need to be achieved:

- Self-management of mental health is encouraged and supported at all levels.
- Routine planning for relapse prevention, rehabilitation and recovery occurs throughout the mental health service system.
- Effective and appropriate discharge and continuing care planning is implemented in all services.
- Crisis plans are available and implemented.