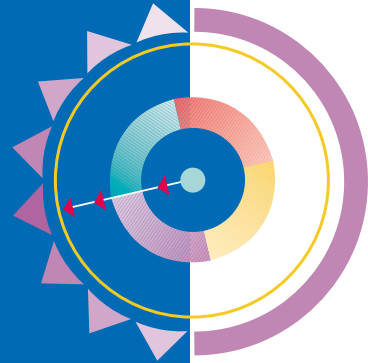


*Victoria's Mental Health Service
Resources for Case Managers
Individual Service Planning*

**Human
Services**



Peoplefirst



Resources for Case Managers
Individual Service Planning

July 1998

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Introduction

Individual Service Planning is intended to be a resource for clinical staff. The document has evolved from consultation with staff about the experience of implementing Individual Service Plans (ISPs). It acknowledges the key link with the needs for service assessment process, considers questions commonly posed by staff, explores some of the more complex issues which arise from the collaborative nature of the task and provides case studies and examples to illustrate the process.

The policy document, *Improved Access through Coordinated Client Care* (1994), established case management as the core feature of service delivery across Victorian public mental health services.

Case management assists clients through the interrelated steps of entry, assessment, planning, implementation, monitoring and review, and closure—the core functional components of the service delivery phase. Care is coordinated across different public mental health services and settings to ensure continuity of care. The capacity for case managers to link and collaborate with the wider health system and other relevant services is also central to a successful case management system.

The Psychiatric Services Branch has pursued a number of initiatives to assist the implementation of case management across Victorian public mental health services.

Priority has been given to training, and to providing information to staff to enhance their undertaking of case management roles and the skills needed to carry out the key functions and tasks involved.

The *Consumer Information Guide—How Case Management Can Work for You* (1995) was prepared to inform consumers and their families about case management. The guide aims to strengthen the capacity for consumers to participate in the collaborative work which is central to case management.

A range of practice guidelines has been developed to support case management staff in their interactions with other agencies and service systems. Included are practice guidelines assisting case managers in their work with police, drug and alcohol agencies, Protective Services and Intellectual Disability Services.

Case management is central to improving working relationships between public mental health services and general practitioners (GPs). Strategies for collaborating effectively with GPs are outlined in *Sharing the Care—GPs and Public Mental Health Services* (1996).

The current document, *Individual Service Planning*, forms part of a *Resources for Case Managers* series, providing additional support and information to complement the knowledge and skills of case managers in public mental health services.



Case Management and Individual Service Plans (ISPs)

Case management is well established as an effective way of ensuring continuity of care for people with mental illness. For the individual client, case management ensures that services are provided which are appropriate to his or her treatment and support needs, and also that service provision is timely and effective.

The core tasks of case management—assessment, planning, implementation, monitoring and review—are interrelated, but it is planning that provides the linchpin to these components.

The product of assessment is the ISP. The function of the plan is to record the needs and strengths of the user and the steps to be taken to improve their situation. It is an ongoing dynamic record that changes with the ongoing assessment of the user's needs and the continuous monitoring of outcomes.

Onyett, Steve 1992, *Case Management in Mental Health*, Chapman and Hall, London, p. 130.

The *Improved Access through Coordinated Client Care* policy provides a framework for the process of case management in public mental health services in Victoria. An essential part of this process is the establishment of a management plan which clarifies goals and expectations and identifies appropriate services for each client. An ISP is developed for each client, relating directly to the information provided by the client's assessment. This is a tool to help the client, not an end in itself.

The ISP should detail:

- The current situation and definition of problems.
- The goals to improve the situation and indicators of their achievement.
- The strategies for achieving the goals.
- The person/s responsible for implementing strategies.
- The date of review.

For many clients, the ISP may be brief and cover a limited number of areas. For others with more complex needs, the ISP will be more comprehensive.

Specifically, the policy states that:

- The case manager is responsible for ensuring that the ISP is developed.
- The Director of Clinical Service (DCS) or the director's delegate is responsible for ensuring that the ISP meets appropriate clinical standards.
- The ISP will be developed in collaboration with the client and, where the client has given consent to their involvement, with the client's carers, family members and service providers.
- A copy of the ISP would normally be made available to the client and, with the client's written consent, to agencies outside public mental health services which will be providing services to the client.
- Significant changes to the ISP must be endorsed by the multidisciplinary team and approved by the DCS.

Treatment and rehabilitation should be tailored to the individual patient. This assumption emphasises the complex decisions that professionals and patients must make together. The needs of each patient vary from those of the next, and each patient's needs vary over time. To make individual treatment plans work, patients and family members must have a role in setting goals and outcome measures for services. The patient's wishes should guide and advise the treatment team.

Munetz, Birnbaum and Wyzik, 1993, 'An Integrative Ideology to Guide Community Based Multidisciplinary Care of Severely Ill Patients', *Hospital and Community Psychiatry*, Vol. 4, No. 6, pp. 551-5.



Planning Based on Assessment

The needs for service assessment includes twelve areas for assessment, covering aspects of daily life particularly pertinent to the experience of mental illness and associated disabilities. The approach implies that treatment and lifestyle issues need to be addressed together, in order to achieve the optimal outcome for any individual.

The naming of the areas reflects the preference of clients for everyday language and assists collaborative practice in the development of ISPs.

ISPs are guided by the needs identified through this assessment process. In particular, the planning process will reflect the priority needs as agreed by the client and case manager. The assessment and planning processes are linked across services, by the consistent use of need categories, facilitating a collaborative approach between service providers and consumers.

Needs for Service Categories

- Emotional and Mental Wellbeing.
- Dealing with Stress.
- Personal Response to Illness.
- Personal Safety and the Safety of Others.
- Friendships/Social Relationships.
- Work/Leisure/Education.
- Daily Living Skills.
- Family's Response to Relative's Illness.
- Income.
- Physical Health.
- Housing.
- Rights and Advocacy.

The need categories along with prompts for areas to consider in the assessment and planning process are listed below:*

Emotional and Mental Wellbeing

The entire experience of mental illness and treatment has a major impact on emotional, mental and spiritual wellbeing. Acute symptoms are manifest in changes in thinking, reasoning, perception and mood. The negative symptoms related to major mental illness can significantly mar the range of emotional experience, often hindering purposeful and productive activity, and social and intimate relationships. Clients can experience anxiety, depression and related emotional difficulties, regardless of their primary diagnosis.

Areas To Consider

- Mental status examination, covering:
 - appearance, behaviour, speech, appetite, sleep, orientation, memory, impulse control, insight, judgement, thought process, perception, mood, substance use;
 - psychiatric history;
 - personality issues; and
 - personal history.
- Medical examination, to identify any physical factors affecting mental state, any history of injury or congenital problems.
- Special attention for suicidality.
- Impact of positive symptoms, such as intrusive thoughts, mania, hallucinations.
- Impact of negative symptoms, such as emotional blunting, absence of pleasure experiences and volition, cognitive difficulties and related disability.

* Taken from *Needs for Service Assessment and Review—A Collaborative Approach*, 2nd Edition, 1996, Psychiatric Services Branch, Department of Human Services, Victoria.

- Impact of person's emotional and mental wellbeing on others who are close, such as a child or spouse, and, conversely, the impact of other family member relationships on emotional wellbeing of person.

Dealing with Stress

People who have experienced mental illness are often more vulnerable to stress in everyday life. This can arise with both negative and positive life experiences. People have a range of ways of coping with stress. There is a considerable literature addressing the value of assisting people with coping strategies that can lessen the likelihood of relapse or the severity of its impact.

Areas To Consider

- Personal strategies for dealing with symptoms and recognition of early warning signs.
- Capacity to identify more and less effective strategies for dealing with stress.
- Obvious stressors in the environment (practical and interpersonal).
- Buffering/supportive experiences.
- Attitudes to seeking help.
- Judgement and decision making.
- Balance of useful and problematic coping strategies, such as alcohol use.
- Early life experiences contributing to stress, such as unresolved trauma.

Personal Response to Illness

The experience of mental illness can have a major effect on how people perceive themselves and their hopes and dreams for the future. Mental illness involves stigma in most cultures. The social and personal implications associated with being diagnosed as mentally ill are vast, and the person's response to these can influence recovery. Poor self-esteem, lack of confidence and social distress or anxiety can have a major impact on a person's outlook for the future.

Areas To Consider

- Confidence in, or confusion about, identity.
- Personal turmoil and distress related to illness.
- Grieving for loss of old self or dreams for the future.
- Resolution of trauma related to illness and treatment experiences, such as embarrassing behaviour, loss of children or estrangement from loved ones.
- Links with this and any previous unresolved trauma.
- Level of hope and confidence in the future.
- Self-esteem, in balance with level of distress, anxiety, sadness.
- Degree to which the client experiences control over his or her life and availability of appropriate support.
- Strengths, such as cognitive coping skills, humour, hopeful attitude.
- Robust sense of self.
- Personal explanatory model of mental illness and its fit with the service culture and the family culture.

Personal Safety and the Safety of Others

Safety issues are of primary concern for clients, carers and service providers. Issues of the client's own safety and vulnerability in the community and the safety of others, when there is a risk that the client can threaten others' safety, are both crucial.

Areas To Consider

- Safety of client's physical and emotional environment, risk and/or previous experience of physical or sexual abuse by others.
- Potentially high-risk behaviour, such as wandering in traffic, intentional self-harm and/or suicidality, risk of violence towards others, especially family members or other carers, and – any contingency plans.

- Physical safety and emotional security of children of parent with a mental illness.
- Personal level of autonomy versus dependency.

Friendships/Social Relationships

Social competence has been associated with better recovery from serious mental illness in longitudinal studies worldwide. Studies indicate that 40–45 per cent of people who suffer a serious mental illness experience a social recovery, in addition to the 25 per cent who have a full recovery. Studies identify social relationships and particularly friendships as most important areas of need. Many people experience loneliness and difficulty being with others in a comfortable way.

Areas To Consider

- Size and quality of friendship network.
- Level of enjoyment and satisfaction from relationships.
- Value placed on peer relationships.
- Levels of comfort or anxiety.
- Quality of intimate and sexual relationships.
- Practical barriers to friendship, such as previous experience of trauma in relationships.
- Performance of social roles.
- Level of support in family relationships.

Work/Leisure/Education

Purposeful activity is constantly raised, by consumer studies, as a highly valued goal. Employment and career options are frequently limited for people with mental illness, because of the episodic nature of illness and recovery and stress involved in maintaining full-time employment and/or tertiary education. Leisure activities that are interest driven are important for maintaining a sense of purpose, individuality and enjoyment, regardless of work suitability or availability.

Areas To Consider

- Personal interests.
- Motivation.
- Skills.
- Cognitive abilities, such as capacity for new learning and problem solving, concentration and memory.
- Impact of current negative and positive symptoms on these factors.
- Likely opportunities for staged involvement in meaningful activities.
- Previous or current work/leisure/education experiences.
- Interplay between social and task issues.

Daily Living Skills

The ability to maintain independent living skills can influence the likely housing and social relationship options for people with a mental illness. Some clients are unable to use these skills for short periods during acute illness and need time-limited support during a recovery period. Others continue to experience difficulty with performing household and community survival activities. Developing such skills may be very important to some people and a low priority for others. Some clients may experience great difficulty relearning these skills, even when motivated. The benefits of providing basic support versus assistance with skills (or both) must be considered in the light of the client's own goals and the likelihood of a positive outcome.

Areas To Consider

- Level of concern or distress about performance of daily living skills.
- Requirements of others dependent on the client for personal care and survival, such as children, elderly relatives.
- Particular need for skills in current or preferred living environment.
- Availability of support options in the formal and informal network.

- Cognitive abilities, such as capacity for new learning, concentration and memory.
- Social versus task issues.
- Impact on others caring for the client.

Family's Response to Relative's Illness

Family members and other carers can experience major grief, personal turmoil and disruption to family life, when a close relative is mentally ill. Family members and the client need support in their relationships and timely information to adjust to the impact of the illness in each other's lives. Information about the service system and support organisations is crucial.

Areas To Consider

- Attitudes toward and explanatory models of illness, cultural perspective on help seeking and response to person with illness.
- Tension levels in family relationships, need for and response to information about illness/treatment, guilt and blame issues for all family members, resources and strengths of family unit or alternative caregivers.
- Economic or health problems.
- Degree of support experienced by member with a mental illness, degree of isolation or connectedness of family with community, special needs of children of mentally ill parents.

Income

People who experience mental illness are often severely economically disadvantaged for long periods of time. Lack of access to flexible options in the paid workforce results in poverty. Clients often have extra health care costs associated with their illness, and available supported accommodation options frequently leave them with minimal disposable income. Leisure pursuits and attempts at more independent living, necessary for personal recovery, are often inaccessible because of poverty.

Areas To Consider

- Financial requirements to meet lifestyle needs evident from other areas of need.
- Level of autonomy over finances, for major issues and everyday living.
- Potential for exploitation by others.
- Potential sources of additional income.
- Advocacy requirements re income security.
- Problem spending, for example on illicit drugs during manic episodes.
- Coping strategies or contingency plans.

Physical Health

People who have a serious mental illness have higher rates of physical morbidity and associated mortality than the general population. Often clients with associated disability do not access preventative health services and may not identify illness and seek appropriate treatment. Some treatments for mental illness lead to long-term health risks. Problematic alcohol use and illicit and prescribed drug abuse can also compound health problems.

Areas To Consider

- Recency and outcome of general health review.
- Attitude to health care.
- Autonomy regarding access to services.
- Health information on risks, such as those related to sexuality, drug use and preventative screening.
- Sensory, nutrition, mobility issues.
- Side effects of psychotropic and other medication.
- Risks to health in physical environment.
- Drug dependency.
- Other major injury or illness, such as head injury or diabetes.

Housing

Evaluative studies of mental health programs worldwide have shown that stable and suitable housing with appropriate support is associated with improved outcomes for people with mental illness. Inappropriate living situations can significantly contribute to stress in the day-to-day life of people with a serious mental illness.

Areas To Consider

- Availability of housing options that match the preference of client.
- Specific support needs, influenced by symptoms, disability, gender, or cultural issues.
- Income issues.
- Social issues that will affect living with others.
- Family issues, where living with family.

Rights and Advocacy

Because of the level of social and economic disadvantage experienced by people with mental illness, attention to consumer rights is important for achieving improved outcomes. Linking with self-help and consumer groups and legal services may assist individuals overcome disadvantage and discrimination.

Areas To Consider

- Information requirements about advocacy groups.
- Rights in relation to mental health care, tenancy, health care and income security.
- Ability to understand rights.
- Choice about including a personal support person.
- Guardianship or administration requirements.



Getting Started: Questions and Answers

Q. How Much Detail Is Required in an ISP?

- A. Not too much. It will vary somewhat from client to client, but the ISP should be a succinct summary of the work you and others will be doing with each client. The ISP should identify the main aims, strategies and persons responsible for actions. On an ISP grid, it would be reasonable to have one sentence under each heading (such as 'Current Situations', 'Goals', 'Strategies', etc.) which captures the point, in a way that another person could read and understand. It is important that the ISP is useful as a prompt to you and the client. It does not replace ongoing file notes, which might include more detailed information.

Q. Do I Need To Complete All Categories of the ISP at the One Time?

- A. No. It is not necessary to develop a plan for every need category, only the ones that are highlighted as needing attention as you work through a needs for service assessment. The areas focused on in the ISP may be high priority from the point of view of the client, you as case manager and/or others involved in the needs for service assessment. Also, the ISP may be completed over some time, perhaps days or weeks, depending on what best suits the people involved.

Q. Does the Needs for Service Assessment Replace an Intake Assessment?

- A. No. The intake assessment you carry out fulfils a different purpose and it therefore includes different information, such as a detailed personal, family and treatment history and mental status examination. This is useful background information, of which you might remind yourself when preparing for the needs for service assessment. The needs for service assessment differs from the intake assessment, in that the needs for service assessment is explicitly directing a collaborative planning process, hence the language used is non-clinical, designed for all participants to share.

Q. Do All Staff, Including Medical Staff, Have To Complete Needs for Service Assessments and ISPs?

- A. Yes, if they are the case manager of a client. Case managers are responsible for completing a needs for service assessment and ISP for each client. While staff working on discrete Crisis Assessment and Treatment (CAT) services do not have a case management role, they will often have an important contribution to make to needs for service assessments and ISPs. Treatment plans, however they are recorded in a clinical file, do not replace the ISP, which is as much the property of the client as it is a part of the clinical file.

Q. How Soon Does a Needs for Service Assessment Have To Be Completed and an ISP Put in Place?

- A. Within a matter of weeks. It is possible that the first needs for service assessment and ISP for a new client will be completed within a few days of contact with the service, but it may take longer for the case manager to develop sufficient rapport with the client to engage him or her in the process. It may also take some time to establish links with important others, such as carers, family members or disability support workers. It is important that case managers start the process of needs for service assessments directly on first contact, but it is recognised that this may be completed in several steps. Subsequent needs for service assessments and ISPs are to be completed at least as often as every six months.

Q. Do Clients Have To Be Given a Copy of Their ISP?

- A. Yes. The ISP belongs as much to the client as it does to the clinical file, and a copy should therefore be taken away by the client at the end of the process. If the case manager has a concern about the client disagreeing with or being distressed by its contents, then particular care needs to be taken with the language that is used and with discussions which help to validate the range of views. This can be one reason a case manager takes longer to complete an ISP.



Getting the Balance Right

Balancing Needs and Resources—What Is the Case Manager’s Responsibility?

The case manager has a key role in the identification of client needs and the planning of services to meet those needs. Some individuals will have a set of complex needs that may require a very broad and detailed service response. In such cases, it will be important to prioritise needs, in consultation with the client and significant others, to guide a service response that may be constrained by available resources.

Constraints on resources do not alter the requirement for a comprehensive assessment of need, but there will be occasions when a specific service is not available at a particular time. In such a case, the case manager could consider the following steps:

- Where a desired service or specific intervention is unavailable, this is clearly explained to consumers and relevant caregivers.
- Where there are resource implications that significantly limit the adoption of best practice, these are made clear to the consumer and relevant caregivers. It will be important to discuss this with the service manager. It may be useful to consider mechanisms by which the resource constraints can be recorded for the service, in a way that aids review of overall service planning and targeting.
- It may be important to consider other options for meeting identified needs and to explore these with the consumer and caregivers.

Involving Families, Carers and Other Service Providers—How Are Consumers’ Rights Protected and Their Views Given Precedence?

ISPs are a planning tool, designed to ensure that services are delivered according to the individual needs of each client. Clear documentation and regular review of the plan allow services to monitor the progress they are making towards successfully meeting these identified needs.

The collaborative approach to individual service planning is focused primarily on the service user. The approach is based on a philosophy of maximising the involvement of individuals in the management of their illness and its lifestyle consequences, in order to facilitate improved outcomes.

Consideration of the range of people who might participate in the process, the rights of consumers and the precedence of their views, should include the following points:

- The central focus is on the partnership between those using and those providing services.
- Friends, families and other carers will often be important figures in a service user's life and have a significant role in providing support and care. They may be able to make an important contribution to assessment of client needs and provide support and assistance to clients in achieving their goals. They can be involved in the individual service planning process and be given information relating to it, with the consent of the client. Clients should be clearly informed that they can invite family members or friends to participate in the process and assist them with contact with services. In many cases, improved outcomes can be achieved when family and significant others are able to participate in the process.
- Equally, service users should be aware of Section 120A of the *Mental Health Act 1986*, which sets out confidentiality requirements in respect to information about consumers and the exceptions to these requirements.
- People with a mental illness often require a range of services. Cooperation among service providers can help to improve access to services and lead to improved service outcomes. Other relevant service providers can be invited to participate in the individual service planning process, with the client's consent. It will often be important to negotiate with clients the involvement of primary health care providers, disability support workers and ethnic workers.

Recognition of the different views and experiences of the consumer, service providers and family members or other carers in the individual service planning process can ensure a relevant and comprehensive document. However, client choices and preferences should always be a major guide for decision making about the participation of others and the degree to which information is shared.

Case managers will increasingly rely on the use of negotiation, mediation and other problem solving strategies, when there are conflicts among the views and priorities of different participants that may impede appropriate service delivery for the client.

How Can Services Empower and Enable Consumers To Participate Fully in the Process?

The collaborative approach to developing and implementing ISPs is based on effective relationships between service providers and service users. It is important to acknowledge that effective relationships may take time to evolve and that as rapport and trust increase, clients may feel more able to express their needs and preferences.

For some individuals, it may always be difficult to participate fully and openly in the process. However, it may be worth considering the following:

- The environment in which case managers and clients identify needs and service plans; for example, some individuals may feel there is not sufficient privacy at home for them to discuss their goals, while others may feel more comfortable in such a non-clinical environment.
- In the acute phase of an illness, individuals may not be able to focus adequately on longer-term or detailed lifestyle goals. The ISP may need to reflect the immediate needs, until the situation is more settled and broader needs and service plans can realistically be considered.
- Service users' perspectives on needs, preferences and outcomes can sometimes be gained most effectively with the involvement of another worker or carer with whom there is an existing relationship and rapport. For example, this may be the case particularly with ethnic workers for clients of non-English speaking background.
- Where the client's capacity to participate in a meaningful way significantly constrains the process—for example, a client with an acute paranoid psychosis may be fearful of becoming involved—it may be necessary to attend very briefly to the needs for service assessment and ISP and bring the review period forward to, for instance, a date 3 months hence.

Can a Collaborative Approach to the Process Place Case Managers in Conflict with Duty of Care Requirements?

Psychiatric service providers are obliged to fulfil the requirements of the Mental Health Act and policy guidelines relating to the Act concerning information about rights and treatment. There will be situations where involuntary treatment and care will be initiated by clinical staff in line with requirements of the Act, sometimes in direct conflict with the individual's wishes. Services will need to consider the impact of involuntary treatment on the collaborative approach to service delivery and address this with individual clients and their carers.

Duty of care considerations should always guide decision making in the ISP process.

Decision-making factors to be considered include:

- safety for all participants;
- ensuring the client's participation in his or her own treatment and lifestyle decisions;
- use of optimal treatments and interventions, for short- and longer-term outcomes; and
- sensitive consideration of the needs and concerns of immediate family members and caregivers.

It is important to note that duty of care is not limited to situations of involuntary treatment and that the use of ISPs does not alter existing duty of care requirements for case managers. Good practice will continue to involve balancing client preferences, safety and welfare considerations and optimal treatments and interventions, in the context of delivering services in the least restrictive environment.



Examples

Graham

Background

Graham is a 50 year old single man who lives alone in a bedsit public housing flat. He has a long history of treatment for bipolar affective disorder, complicated, in the past, by alcohol abuse. He has been living in his flat, where he has been receiving meals on wheels and home help for the past three years, following a long period of homelessness. It has been an ongoing struggle for Graham to maintain his flat in a reasonable living condition and get along well with his neighbours.

Graham values highly having his own flat and living independently but feels lonely and bored at times. He enjoys visiting a local welfare service and a drop-in component of a psychiatric disability support service. However, he struggles to be sufficiently organised to attend at the right time and to keep money aside for tram fares.

Graham is regularly seen by workers from the local Community Mental Health Service (CMHS), who visit him at home. He has regular admissions to the acute inpatient unit, usually two–three each year. He enjoys seeing the community mental health workers. He has no family in Victoria and only intermittent social contact with some other men in his block of flats. The mental health workers, along with staff at a local welfare service, make up his only regular social and support network. Despite this, he accepts treatment for his psychiatric disorder only reluctantly and at times will refuse or cease to comply with his medication. He is particularly bothered by some of the sedative effects of the medication.

The case manager and treating doctor at the CMHS feel particularly concerned about Graham's unstable mental state, the need for regular inpatient admissions and the disruption this brings to Graham's life. They are also concerned about his often neglected state of self-care and general health and wonder how long he can continue to live independently in his flat.

A worker at the local welfare service has known Graham for many years. He recognises how important it is to Graham to have his own flat. He is concerned about Graham's inability to manage his finances effectively and his sometimes impulsive and reckless behaviour, which places his security of tenure at risk. He shares with Graham concerns about some of the side-effects of the medication he is prescribed.

Coordinating the Needs for Service Assessment

A needs for service assessment is coordinated by the case manager and involves other workers at the CMHS and the welfare worker. Graham is not interested in participating. He demonstrates this by not being at home for arranged visits and rejecting written information. During the process, he throws out all of his medication and refuses his usual fortnightly injection. Staff are concerned that this may also be a protest at the introduction of this new demand on him.

The case manager decides on a different approach and, during a visit to a local coffee shop, asks Graham about what he would like to see change for himself over the next year and what he would like to keep unchanged.

Graham is able to respond to this approach and identifies the following goals:

- continuing to live in his flat;
- cutting down his medication;
- having a girlfriend; and
- getting a drivers licence and buying a car.

The following week Graham agrees to have coffee with his case manager and treating doctor as well as the welfare worker. The case manager prompts Graham to talk again about the goals he has identified. He has forgotten about the drivers licence and car but, when reminded, agrees that he wants to include these. He participates very little, but the workers persist and talk briefly about what they see as important for him.

The welfare worker:

- staying in the flat but getting some assistance with management of finances;
- changing to a more suitable medication regime; and
- greater access to social opportunities.

The doctor:

- a continuous period of time on one medication regime to assess effectiveness and monitor side-effects accurately; and
- greater attention to hygiene and general health needs.

The case manager:

- to live safely in an independent setting; and
- to have longer periods of stability between acute episodes of illness.

The case manager prepares a copy of the summary of needs for everyone. It is prepared using simple language and reflects the priority needs identified by everyone involved. Care is taken to ensure that Graham's views are accurately reflected. The summary includes a note of differences in the views expressed; for example, while the issue of medication is clearly seen as a priority by all, Graham's view is that it should be reduced, while others are suggesting a change.

Need Summary To Accompany ISP*

Name: Graham. B.

Address:

Date Completed: 22/7/95

Participants and Their Role:

- Graham, client of the CMHS;
- case manager at the CMHS;
- doctor (psych. registrar) at the CMHS; and
- welfare worker at a local non-government welfare service.

Priority Needs Areas Identified:

Client (Consider Your Own Needs and Your Opinion about the Needs of Your Family or Other Caregivers):

- I want to continue living in my own flat.
- I need to have my medication cut down; I probably need to have it stopped altogether.
- I want to have a girlfriend.
- I need to get a drivers licence again and buy a second-hand car.

Family Member, Friend or Advocate (Present at Client's Request):

N/A

* Format taken from *Needs for Service Assessment and Review—A Collaborative Approach*, 2nd Edition, 1996, Psychiatric Services Branch, Department of Human Services Victoria.

Family Members and Other Caregivers (Consider Your Own Needs and Your Opinion about Those of Your Relative Who Requires Services):

N/A

Workers (Specify Name, Role and Service):

Case manager (CMHS):

- assistance to live safely in an independent setting.
- improved mental state—longer periods of stability between acute episodes of illness.

Doctor (CMHS):

- stable medication plan to allow accurate assessment of side effects and efficacy of treatment; and
- assistance to attend to self-care and health needs.

Welfare worker (local NGO agency):

- assistance to manage finances;
- reduced side effects; and
- increased opportunities for socialisation.

The Attached Service Plan Will Cover the Following Priority Needs:

Emotional and Mental Wellbeing

- Adjust and stabilise treatment; aim to minimise side-effects and reduce acute symptoms.

Income

- Assist with budgeting and management of income.
- Assist with savings plan.

Daily Living Skills

- Greater attention to self-care needs.
- Increased assistance with cleaning of flat.

Physical Health

- Assistance to attend GP.
- Thorough assessment of health needs.

The Attached Plan Will Not Cover These Other Priority Needs at This Time:

Friendships/Social Relationships

- Assistance with increased access to social opportunities on a regular basis.

The Reasons for This Are:

Case manager will concentrate on helping with priority needs identified above, which will involve an increased time commitment. Welfare worker unable to commit more time at this stage. Graham doesn't know of anyone else who can help him in this area but plans to talk to some other men in the flats and see if they have any ideas. Everyone agrees to encourage Graham to keep up his occasional visits to the Disability Support Service. It is agreed that this area will be reviewed again in six months time.

Differences in Opinion To Make Note of:

Graham believes his medication should be reduced or stopped. The other participants agree that it is problematic at present but believe it should be altered rather than stopped. The alteration may, over time, include a reduction. The doctor and case manager strongly believe that medication can be helpful for Graham.

Developing the ISP

The ISP is prepared. It has a focus on four of the areas identified in the Needs for Service Assessment:

- emotional and mental wellbeing;
- income;
- daily living skills; and
- physical health.

As the case manager and Graham work through the ISP, Graham acknowledges that it is relevant to the goals that he has identified, although he remains irritated that his medication isn't being reduced or stopped immediately. The case manager acknowledges that the plan doesn't directly address the social issues raised by Graham and the welfare worker and talks with Graham about this in terms of priorities, time constraints and possibilities in the next six month period.

Graham accepts a copy of the completed ISP but quickly misplaces it. He declines the offer of another copy. The case manager makes a note to have a copy on hand when seeing Graham, to refer to when necessary or to give to Graham if he expresses interest.

The process has taken longer than the case manager had anticipated. However, in discussion with the multidisciplinary team, the case manager expresses satisfaction that Graham was able to become engaged in the process and, while not participating fully, had been able to clearly state what was most important to him.

Individual Service Plan 1

Need Category What Part of Life	Current Situation What It's Like Now	Goals/Hopes What We Want
Emotional and mental wellbeing.	Fluctuating mental state. Periods where no medication is taken. Regular admissions to hospital.	An effective medication plan producing no or minimal side effects. Longer periods without need for admission to hospital.
Daily living skills.	Graham receives: – Meals on Wheels each day; – Home Help once a fortnight. Flat in regular state of disarray. Neighbours complain about smell and about rubbish being thrown out the front door.	To maintain flat in a reasonable condition. To reduce risk of termination of tenancy or move to supported housing due to risk to self.
Income.	Graham manages own income with some budgeting assistance from welfare worker. Often without money to meet basic needs. No savings.	Manage income so that basic needs including transport needs can be appropriately met. Small savings plan.
Physical health.	Graham does not worry about his general health. Longstanding need for dental work. Problematic skin condition—eczema. Current complaints of abdominal pain.	Regular feed-back for Graham about his general health. Attention to dental needs. Immediate attention for abdominal pain.

Strategies/Interventions	Timing and Responsibility	Outcome
What We Are Going To Do	How Long Will We Try It? Who Is Involved?	What Happened?
<p>Sustained period on a consistent range of medication.</p> <p>Close monitoring of mental state and persistence with medication plan.</p> <p>Following sustained period of time on consistent range of medication assess with regard to mental state and side effects and prepare to make alterations.</p>	<p>Six month period.</p> <p>Graham to use Dosette.</p> <p>Case manager to visit three times weekly and to check side-effects and mental state.</p> <p>Treating doctor to make regular assessment of side-effects and mental state.</p> <p>Make changes within the six month period, if risk to Graham's wellbeing.</p>	
<p>Increase home help to once per week.</p> <p>Early identification of problems in collaboration with Housing Estate Worker.</p> <p>Regular prompting and support for Graham to carry out basic tasks.</p>	<p>Case manager to liaise with local council about services.</p> <p>Case manager to liaise with housing worker each month.</p> <p>Welfare worker will provide outreach visit once each week and assist/prompt Graham with appropriate rubbish collection and removal.</p>	
<p>Administration order.</p> <p>Close liaison with Administrator to ensure management plan meets Graham's individual lifestyle needs and has some flexibility.</p>	<p>Case manager to coordinate application for Administration Order.</p> <p>Graham and welfare worker to continue regular budgeting discussions.</p> <p>Graham to put aside money for three tram fares each week.</p>	
<p>Introduce to GP.</p> <p>Liaise with GP regarding Graham's health needs.</p> <p>Explore options for access to affordable dental care.</p>	<p>Treating doctor to liaise with GP.</p> <p>Case manager to support Graham in regularly attending GP.</p> <p>Case manager to explore dental care options with Graham.</p>	

Review

Over the next six month period, the case manager and other staff involved in Graham's care work with the ISP as their guide. On occasion, they have to give priority to short-term issues that arise and are not related to the activities outlined in the ISP. However, at the point of six monthly review, the case manager is able to spend time with Graham, the treating doctor and others involved in the process and consider the progress made towards the set goals.

With encouragement, Graham is able to participate again in the process, although the workers are mindful that he finds it difficult to concentrate on the issues for any length of time. The review takes place over several visits and appointments.

Emotional and Mental Wellbeing

While there has continued to be some fluctuation in Graham's mental state, he has generally been settled for longer periods than usual. One acute relapse was managed by the case manager, working in collaboration with the CAT service, with the assistance of a short stay in the respite house available to the area service.

Graham has managed, with consistent prompting, to use his Dosette reasonably well. The treating doctor feels that he has been able to complete a thorough assessment of side-effects experienced by Graham and has already instituted some changes in the hope of reducing the sedation, that Graham experiences, while continuing to provide some protection against mood changes and psychotic symptoms. However, he feels pessimistic about the possibility of countering the side effects to the extent that Graham would like.

Daily Living Skills

Regular liaison with the housing worker has proved to be a valuable intervention. Complaints from other tenants continue, about Graham's disruptive behaviour and failure to care adequately for his flat, but the housing worker has a better understanding of his situation and is prepared to try and mediate around problem issues.

The increased input from Home Help has assisted Graham marginally but the flat very quickly deteriorates to a state of significant disarray and continues to cause him stress. However, the welfare worker has been able to assist Graham successfully with appropriate rubbish removal each week so that this is less of an issue for Graham's neighbours.

In general, despite some improvement in the care of his flat, Graham continues to only just manage in this independent living environment.

Personal care continues to pose problems for Graham, compounding his social isolation and contributing to his poor physical health. Without regular prompting and supervision, he continues to neglect very basic hygiene needs. Staff feel particularly concerned about a deteriorating eczema condition which is exacerbated by neglect of self-care needs.

Income

An Administration Order is now in place and is working well. Graham's bills are paid automatically by the administrator and Graham accesses a certain amount of money for his general needs each week. However, from these funds, he continues to find it difficult to set any money aside for public transport.

The administrator ensures that \$15 each fortnight is set aside in a savings plan. Graham is pleased with this, despite his ongoing difficulties making ends meet.

Physical Health

Graham's physical health continues to cause some problems. He is now linked in to a local general practice but finds it difficult to attend appointments or wait in the waiting room to see the doctor, unless the case manager is with him. He also has difficulty complying with the GP's directions, for example, using the cream for his skin condition appropriately.

On the occasions that he has seen the GP, he has requested different medications for his mental health needs than those prescribed by the treating doctor at the CMH service. Significant liaison work has already been necessary to ensure a coordinated service response between the CMH service and the GP.

Graham is on the waiting list for free dental care and is expecting to have his first appointment soon.

Priorities

In the process of reviewing the past six months, the following priorities emerge:

Graham:

- Continues to feel constrained by side-effects and would like his medication changed or ceased.
- Staying in his flat remains an important goal for him.
- Meeting people and perhaps finding a girlfriend.

Case manager:

- Despite some small gains, stability in the area of emotional and mental wellbeing remains a priority.
- Poor living skills—in particular self-care skills—are beginning to impact on many areas of Graham's life.

Treating doctor:

- Continuing to aim for the best possible outcome for Graham in terms of efficacy of treatment and minimisation of side effects remains a priority.
- Physical health needs require more attention.

Welfare worker:

- Assisting Graham to maintain current housing remains a priority.
- Feels very concerned about Graham's physical condition and his increasing social isolation.

In coordinating the new ISP, the case manager aims to reflect the above priorities by retaining a focus on emotional and mental wellbeing, daily living skills and physical health and additionally giving some focus to the category friendship/social relationships. The inclusion of the latter ensures attention to Graham's problems of social isolation and may also provide Graham with some motivation to attend to basic self-care needs.

Graham agrees to the changes in the ISP. He wavers between feeling pleased that further changes have been made to his medication and angry that it hasn't been stopped completely. He is pleased at the plan to assist him to attend the Disability Support Service.

Individual Service Plan 2

Need Category What Part of Life	Current Situation What It's Like Now	Goals/Hopes What We Want
Emotional and mental wellbeing.	Some fluctuation in mood continues. Graham is keeping to the medication plan (with a lot of help and supervision). Side effects of treatment continue to trouble Graham.	An effective medication plan producing no or minimal side effects. Longer periods without need for admission to hospital.
Daily living skills.	Graham is receiving: – Meals on Wheels each day. – Home Help once a week. His flat continues to be in a poor condition. Graham continues to have difficulty looking after his self-care.	To maintain flat in reasonable condition. Attend more regularly to self-care needs.
Physical health	Graham is linked with a GP but has difficulty attending appointments. Awaiting dental appointment. Eczema condition seems to be getting worse.	Regular attention to general health care needs. Attention to dental care needs. Improvement in skin condition.
Friendships/social relationships	Graham has little social contact with anyone other than workers. Graham doesn't look after himself and the way he presents—this might offend some people in social situations.	Establish opportunity for regular social contact. Opportunity for social interaction to provide motivation to improve self-care.

Strategies/Interventions	Timing and Responsibility	Outcome
What We Are Going To Do	How Long Will We Try It? Who Is Involved?	What Happened?
<p>Adjustment of medication to provide further relief from side effects—assess adjustment in six months time.</p> <p>Continued close monitoring of Graham’s mental state and his willingness to keep to the medication plan.</p>	<p>Graham to continue using Dosette.</p> <p>Case manager to continue prompting and monitoring re medication during regular visits.</p> <p>Treating doctor to continue regular assessment of side effects and mental state.</p>	
<p>Maintain home help assistance</p> <p>Continue liaison with housing worker.</p> <p>Regular prompting and support for Graham to carry out self-care tasks more regularly.</p>	<p>Case manager to continue liaison with housing worker.</p> <p>Welfare worker to continue prompting and assistance with rubbish.</p> <p>Graham to have a full shower three times each week and wash clothes each week.</p>	
<p>Continue liaison with GP.</p> <p>Prompting and assistance for Graham to attend appointments.</p> <p>Further assistance with eczema treatment.</p>	<p>Case manager to prompt and assist Graham to attend appointments.</p> <p>Treating doctor to liaise with GP.</p> <p>Case manager and treating doctor to prompt and help Graham to keep up with his eczema treatment.</p>	
<p>Spend one afternoon each week at local Disability Support Service Drop-In program.</p>	<p>Case manager to use one appointment each week to drive Graham to Disability Support Service.</p> <p>Graham responsible for finding his way home.</p>	

Andrew

Background

Andrew is a 27 year old man living alone in a small flat around the corner from the CMHS which he attends. He works in a local hardware store as a storeman. He has a few friends in the area, although he grew up in a country town where his family still live. He likes to socialise in a nearby hotel, where he plays competition pool. He describes himself as shy, wishing he could get to know some more friends and find a girlfriend.

Andrew has been seeing his case manager for two months, since his second admission to a psychiatric hospital, this year. He attends appointments weekly in his lunch-break. Andrew's boss is supportive of Andrew keeping appointments, knowing from Andrew that he is seeing a 'counsellor', since his 'breakdown'.

Andrew was acutely psychotic at both admissions. The diagnosis, first made three years ago, was drug induced psychosis and, on the second admission, acute schizophrenia. He was in hospital on this occasion for two weeks. Andrew made a quick recovery from the acute symptoms of psychosis both times. He was symptom-free for two-and-a-half years between episodes and took no medication for most of this time. Andrew now takes a very small amount of antipsychotic medication, which he is anxious to cease. The case manager has seen Andrew jointly with a medical officer on the team on two occasions and the medication has been reduced by half since discharge.

Andrew is particularly distressed by some of his experiences of his own acute symptoms and his observations of other people in the acute ward. He feels ashamed of his own out-of-control behaviour and bizarre thoughts, afraid of others' aggression and horrified at the prospect of being sick in the future.

Looking back now, Andrew thinks he was particularly stressed before the recent episode, having just broken up with a girlfriend and lost some money on a speculative business deal with a friend from the hotel.

Andrew drinks alcohol regularly and occasionally heavily, at these times missing work with a bad hangover. He used to smoke marijuana regularly, as he felt it helped him to relax in social situations, but he avoids it now because he is very afraid of becoming psychotic.

Andrew values the independence that work and a wage gives him, although he doesn't like his job. He was unemployed for nearly a year before finding this storeman job. He is very proud of his car and would like to save for a flat in town or a house in the country. He has found it difficult to save money in the past.

Developing the ISP

Over the past three weeks the case manager and Andrew have been talking about his plans for the future and the help he needs. They have looked through the needs for service categories as a prompt for discussions. Andrew recognises he needs support at the moment, but does not feel comfortable with anyone, apart from himself, speaking to family, friends or employer about what has happened. Last time, both parties met with the team doctor and focussed the discussion on a couple of categories.

Together, Andrew, his case manager and the treating psychiatrist have built a picture of what issues are important to address and how and when this should be done. The case manager and Andrew do not agree entirely about some of the priorities, for example (under Emotional and Mental Wellbeing), Andrew thinks that ceasing medication now is most important, as it will prove to himself and others that he is normal and OK. The case manager sees his reasoning but thinks that there is some risk of symptoms returning, if medications are ceased too quickly, and that some time needs to be spent on identifying stresses and early warning signs, to cease medication safely. Agreement is made to keep aiming for medication reductions whilst taking the time to carefully attend to Andrew's feelings about diagnosis, his relapse signature and coping with stress.

Eventually settlement is made on three main areas to work on together. There are other areas to discuss, but they won't be the focus of the ISP this time. For example, Andrew does want to build new friendships and budget to save money, but these are things he will work on himself. He might bring them up later in the year if he wants some help. He has been very careful to avoid drinking to excess since discharge, so he is only

allowing himself one drink when he visits the pub, as he doesn't want to jeopardise his work and he doesn't want to risk damaging his car if his driving were affected by medication and alcohol together. Andrew hasn't known anyone, apart from professionals, who seemed to know about mental illness like his, but he decided to think about speaking to others with similar experiences of psychosis.

Andrew commented that he felt good about having a plan to work on for a set time. The process made him feel hopeful about recovering and maybe moving away from the mental health system when he achieved his goals. The process gave an opportunity to notice how well Andrew was already managing his own life and recovery from illness.

Need Summary To Accompany ISP*

Name: Andrew

Address:

Date Completed: 12/11/95

Participants and Their Role:

- Andrew.
- Case manager.
- Treating psychiatrist.

Priority Needs Areas Identified:

Client (Consider Your Own Needs and Your Opinion about the Needs of Your Family or Other Caregivers):

- Cease medication and show that I can live a normal life.
- Stay relaxed and avoid stress.
- Understand more about psychosis.

Family Member, Friend or Advocate (Present at Client's Request):

N/A

Family Members and Other Caregivers (Consider Your Own Needs and Your Opinion About Those of Your Relative Who Requires Services):

N/A

* Format taken from *Needs for Service Assessment and Review—A Collaborative Approach*, 2nd Edition, 1996, Psychiatric Services Branch, Department of Human Services Victoria.

Workers (Specify Name, Role and Service):

Case manager (CMHS):

- Identify relevant stressors and early warning signs that may be associated with a relapse.
- Explore different ways of coping with stress.

Doctor (CMHS):

- Continuing psychiatric treatment, including some medication.
- Further education about psychosis.

The Attached Service Plan Will Cover the Following Priority Needs:

Emotional and Mental Wellbeing:

- Continued treatment with psychiatric medication with regular and careful review.

Dealing with Stress:

- Identifying stressors and exploring coping mechanisms.

Personal Response to Illness:

- Education and information about psychosis.
- Support to reflect on own experience.

The Attached Plan Will Not Cover These Other Priority Needs at This Time:

Friendships/Social Relationships

The Reasons for This Are:

Andrew does want to build new friendships, but this is something he feels he can work on himself, at the moment. He doesn't feel that it is something he wants to discuss with his doctor or case manager.

Differences in Opinion To Make Note of:

Andrew believes that his medication could be ceased and that he could cope normally without it now.

The psychiatrist and case manager feel that it is too big a risk to stop medication so soon but agree that they should work towards seeing it gradually reduced.

Need Category What Part of Life	Current Situation What It's Like Now	Goals/Hopes What We Want
Emotional and mental wellbeing	Symptom-free on low dose of medication. Anxious about possibility of relapse.	Minimum/nil medication without recurring symptoms.
Dealing with stress	Anxious regarding ability to take up responsibilities, cope with usual activities, for example, return to work and work performance, socialising. Recovering from psychosis which was associated with particular stresses.	Understand own vulnerability to stress. Be confident in usual activities. Be unafraid to explore new interests.
Personal response to illness	Andrew is fearful regarding relapse, distressed about his experiences. He has limited knowledge about illness or ways of managing health.	To feel more comfortable with the knowledge of his experiences. To be well informed regarding illness and positive actions he can take.

Strategies/Interventions	Timing and Responsibility	Outcome
What We Are Going To Do	How Long Will We Try It? Who Is Involved?	What Happened?
Review medication on basis of careful mental state review.	Treating doctor and case manager meet with Andrew.	
Identify experiences which have been very stressful, not past successes. Apply stress/vulnerability model to managing own health.	Andrew working with case manager at regular appointment weekly for one month and review.	
Share written material on psychosis and relapse prevention. Develop an understanding of Andrew's relapse signature. Reflecting on his feelings, actions and thoughts regarding illness.	Andrew working with case manager at regular appointments.	

Jana

Background

Jana is a 20 year old woman living in a group home with another young woman, Ellen, and a young man, Ivan. Jana's family live in an outer suburb, but Jana moved to the area twelve months ago, when she was offered a place in the group home. Jana spends much of the week at a local council youth drop-in centre and a support worker there, Bronwyn, knows Jana well. Bronwyn describes Jana as impulsive and like a child in some ways but feels that they have developed a reasonable relationship since Jana began attending the youth centre.

Jana complains she has no friends in the area, that her old school friends are too far away and not interested in her any more. Friends and family say that Jana is often impossible to be with; they describe her as dangerous when she doesn't get her own way.

The case manager has known Jana for ten months as a client of the CMHS. Jana was referred by the CAT service in the area, after they responded to numerous distress calls from Jana and her house mates late last year, during which Jana talked of not coping and wanting to suicide. When the CAT service was called, Jana was often intoxicated and had been arguing with other residents or their friends at home. At times, Jana had been abusive and threatening violence to others and harm to herself. She had broken belongings of her own and others. At these times, Jana has demanded that she be taken to hospital.

Jana had a brief two day admission to the area acute unit, after being visited by the CAT service, who found Jana unconscious following a large overdose. The diagnosis made during admission was depression and borderline personality disorder. Jana has taken one other overdose in the past. She has also injured herself with burns and cuts to her arms. Jana is not currently on any regular medications, but the CMHS does supply her with small amounts of sedatives when she is particularly distressed and not sleeping.

Jana's previous case manager left one month ago. The current case manager has seen Jana several times, as she drops into the CMHS often. The case manager has been able to spend half an hour with Jana at least

once each week when she drops in, but Jana has not managed to keep any planned appointments with the case manager or the treating doctor in this time. This has been a settled month for Jana, in that she has taken no overdoses, she has told staff, when they visit, that she is feeling less angry, that she likes the people at the youth centre, and the CAT service say they have only had calls, via the hospital, from Jana or her house mates twice this month.

Jana's family had contact with the previous case manager around the time of her admission. They relayed how powerless they have felt since Jana left school and moved from home shortly after. Jana has not let them know her address, so they speak to Jana only when she telephones them. They are interested in attending an appointment for planning to help Jana, if she would consent. Jana seems to have mixed feelings about her parents, in that she complains that they are not interested in her, that they don't want to visit or help her financially but she was dismissive when they offered to visit and to lend her furniture recently. Jana has a younger brother who lives at home and who, Jana says, is a spoilt brat.

Jana has used marijuana regularly with friends since she was 15 years old and has used amphetamines on two occasions. She uses less marijuana now, as it is not allowed in the house and one of the other residents is very against it. Jana regularly drinks alcohol heavily and this is often associated with aggressive and suicidal impulses.

Jana has a history of being sexually assaulted twice, at age 16 and 19. She reported both assaults at age 19 and they are yet to be heard in court. Her previous case manager queried a history of childhood sexual abuse which Jana denies.

Jana has been unemployed since she left school at age 16 and she had just about given up her ideas of training in the hospitality area. With Bronwyn's encouragement, Jana recently visited a work rehabilitation centre and she is hopeful of finding work with their help.

The case manager intends reviewing the ISP drawn up between Jana and the previous case manager six months ago. Bronwyn heard about this from Jana and is keen to participate.

It was mentioned to Jana last week and she thought it was a waste of time to her. She was emphatic in not consenting to her parents being present 'like a bloody parent-teacher night' but was willing for the case manager to speak with them. She is also willing for the CAT staff and nursing staff she knows from the inpatient unit to be involved but she doesn't want the case manager to speak to the work rehabilitation staff.

The case manager decides to approach the needs for service assessment very informally with Jana, aiming to discuss one or two categories in the course of each conversation with Jana over the coming weeks, without sitting down over forms. She frames these conversations as a useful way they can get to know each other, so that she can be most helpful to Jana. The case manager also speaks to Bronwyn, the CAT team staff and the other continuing care staff about their ideas and concerns.

Jana talks freely in the first week about her friendships, her work and leisure interests and her views about her need to go to hospital sometimes when she can't cope. The case manager drafts brief NFS comments under the categories of Dealing with Stress, Personal Response to Illness, Friendships/Social Relationships and Work/Leisure/Education.

The case manager calls Jana's parents and speaks to her mother about the ideas Jana is raising and to hear from them about their experiences with Jana and the centre. She is generally positive about the contact with case managers and sad but accepting of the limited contact they have with Jana at present.

Over the next fortnight, Jana is more reluctant to discuss her skills at home, her physical health and her family's response to her situation. Jana is particularly angry on the occasion when the case manager raises the topic of her safety and the safety of others and she leaves the centre yelling abuse at the case manager.

That afternoon, the case manager calls the CAT service and speaks to the on-call worker about CAT contacts, the issues raised in NFS assessment and possible strategies that would involve the team. She calls the acute unit and has a similar discussion with the unit manager, reflecting on Jana's admission last year and Jana's ideas about what helps.

From the accumulated information, the case manager notes four key NFS areas:

- Friendships/social relationships.
- Work/leisure/education.
- Personal safety and safety of others.
- Emotional and mental wellbeing.

The case manager rings Jana's home in the morning and arranges to see Jana at the youth centre. Jana, Bronwyn and the case manager have a positive conversation about how much better things have been with Jana in the past few months, and the case manager is able to reflect the evidence of improvements by mentioning some of the differences between the present situation and the past, as noted in NFSAs and ISPs in Jana's file. Jana and Bronwyn suggest some practical tasks they can each plan to do that Jana thinks would help her. Jana sits blankly whilst Bronwyn and the case manager discuss again the importance of safety and strategies for Jana and others to limit harm to Jana and others.

The case manager drafts an initial ISP, focussing on the key needs areas.

The next time Jana drops in, they look at the ISP together. Jana is not happy with the description of the present situation regarding her safety, but tolerates it in the plan, once she has added a comment about her own view of the situation. Jana takes a copy of the ISP for herself and one to give to Bronwyn.

The case manager adds the ISP to the file, noticing that it has taken four weeks to complete the process. She sets a review date for six months hence.

Need Summary To Accompany ISP*

Name: Jana

Address:

Date Completed: 2/12/95

Participants and Their Role:

- Jana.
- Case manager.
- CAT service.
- Inpatient service.
- Youth worker.
- Jana's mother.

Priority Needs Areas Identified:

Client (Consider Your Own Needs and Your Opinion about the Needs of Your Family or Other Caregivers):

- Make some friends who will stick by me.
- Get some work as a waitress or in a kitchen.
- Go to hospital and get looked after if I really can't cope.

* Format taken from *Needs for Service Assessment and Review—A Collaborative Approach*, 2nd Edition, 1996, Psychiatric Services Branch, Department of Human Services Victoria.

Family Member, Friend or Advocate (Present at Client's Request):

N/A

Family Members And Other Caregivers (Consider Your Own Needs And Your Opinion About Those Of Your Relatives Who Require Services):

- Mother—ongoing treatment and support from the CMHS.

Workers (Specify Name, Role and Service):

Case Manager (CMHS):

- Treatment and monitoring of depression and emotional problems.
- Developing longer term relationship/s with friends.
- Identify stresses and events associated with impulsive behaviour.
- Safety of self and others.

Youth Worker:

- Developing stable relationships with peers.
- Work rehabilitation and training.

CAT Service:

- Continuing support and limit setting from CMHS.
- Safety of self and others.

The Attached Service Plan Will Cover the Following Priority Needs:

- Friendships/social relationships.
- Emotional and mental wellbeing.
- Personal safety and safety of others.
- Work/leisure/education.

The Attached Plan Will Not Cover These Other Priority Needs at This Time:

N/A

The Reasons for This Are:

N/A

Differences in Opinion To Make Note of:

Jana does not agree that issues of safety—hers or others—are as important as other participants believe them to be. She believes that if she could get more help when she needs it, the issue of safety would not arise at all.

Need Category What Part of Life	Current Situation What It's Like Now	Goals/Hopes What We Want
Emotional and mental wellbeing.	Occasional distress, thoughts of self harm, suicide, sense of loss of control. Difficulty sleeping, ruminating on distressing thoughts.	Minimal distress, manage it to feel 'in control'. Minimise use of sleeping medications, avoid excessive alcohol and unprescribed medications.
Personal safety and safety of others.	Jana feels unsafe at times, feels no one is there to help and, has harmed herself. Jana has threatened others and property and, at times, has damaged property.	More sense of control over angry feelings. More access to support when needed. Less thoughts of harm to self. No aggression to others. No serious harm to self, less injury to self.
Friendship/social relationships.	Jana doesn't see old friends, gets on reasonably well with others at home. Doesn't like being visited by an older man who was in the acute unit at the same time as Jana last year.	Some more friends her age interested in similar things, possibly a boyfriend.
Work/leisure/education.	Left school several years ago, no work currently, leisure activities mostly via youth centre, often bored. Long interest in hospitality area, introduced to workers at a local work training agency recently.	Wanting to work in restaurant or hotel, part-time initially; wanting more money for a range of leisure activities, for example, going to see live music.

Strategies/Interventions	Timing and Responsibility	Outcome
What We Are Going To Do	How Long Will We Try It? Who Is Involved?	What Happened?
<p>Express distress and emotions and be heard, identify what triggers distress, within supportive relationships.</p> <p>Review medication, on basis of present stresses and mental-state review.</p>	<p>Jana to approach case manager and/or Bronwyn weekly and arrange uninterrupted time to talk. Case manager to visit at home fortnightly at arranged time.</p> <p>Jana to contact case manager if sleeping poorly. Treating doctor and case manager meet with Jana regularly and as needed.</p>	
<p>Jana and case manager will regularly talk about ways of managing feelings.</p> <p>Jana will phone for assistance before harming herself, before drinking alcohol—in hours, Jana will call case manager; after hours, CAT will speak with Jana for 10–20 minutes, focus on practical strategies and feedback to case manager next day.</p> <p>Case manager will liaise with CAT and acute unit if Jana is experiencing increased distress.</p>	<p>Case manager and Jana work together weekly. Jana, case manager and other services to be in contact as needed.</p> <p>Jana and case manager to review effectiveness of support contacts regularly.</p>	
<p>Jana to spend time at the youth centre, playing pool, involving herself in more activities, spending less time with just Bronwyn.</p> <p>Jana, case manager and Bronwyn to discuss issues in an ongoing way re building relationships.</p>	<p>Jana to initiate, with support of Bronwyn and case manager.</p>	
<p>Jana to join work training program, with support of Bronwyn.</p> <p>Jana to try out social activities via the drop-in centre.</p>	<p>Commence program this week, Bronwyn to be support/contact person for agency; Jana, Bronwyn and case manager to review support needed after two weeks.</p>	



Steps to the Development of an Effective ISP

- The case manager coordinates a needs for service assessment and prepares a needs summary written in clear and simple language.
- A copy of the needs summary is given to the client.
- The needs summary has identified the priority needs for attention in the ISP and clarified and included note of any differences of opinion among those involved.
- The case manager and client discuss ways to develop the ISP. Included in the discussion are:
 - clarification about client preferences and choice regarding who is to participate.
 - how to ensure that others who are to participate have the opportunity to do so.
- An ISP is developed by the case manager in collaboration with the client and other participants to meet the priority needs identified in the needs for service assessment.
- The ISP includes information about:
 - the current situation and definition of problem/s;
 - the goals to improve the situation and indicators of their achievement;
 - the strategies for achieving the goals;
 - the persons responsible for implementing strategies.
- The completed ISP is endorsed by the Director of Clinical Services or delegate.
- A date for review of the ISP is set for six months time.
- A copy of the ISP is given to the client and other relevant parties.
- A copy of the ISP is placed in the clinical file.