

*Victoria's Mental Health Service
Resources for Case Managers
Needs for Service Assessment and
Review: A Collaborative Approach*

Human
Services



Peoplefirst



Resources for Case Managers
Needs for Service Assessment and Review:
A Collaborative Approach

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Needs for Service Assessment and Review in Mental Health Services

Needs for Service Assessment at a Glance

A collaborative approach will be adopted when assessing needs for service and reviewing outcomes of an Individual Service Plan (ISP).

A simply written summary of priority needs, noting the range of views of those involved, will be given to consumers, together with the ISP based on these needs, and attached to the clinical file within six to eight weeks of initial contact.

Information will be provided for consumers and their families and/or other carers about needs assessment and review, in a relevant and accessible manner.

Information will be recorded and collated across the areas of need, for individual review and for overall service planning and review.

These guidelines describe basic expectations for needs for service assessment and review. They build on policy outlined in the *Improved Access through Coordinated Client Care* document for service delivery in mental health services. The guidelines cover an approach to assessment, categories for assessment and review and related documentation.

People with serious mental illness characteristically have diverse needs. To meet these needs, it may be necessary to use a range of services, including disability support as well as treatment services.

These guidelines are relevant for individual assessment, planning and review, as well as broader issues of service planning and evaluation of outcomes. They have been developed in consultation with consumers, their families and other carers, mental health service workers and disability support workers across Victoria, through the *Needs Assessment and Consumer Outcomes (NACO) Project*.



A Collaborative Approach

This approach is based on a philosophy of service delivery that involves a partnership between those using and those providing services. Prominent advocates of a collaborative approach emphasise the importance of maximising the involvement of the person using the service in the management of his or her illness and the consequences. This approach can lead to improved outcomes. Clients often require a range of services. Cooperation among different services can help to improve access.

The episodic nature of mental illness, balancing community safety and individual rights, and finite resources contributes to a complex context for promoting a collaborative approach.

The principles outlined here are intended to guide this approach.

Principles

- Empowerment of consumers, by maximising their autonomy in decision making about management of their illness, its lifestyle consequences and their use of services.
- Recognition of the different views and experiences of the consumer, service providers and family members or other caregivers.
- Development of a partnership relationship between those using and those providing services.
- Use of negotiation, mediation and other problem-solving strategies, when conflicts are likely to impede appropriate service delivery for the consumer and carers.

Fostering Relationships

Cooperation among the key services is necessary for responsive service provision. Often, good working relationships are established on an informal basis by individual workers. If all consumers are to benefit from this, effort is required to build formal cooperative links between services. This is particularly important for clinical mental health services, disability support services and primary health care providers, as they all play a pivotal role in direct service delivery.

It takes time to develop relationships between clinical staff and consumers. There is an evolving understanding of personal and cultural issues. When a sense of trust and rapport is developed, consumers are more able to express their needs and preferences. In the acute phase of illness, it may be impossible for people to identify longer-term lifestyle needs. A personalised approach to provision of treatment and support at this time, however, can build the foundations for a positive relationship.

There may be a friend, family member or other service provider, such as a disability support worker, who has a good rapport with the person with a mental illness. This relationship, when respected by the range of services, can assist in gaining a good sense of need, preferences and outcomes from the consumer's perspective. Links with ethnic workers provide a clear example of this for people from non-English speaking backgrounds.

Process Outcomes

When a collaborative approach is adopted, it should be evident in the following areas of practice. These areas can be included in local procedures for quality assurance. To be confident in this approach, clinical staff need access to training and support on issues of confidentiality and consent.

- Consumer's choice and preferences are used as a major guide for decision-making about services provided for them.
- Consumers are given information in a timely and sensitive way to ensure their maximal participation and confidentiality is respected.
- With the informed consent of the consumer, carers are given appropriate information. (*The Mental Health Act 1986*, Section 120A)
- Consumers are clearly invited to rely on a family member, friend or other independent advocate to assist them with contact with services.
- Any implications for those living with them or supporting them in other ways are addressed, and the nature of this information and support to carers is explained to direct consumers in a timely and sensitive way.

- Where interventions are pursued in conflict with consumer or carer preferences, reasons for this are clearly explained to them, documented and the outcome reviewed.
- Where a desired service or specific intervention is unavailable, this is clearly explained to consumers and any relevant caregivers.
- Appropriate services are involved in the assessment and review process, through negotiation with the consumer and their carers, with the consumer's consent. This can often include primary health care providers, disability support services and ethnic workers.
- Consumers and carers are given clear information about how to lodge a complaint or offer suggestions if they believe they have not been appropriately involved in the decision-making. To ensure consumers that access to services will not be jeopardised, service mechanisms are in place to address complaints. Some services have already found many of these procedures useful for service development and averting individual crises that were likely to lead to relapse.

Duty of Care

There will be situations where involuntary treatment will be initiated by clinical staff in line with requirements of the Mental Health Act, either in direct conflict with the person's wishes or when the person is judged to be without the capacity to consent. It is essential that people are clearly informed about such decisions and the reasons for them at the earliest possible time. With their consent, this can occur whenever possible in the presence of someone they trust.

Public mental health services are obliged to fulfil the requirements of the Mental Health Act and policy guidelines relating to the Act concerning information about rights and treatment. In order to continue to maximise the chance for collaborative work, clinical staff will need to deal with the impact of involuntary treatment in the person's life and its meaning for him or her.

Illustration of Collaboration in Practice

The following example briefly illustrates collaborative practice. It describes a relatively straightforward path, and we are all aware that this path is often less clear in practice.

Brief Example

Nineteen year old Andrew is reluctant to use any treatment services. Although he knows he has trouble thinking clearly, hears voices and feels depressed, he does not believe he is mentally ill. He is ambivalent about using prescribed medication. It helps him think more clearly but slows him down and makes it hard for him to maintain his belief that he is not mentally ill. Sharing general community views about stigma and mental illness, he sees being mentally ill as the worst possible thing in life. Finding a girlfriend and a job in the music industry are his goals for the future. Recently, since the onset of psychotic symptoms, he has been on a short fuse at home, with several aggressive outbursts resulting in broken windows and furniture. He is prepared to have his family involved with services. Andrew is comfortable participating in a leisure activity program at the local disability support service and does not have temper outbursts there.

His parents are in a state of grief and fear about his circumstances. They see his goals as sad and totally unrealistic, at least in the medium term. They are most concerned about his mental and emotional wellbeing and safety for everyone.

Clinical staff recognise the values of his hopes and goals for the future. They are concerned about his current symptoms, his adjustment and response to his experience of mental illness and potential consequences for his own and his family's safety, his general functioning, quality of life and prospects for recovery.

Staff of the mental health service are convinced that stabilising Andrew's mental state with the use of carefully prescribed medication is a primary strategy to meet a range of ongoing needs. They give careful attention to informing him about its effects and potential side effects in the short and longer-term. They also inform him about possible outcomes without the use of medication. They make it clear that they understand his reluctance

and concerns about being labelled as mentally ill and make sure he gets access to information that he can explore with workers and others about recovery from mental illness.

Andrew is still reluctant and suggests a month trial with medication and then a month without. His parents are very cautious about this suggestion. With encouragement from clinical staff, they agree to support him in this trial, hoping that he will continue to use the medication if it helps him and he feels more in control of its use.

Staff consider the safety issue with Andrew and his family and spell out decisions that might be taken if they think he or others are endangered.

Decision-Making Factors

The following factors are weighed up when making decisions about service delivery:

- *safety must be the factor that is given most careful attention.*
- *safety for all participants.*
- *ensuring*
 - *Andrew's participation in his own treatment and lifestyle decisions; and*
 - *provision of maximal information about options and probable consequences.*
- *use of optimal treatment/interventions, considering efficacy for short and longer-term outcomes.*
- *ensuring immediate family members' concerns for their son's and their own needs are sensitively considered with appropriate intervention.*

Resources

Available resources in the formal and informal network will influence decision-making based on the above factors.

Where there are resource implications that significantly limit the adoption of best practice, these will need to be made clear to Andrew and his family. (When possible, these can be recorded for the mental health service in a way that aids review of overall service planning and targeting.)

Balancing Needs and Resources and Negotiating Plans for Service Provision

It is apparent in this example that several decisions will be made about the nature of services offered and accepted among the key people involved. All parties will need adequate information on which to base such decisions. This information base is usually developed through establishing a relationship, not just exchanging 'facts'. Andrew's consent will be sought for any exchange of personal information. Andrew and other family members will need support and assistance with managing issues of safety and will need clear information about why a particular strategy is adopted.

Clinical staff are likely to attempt to engage Andrew more positively in treatment, by working with him on steps towards meeting his longer term goals. This will involve consideration of his own explanatory views and can include some flexibility and trial and error with his use of prescribed medication. Cooperative work with the disability support service can promote progress towards Andrew's goals in an environment that he prefers, where he can have other experiences that may in time influence short and longer-term goals.

Andrew and clinical staff will need to hear family members' views about their experiences in day-to-day living consequent to treatment decisions, in order to monitor and inform ongoing decisions.



Needs for Service Assessment and Review Categories

Categories of need can be developed in a variety of ways to ensure a relevant comprehensive assessment.

- The categories outlined are derived from professional literature, consultation with consumers and carers, and the local Project Focus study (1991–1992), which explored *Needs for Care* and effective interventions for people with mental illness.
- They reflect the broad life activity areas commonly covered for assessment and individual planning in many fields of human service delivery.
- Greater emphasis is given to dealing with stress and the personal and family response to the illness as major categories than in other service fields. It is essential that these areas are given more emphasis in mental health care, as they are directly associated with potential for recovery or relapse.
- Consistency in the use of need categories across services can assist the collaborative approach between service providers and consumers, and among the range of service providers.

Consistent information can be provided for consumers and carers about the sort of areas that are likely to be explored by workers and for what purpose. It can also assist the aggregation of data on needs for comparative purpose to address questions like *How well are we meeting the need for supported housing?* or *How often do individuals identify dealing with stress as a priority need?*

Stress/Vulnerability Model

The assessment coverage reflects a recognition of the significance of vulnerability to stress. This approach assumes that symptoms can be reduced by interventions in a range of need areas. Where symptomatology cannot be reduced, improvement in quality of life through reducing disability and disadvantage may be achieved. This approach implies that treatment and lifestyle issues need to be addressed together in order to achieve the optimal outcome for any individual.

The needs for service assessment covers similar territory to a biopsychosocial assessment. However, it places greater emphasis on specifying the priority needs that can potentially be met by services, arising from a broad assessment. It takes into account the range of services that are available and the acceptability of services to consumers and carers, in order to maximise positive outcomes in the short and longer-term.

Language

The language adopted for the categories reflects the preference of consumers, who were consulted in the NACO project. It is important within a collaborative approach that there is a common understanding of terms, using plain language and avoiding jargon. The information developed for consumers will assist them with understanding the assessment and review process. This will involve ongoing evaluation of the usefulness of information provided.

People from non-English speaking backgrounds face many barriers with access to responsive services. This not only involves language barriers but also cultural barriers that relate to explanatory models of illness and attitudes to seeking help from services. In the assessment and review process, every effort should be made to ensure a more culturally sensitive process for consumers.

Comprehensiveness

Many of these categories are intertwined in the reality of people's lives. By specifying them, it ensures that areas are not overlooked by the services or consumers. It promotes a balance of emphasis in the different need categories that reflect consumer and carer needs, not the service system's biases.

Some specific areas to consider are included to illustrate territory covered within categories. These can signal when a more in-depth assessment is required. This may be carried out by a specialised practitioner or service, once the overall priority need has been established. For example, many disability support services will cover an in-depth assessment of housing support, work and leisure needs, and evidence of past head injury may lead to neuropsychological assessment to determine any new learning problems.

List of Need Categories

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. People 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.
- 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 serious 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 parents with a mental illness; and consideration of the requirements for the involvement of Protective Services.
- 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 have 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.
- Successful experiences.

Daily Living Skills

The ability to maintain independent living skills can influence the likely housing and social relationship options for people with a serious mental illness. Some people 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 people 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 seeking help and response to person with illness.
- Tension levels in family relationships, need for and response to information about illness/treatment, resources and strengths of family unit or alternative caregivers.
- Economic or health problems.
- Degree of support experienced by member with a mental illness, guilt and blame issues for all family members, degree of isolation or connectedness of family with community, special needs of children of mentally ill parents.
- Confidentiality.

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. People 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, people 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 or other seriously disabling psychiatric disorders and because of community stigma, attention to rights and advocacy for active community participation are important for achieving improved outcomes. Linking with self-help and consumer advocacy groups and legal advocacy may help individuals overcome 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 and information about services and to self-advocate.
- Choice about including a personal support person.
- Guardianship or administration requirements.



Process of Assessment

This approach to assessment can be time intensive, particularly at initial stages of establishing needs and an ISP. If consequent service delivery is coordinated and responsive to individual need, this can, however, be more efficacious. Caseloads will need to reflect sensibly the level of intensity of work at different stages, in addition to the complexity of needs. Brief measures of response difficulty and levels of functioning, existing informal support networks, and the level of expertise of staff can influence how reasonable caseloads are determined.

Initial Assessment

The initial service requirements for any person are addressed at the intake assessment, where immediate and short-term needs are identified. Initial contact often occurs in the context of a crisis situation or after onset of an acute episode of illness. The *Crisis Assessment and Treatment Service Guidelines For Service Provision* and the *Improved Access through Coordinated Client Care* policy both outline the focus of assessment for intake. Giving careful attention to risk assessment is important at initial contact.

At this initial assessment, the wide range of needs for service categories is addressed but in the context of immediate need, for example ensuring that the person's children are safe and well cared for and that Protective Services are notified if appropriate, or the person's housing tenure is not put at risk and that appropriate treatment is initiated. It is essential that other key services are identified at this time so that a culture of collaboration can be initiated and maintained.

Case Manager's Role

When crisis stabilisation has occurred and/or the person is not so acutely ill, issues of longer-term recovery and associated needs and goals for the person become more relevant.

It may take some time to build a trusting rapport with a person and other caregivers and family members. It may also take some time for people to identify their needs and goals related to these. The clinical mental

health service will assign a clinical case manager. It is the case manager's responsibility to ensure that the needs for service assessment and subsequent planning and review occurs within a collaborative framework.

In reality, case management functions may be assumed appropriately by a key worker in another service, whilst the clinical case manager maintains a monitoring role for the clinical mental health service. In order to determine the appropriateness of such arrangements, there should be formal efforts to promote linkages amongst relevant services as well as the effort by individual key workers or clinical case managers.

At the time of initially assessing needs for service and at review, the case manager will be mindful of the value of involving disability support and primary health care in the ongoing provision of service. It is important that referral options and shared or collaborative service provision are addressed at an early stage, not just when considering closure.

It is essential that the consumer's preferences and choices are respected about who is involved and how the assessment of need is conducted and reviewed.

Promoting areas of need on a regular basis can help identify changing needs over time and facilitate the consumer's involvement in an ongoing way. Some consumers refer to the experience of being processed when practitioners are using guides to assessment. *It is important to emphasise that the assessment process be sensitive to the individual's preferences about process and timing.* A person's privacy should not be invaded unnecessarily.

Diversity of Individual Need

There will be great variability in the needs identified and their consequences for service delivery. For some people, only a few need categories may be relevant, even though intensive work may be indicated over a considerable period of time. For example, a person who has depressive symptoms and suicidal ideas or intentions may have only one or two priority need areas, such as *dealing with stress* and *emotional and mental*

wellbeing. Such needs may arise in the context of a recent crisis with a background of early life experiences of trauma and may require intensive therapeutic work in addition to referral to a sexual assault service. It is also likely, however, that many people with serious mental illness will have a range of complex needs and that there will be differing priorities within these over time. It is sobering to note that nearly 90 per cent of people who do use psychiatric services are not employed and a high proportion are receiving a disability support pension, indicating long-term disability. Many of these people are perceived as socially isolated.

Consumer and Carer Information

A person's changing needs and state of mental health will influence how to convey information effectively. It is clear, from a wide range of consumer research projects, that many consumers do not believe they receive appropriate and adequate information, to assist them to make choices about their treatment and care. Staff of mental health services, however, often believe they are providing information effectively.

Family members and other carers express similar concerns to consumers about a lack of information about mental illness, services and issues for them as carers and or relatives. A key issue to inform carers about is confidentiality, when the consumer does not consent to full disclosure of information. It is important that carers' concerns are heard in these circumstances.

It is important that a range of methods are used to provide information and that this is done in an open-ended way, where consumers and carers (with the consumer's consent) are offered information and given opportunities to ask about any issues related to mental illness, treatment and service provision.

Information about the assessment and review process must be made available and culturally accessible to consumers, family members and other carers.

Need Summary and ISP

A requirement for ongoing work with any person is the preparation of a summary of priority need areas as the first step toward an ISP. This will be prepared within the first six to eight weeks of contact and reviewed after six months as outlined in Improved Access Through Coordinated Client Care. Earlier reviews may be appropriate in given circumstances.

The workload for some services may make this very difficult to achieve in the short term. Local criteria will need to be set that will guide priorities for review, in the staged implementation of the coordinated client care policy.

For people with persistent illness and high levels of disability, changes in life circumstances and opportunities to make choices can often be overlooked. The review provides a marker in time. Even after many years, a person may be ready to look at issues that have been raised previously with little response.

- The assessment process may involve several steps and a range of contacts with the person and other family and caregivers, and other relevant service providers.
- The written summary with accompanying ISP should reflect the discussion and negotiation of priority needs amongst the person, carers and workers.
- Differing views will be explicitly recorded.
- A focus on priority needs may avoid unnecessary documentation in an ISP.
- The person will have the opportunity to nominate a friend or family member to be present when finalising the summary and plan. A week will be given for the person to reconsider the priority needs and the ISP.
- The need summary with the ISP is a document for clients. They can take this with them to other services if they choose.
- The summary and ISP can be placed on the clinical record with a colour code for easy access.

- Sample formats for a need summary and ISP are attached in the Appendices. Formats adopted should be clear, readable, flexible and assist the collaborative process.
- At review it is important to revisit the needs assessment and the ISP with the person and other relevant people.

Sharing Information with Family and Other Caregivers

In the process of assessment, it may become apparent that there is an impasse amongst family members and the primary consumer. Even without overt conflict, it may be appropriate to deal with some issues jointly and some separately. This will be guided by sensitive and honest practice and understanding of confidentiality. Confidentiality provisions do not prevent asking family members and other carers for information but rather relate to disclosure of information. Confidentiality within the meaning of section 120 of the Mental Health Act will be respected and exceptions noted.

Within this context, it is important to involve the person and carers (with consent) in what information will be shared and how this will be done, rather than apply blanket rules.

In a collaborative approach, attempts are made at mediation and negotiation to support primary family relationships and those with other caregivers where possible. Families are the primary support network for many people with serious mental illness. Positive relationships with families are associated with better recovery.

Sharing Information about Progress among Services

The collaborative approach includes working with other services to meet the needs of the individual and relevant family and caregivers. Confidentiality requirements must be maintained sensibly and sensitively. Exemptions outlined in the Mental Health Act relate to informed consent and further treatment. Disability support services, general practitioners and generic community services may be actively involved in providing services to meet identified priority needs.

Whenever possible, it will be valuable for the area mental health service with the clinical case management role actively to incorporate information from these services, across need categories, for review. This will involve clearly explaining this process to people using services and ensuring their informed consent, and actively involving these other services in the assessment and review process as appropriate.

Sharing information for assessment and review for the benefit of the person and overall evaluation of outcomes for consumers is encouraged strongly. It is recognised, however, that services may choose not to relay information in accordance with the wishes of particular individuals.



Review and Consumer Outcomes

Closure and Referral

One potential result of review is closure. The circumstances under which closure will occur must be made clear in the information for consumers and carers as must information on how to access services again, when required. This should be a negotiated process between clinical staff and consumers.

Identified priority needs may still persist in some categories of need when closure and referral to primary health care and/or disability support services is judged to be appropriate by the clinical case manager. This judgement should be informed by the consumer's preference, carer's opinions (where it is beneficial to the person) and other service providers currently involved or likely to contribute to ongoing service for the person. This decision should be taken when the need for direct service provision or ongoing monitoring is no longer present.

If a collaborative approach has been adopted throughout the time of service provision, then it should be clear that ongoing service provision is in place from other services and that continuing process for review of needs is available from these services for the person. This can include negotiation with private psychiatrists as well as primary health care and disability support services. It is recognised that the range and level of other health and welfare services varies widely in different areas of Victoria.

Where referrals are made to private health care practitioners, effort should be made to alert these practitioners to the wider range of ongoing needs and the role of other services, such as disability support services, clinical services and other local community services in supporting the person.

Outcomes

The range of needs that have been met can be included in an evaluation of consumer outcomes. At review, needs are reassessed and the outcome of interventions related to needs and goals are reviewed. The degree to which goals are achieved and needs met can be linked with service effectiveness as mental health care outcomes. Need status alone, however, is not measure of consumer outcome in its own right. Ongoing need in

particular areas is not necessarily an indicator of poor effectiveness or need that has been unmet. This information must be matched with planned and attempted interventions and other factors, for example service availability and level of disability, diagnostic complexity, service response difficulty and level of environment support. The information on met and unmet needs can, however, give good indication of changes in quality of life.

The perspective of all parties and the acceptability of interventions planned and attempted will be noted in the information collected on needs. This provides useful information, for ongoing monitoring and review, about the relationship between the effectiveness of interventions and their acceptability to consumers and carers. The level and type of continuing unmet priority needs at the point of closure can also be reviewed to inform local quality assurance processes and to modify practice or resource levels.

Aggregation of this information across the client group, identifying subgroups, is potentially useful for outcome-based performance evaluation and service targeting. For example, it may be noted that 30 per cent of people have a priority need related to housing and that, within six months, this need is met for only 10 per cent of these people. This provides a flag for questioning issues of service availability and the focus of practice.

In order to measure consumer outcomes, additional brief measures that focus on health status, quality of life and levels of functioning from subjective and objective perspectives can be considered. Such measures are under review at the national level for potential inclusion in the national mental health minimum data set. These brief measures can be useful at different points, such as intake, to coincide with the needs for service assessment and for review. Over time, baselines on such measures and levels of need for performance evaluation can be established, that are shaped by realistic expectations of service effectiveness.



Appendices

Appendix 1

Sample Format for Need Summary To Accompany Individual Service Plan

Name:

Address:

Date Completed:

Participants and Their Role:

Priority Needs Areas Identified by:

- **Client (consider your own needs and your opinion about the needs of your family or other caregivers):#**

- **Family member, friend or advocate (present at client's request):**

- **Family members and other caregivers (consider your own needs and your opinion about those of your relative who requires services): ***

• **Workers (specify name, role and service):**

The Attached Service Plan Will Cover the Following Priority Needs:

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

The Reasons (in Brief) for This Are:

Notes

This might be completed by the person directly, in consultation with a friend or advocate or via interview with a worker; different approaches will be appropriate for people at different times.

* Family issues may be addressed in a separate summary, where this is appropriate. The summary and ISP could be signed by participants in the process, if this is appropriate.

Appendix 2

Sample Format for Individual Service Plan (ISP)

Need Category What Part of Life	Current Situation What It's Like Now	Goals/Hopes What We Want	Strategies/ Interventions What We Are Going To Do	Timing and Responsibility How Long Will We Try It? Who Is Involved?	Outcome What Happened?

List of Need Categories:
 Emotional and Mental Wellbeing; Dealing with Stress; Personal Response to Illness; Personal Safety and 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.