ARTICLES

"Whose Plan is it Anyway?"... Reimagining person led planning

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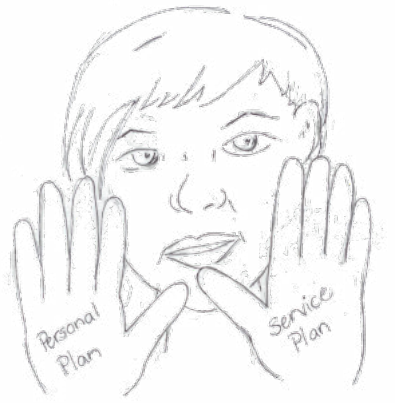
In 2021, many mental health organisations around the world claim to be recovery-oriented. Such claims must never remain in name only, and must clearly demonstrate how service offerings intentionally foster opportunities for people to lead and live their best life, beyond impacts caused by mental illness/ distress. This has, and will ever challenge even the most intentional recovery-oriented services and 'help-providers' . It requires a constant vigilance to program design and logic that aligns its principles, policies, personnel, practices, processes, planning and performance to 'help-seekers' recovery requests. Ultimately, such alignment should create service opportunities where help-seekers experience greater confidence and competency to navigate and overcome the mental health challenges they face.

This paper aims to regenerate and reposition service planning processes within the helping encounter. I am reminded of the adage credited to Benjamin Franklin," that those that fail to plan, plan to fail" and wonder if this may be one reason that many of us have become stuck or lost in either providing or accessing help. Has the time arrived to shift beyond popular person-centred planning processes, still orchestrated and generated by help providers, to planning detailed help-provider responses that are responsive and accountable to those that help-seek?

Personal Plans and Service Plans: have we confused their purpose?

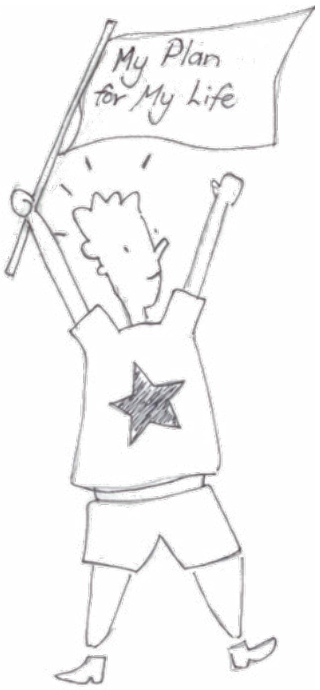


"My personal plan is not a service plan. The service plan is not my personal life plan.
Both are relevant but are not the same as each other."

Traditionally, plans have focussed on activating help-seekers' towards achieving goals, either self -determined or determined by others. Planning is commonly resisted by both help-providers and help-seekers. Common help-providers' outcries against planning processes, especially collaboratively, have been: "I don't have time", "It is just the paper work we have to do", "it doesn't make a difference to what I do", and "people don't know

-Help-Providers is the term used in this paper to identify those that offer help, either natural or paid to help seekers.
-Help-Seekers is the term used in this paper as those that seek help from others.

what they want". From those who seek help there is also resistance to be involved in planning processes: "they ask me what my goals are but other things get put down "," it is the same plan we did last time", "they already have a plan and my hopes are just after thoughts ", or "they just use the plan to monitor me".
The mental health sector world-wide has developed a plethora of planning tools with multiple planning purposes: case management plans, individual service plans, individual support plans, individual recovery plans, personal-centred plans, personal wellbeing plans, risk management plans, crisis plans, relapse prevention plans, care-coordination plans, just to name a few. This list may give you the impression that all plans differ in their purpose but they may be much more alike than they are different. They are either **Personal Plans** or **Service Plans.**



Personal plans are initiated, generated, monitored and owned by the person. They are built around what is important to the person, their aspirations and dreams. They are deeply personal. They belong to the person. They take many forms and unlikely resemble a service plan format, as they are currently known. People develop their personal plans using graphics, photos, and other creative ways to express what is important to them to achieve. Personal plans should never be owned, monitored, copied nor stored by an organisation. A person's life goals and aspirations are not the business of services and should never be articulated on a service plan!

Service plans are generated by the help-provider to guide and account for their service provision to a help-seeker. Service plans are a useful communication tool to ensure the relevancy and fit with the help-seeker's self-mastery (Moore, 2016). Service plans do not contain help-seeker's life goals but the goal of the service intervention offered. It must be remembered that help-providers' key performance indicators (KPI's) are not the help-seeker's business or goals nor vice-versa.

Help-providers often argue that their 'individual recovery plans' capture both personal and service plans together. This is problematic. It creates confusion as to the help-provider's role in a help-seeker's life. Recovery work belongs to the person. It is ongoing, it happens in many life arenas, mostly beyond services. Help-providers cannot take responsibility for a person's recovery work, nor take credit for their outcomes or achievements. Services however can and should take responsibility and credit for creating relevant opportunities that people find useful in undertaking their recovery work.

Who is accountable for the plan?

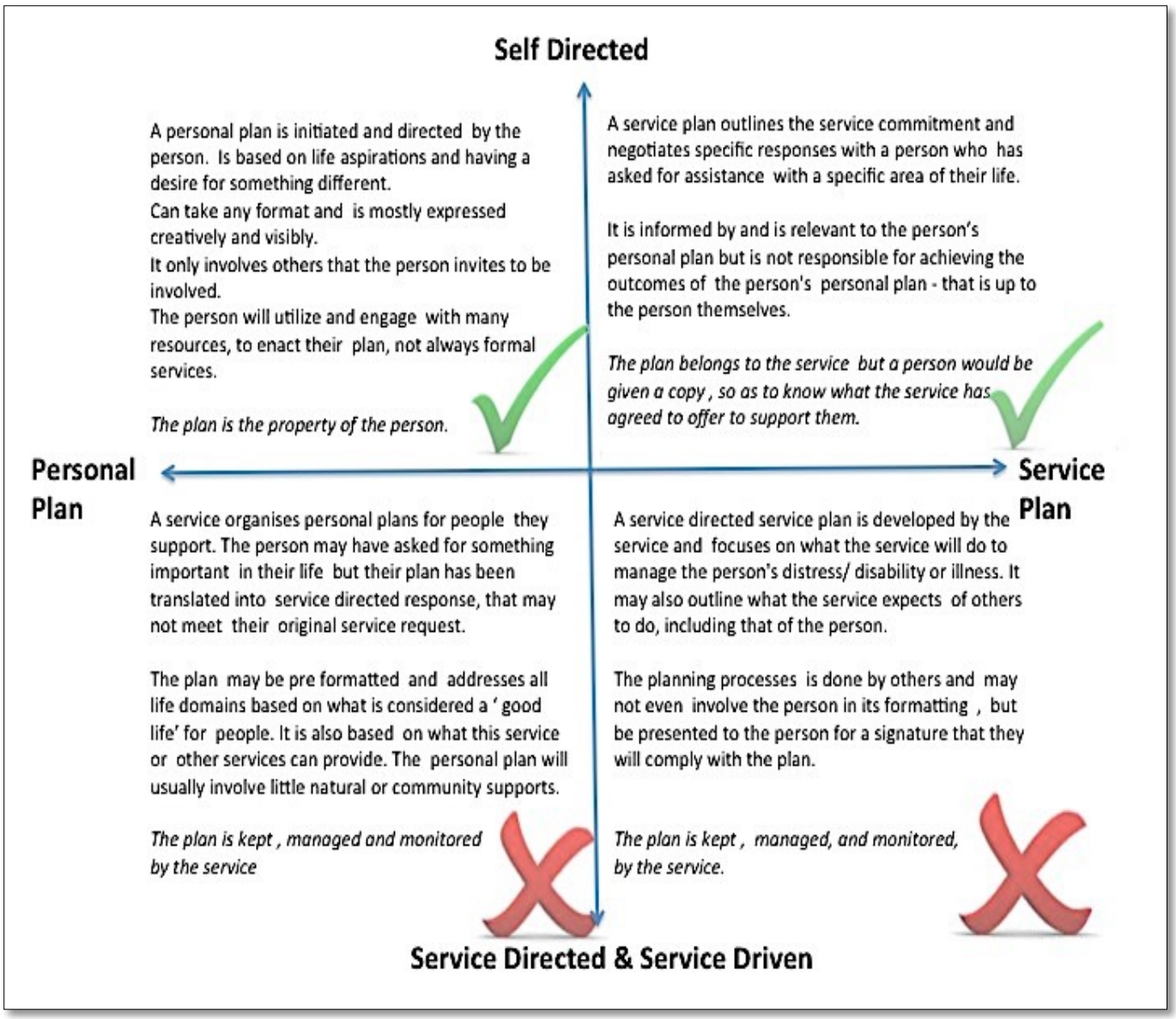
"The hand that holds the pen, holds the power " (Tran, 2021)

We can only activate a plan if we are its author. We cannot write a plan for another and expect it to work, no matter how well designed or well-serving. Only the plan's author can activate it, modify it, monitor it, and celebrate its success. It is extremely unlikely, if not impossible, for a person to reclaim a life beyond the impacts of mental illness when they are excluded from problem solving, making decisions, and informing direction. In this work it is vital that, "people's right to self-determination should never be removed or denied. For

people who experience mental distress this right must be intentionally protected "(Mind Life, 2021)

Some years ago, I accessed my psychiatric medical records under the Australian Freedom of Information Act. I did not recognise me, or my understanding of what was happening for me in most of what was noted. I had to check and recheck several times that I was reading my file and not someone else's file. What surprised me was that it did contain several 'care / recovery' plans. These were compliantly completed, typed out with all the relevant boxes filled in. It surprised me because I did not know they existed. Despite that I had not informed their creation, every action had my name in the column of who was responsible for carrying the recovery objective. Had I missed something, not turned up to a meeting? Had I agreed to something that had conveniently slipped my mind? Looking further I realised that these plans were created in absentia; for me, about me, without me and not of me. The stated recovery objectives were: (1) Helen will become compliant with her medication and associated treatments; (2) Helen will develop insight into her illness, and (3) Helen will agree to not abscond.

This was not my personal plan, nor was it a service plan and on reflection, it was no wonder that it served to keep us all stuck. It was a service-generated plan with service-generated goals, it said nothing about the professional offer aligned to the recovery challenges that I was seeking help to overcome.



It is vital to ensure plans are self-directed or personally driven and not service generated (Fig. 1). In simple terms, service-driven plans are generated and organised by the help-provider/service in isolation of the help-seeker. It should not be surprising that most service generated plans will be ineffective if not designed collaboratively with the help-seeker.

Service generated plans are sometimes mistakenly created as replacements for personal plans, especially if a person has not had an opportunity to develop ideas of what is important for their life. This should be resisted at all costs as (Bates, 2002) warns that, ' the tools and processes of person-driven planning can be used to manipulate the person into compliance with the service system or with powerful others. However, this is not person-driven planning, any more than sawing up firewood is carpentry.'

Person driven service planning processes does not happen without equal collaboration. Collaboration starts with humble inquiry, interest and deep appreciation that both help-providers' and help-seekers' knowledge must work together to plan the service provision, ensuring fit and relevance to the help-seeker over other interested stakeholders.

No one seeks help from a mental health service without experiencing some level of risk or vulnerability. We mostly seek help when we experience barriers or boulders that stop us from being able to fulfil our needs with ease. Such boulders may be in the form of limited knowledge, skills, resources, confidence, or support. Help-providers who are clear in this, resist transactional encounters centred around goal attainment alone (Vaughan, 2021). They will instead inquire about, what stops a person attaining what is important, what they wish to get stronger at, so they can live and lead their life well, and what contribution they would like the help-provider to add to their team. The help provider focuses on transformational outcomes, aiming to leave a help-seeker with the personal mastery and sustainability to influence and navigate the vulnerabilities and challenge they experience.

Who is the leader in the help seeker– help provider relationship?

When providing team supervision, I often ask help-providers, "who is the team leader of this work, who are you accountable to"? They usually name a superior within their organisation that they report to. They rarely name the person they are providing services to as the team leader of the team. Someone I was working with once asked, "if I am supposed to be the CEO [Chief Executive Officer] of my life how come I am the last person to know what has been planned and no one sees they have to account to me for their work?"

The terms self-directed or person-led may convey messages to help-providers and help-seekers that recovery work has to be done solo, without assistance. There are very few of us that are independent and autonomous enough to not require assistance in how we negotiate our needs and every day actions. Seeking help from others does not require a resignation from being the team leader of our life. Ideally and ethically, if invited onto another person's team, as a member, we would be clear in the purpose, our requested role how it aligns to the leader's vision, our expected performance as well as the overall team processes. Our tenure as a team member should not be considered permanent.

Not so long ago I was a patient in intensive care requiring significant help from a range of medical specialists to survive. They were in and out of my room many, many times a day yet always communicating with me what they were doing and why. As I got better they referred to me as the Team Leader. I looked at them quizzically as I was totally trusting their knowledge and skill to get me better, believing that I had little role except to rest and

let them do their job. They quickly explained that they needed me to be the team leader as I was the only constant member of the team. Many people were involved and could easily make a mistake. They needed me to hold the complexity with them and for each team member to be accountable to me for their specialised interventions. This was novel and refreshing and left me wondering if this can happen in intensive care can it also routinely happen within mental health settings.

Inviting help-seekers to become the team leader of their own life, and select the right team members, is not necessarily easy for those who have been locked out of this role for some time. Challenges in adopting their team leadership can stem from, fear, self-stigma, limited self-directing opportunities, negative system experiences, and previous low expectations. Help providers may have to re-think how they invite help-seekers to guide them. This is less about activating or motivating people to be the team leader and more about help-provider's relinquishing the team leader role in a help-seeker's life. Stretching beyond taking responsibility for a help-seeker's life outcome to being responsible to them is an important shift. To do this help-providers must fundamentally believe, relate to and recognise help-seekers' existing resiliency, inner wisdom and self-leadership capacities, and resist the urge to adopt paternal relationships. Even when such personal agency is not easily visible it is imperative that help-providers honour its presence, even when they don't see it, because it does exist and will emerge.

Imagine if the service plan was flipped

Most service plans layouts and subheadings remain oriented to activating the help-seeker and seeking their commitment to undertake tasks to meet their goals. Such planning artefacts strongly communicate held beliefs as to who we are in each other's lives, our responsibilities, sense of power, and the role that self-direction plays.

"You can play a role in my life, but not the lead".

There are many resources in our community that can assist us to live and lead out best lives.

Outside OURSELVES as a major resource we have NATURAL CONNECTIONS such as friends, family, acquaintances. We also have COMMUNITY RESOURCES such as libraries, community centres, sporting groups, spiritual places, interest groups, educational facilities, health centres etc. We also have the vast ONLINE RESOURCES at our fingertips. If these resources are not exactly right we can also access specialist health and community services.

Life Area	Who Would I ask?	What assistance would I request?

Imagine if the tables were turned where a help-seeker was to request from a help-provider specific self -mastering help and in turn the help-provider was accountable to the help-seeker for their service provision (Fig 2.). The service plan artefact would therefore be set up differently with the plan belonging to the help-provider, outlining their offer, success indicators, tenure expectations, and service risk mitigation strategies. (Fig.3). Making our assumptions explicit, within planning artefacts, strengthens how person driven service planning is undertaken and experienced.

Figure 2: Excerpt from Lead My Life Self Inquiry (Glover, 2017)

Figure 3:Example Person Driven Service Accountability Plan Domains

The Service Accountability Plan

[to be completed with and only after conversation with help seeker]

Help Provider's Name. _____ accountability plan for working with... _____the person/team leader's name)
[the owner of the work plan],

Date _____	Date of when the plan will be reviewed by the help seeker and help provider as to its effectiveness. _____
The self- mastery/overcoming help requested from the help-seeker/team leader is .	
Problem identification of what is getting in the way of self-mastery or overcoming is ...	
Identification of existing initiatives (so the help provider does not duplicate them).	
Identification of initiatives already proven to not be useful (so the help provider does not repeat them).	

Identification of the range of support or treatment options that the help provider could provide, along with their associated helpful contributions, limitations and risks to the person's sense of self mastery.

Service Provision objective	Service Provision details	Help Provider	When/ Where/ for how long	Anticipated help/self-mastery indicators	Associated risk in delivery to the person
					[add more rows with each service provision objective]

Commitment

I _____ *[Help Provider's / team member]* can be held accountable to_____ the help/seeker's team leader's name) for the delivery of this plan.

I _____ *[Help provider's manager]* agree to this plan acknowledging that the organisation has the resources to deliver it.

_____ [Help provider's / team member's signature]. _____ [Organisational Manager signature].

I _____ *[Help seeker/ team Leader]* agree to this plan that it has been designed collaboratively and aligns to my recovery needs. I agree to review this service plan with the help providers at the agreed review date nominated above. _____ [Help seeker/ team leader signature].

[signed copies to be given to all parties

Conclusion

In conclusion, the following Person Driven Service Planning Manifesto may act as a useful starting point to renegotiate planning in either your own life or when invited into the lives of others. Such assumptions must be able to be upheld with all people at all times and be clear enough to guide help providers in in their day-to-day practice.

1. We view and relate to the help seeker as the team leader of the team. We recognise that it is the team leader who selects and deselects us as help providers based on our specific skills and attributes. When we are effective in our work there will be a time when our role becomes redundant. This is what we strive towards and celebrate.

2. We acknowledge the team leader as the ultimate decision-maker in all aspects of their life. We embed the help seeker motto of 'nothing about us without us' in all areas of help provision and planning. We will resist our need to determine what is best for people and seek direction from the help seeker to inform our service provision. We know that we have been successful in this when the team leader actively directs all decisions about their life and service provision.

3. Help seekers want transformational change. We spend time to learn from the team leader what they are looking to transform in their life. We explore the diverse factors which may be limiting the team leader's efforts in change. We resist service provision that is solely transactional and does not contribute to specific transformational, self-mastery or service emancipation outcomes.

4. Our service plans are not life-goal focused. We are deeply informed by what is important to the team leader's but resist attaining their life goals as the focus of service provision We focus on what is getting in the way and foster opportunities where people feel more equipped to overcome these barriers. We actively use and offer our professional skills and abilities to the team leader so they can use them as building tools in their endeavours.

5. We will negotiate service provision with help-seeker', ensuring fit and relevance. This includes negotiating expectations, our role, relevant strategies, desired outcomes and expected timeframes of involvement with what the organisation has the scope and resources to offer.

6. We ask people to review our service delivery according to the service plan. A service review's purpose is not to review the person's progress but to review the usefulness of the service response to their recovery challenges.

7. When outcomes have not been reached we consider it as a result of the service provision and not a reflection of a person's capacity or compliance. We will ask for help from the help-seeker to refocus our work/role when we have lost our way. This may eventuate in a new service plan being developed. A new plan should not simply contain the same service offer with new dates.

8. We acknowledge that even the best service provision can help and hinder. Within the planning process we highlight any foreseen risks that service provision may inadvertently cause E.g. increase service dependency, loss or roles, loss of relationships, loss of identity etc.

9. We value feedback about our services provision fit and relevance. We are committed to refining our service provision so that they remain useful to the help-seeker's ability to reclaim a life beyond the impacts of mental illness/distress.

10. We acknowledge that prior to coming to services people have tried many initiatives to meet their needs. A help-provider service, is useful to people only when it offers something unique that is not available through natural occurring mechanisms.

11. We intentionally support people to live, love, work and play in their own community and not within our service. We support people to utilise and access all their community resources and consider our service options as a last response. Service responses are delivered in natural community settings, that promote community tenure.

12. We value the role of planning in our own lives as a useful tool to guide our life direction. We resist participating in other people's planning processes where we have not developed and utilised our own personal plans as help providers.

These above principles may be useful to act as a recovery oriented 'litmus test' within team reviews, peer reflection, and supervision ensuring accountability to a person-led approach. This is not necessarily easy and yet maybe worthwhile to help seekers and providers.

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