

HRN

Stay Strong Plan

DATE:...../...../.....

PRINCIPAL NAME (AKA)	OTHER NAMES	DOB:...../...../.....
-------------------------	-------------	-----------------------

People that help to keep me strong: (family, friends, elders, carers)

I trust this person to give advice about my treatment _____

Things that help to keep me strong: (spiritual, cultural, physical, family, social, mental and emotional) (Tick or circle)

<input type="checkbox"/> Culture, language, heritage, spiritual belief	<input type="checkbox"/> Work
<input type="checkbox"/> Art and craft	<input type="checkbox"/> Music
<input type="checkbox"/> Dance	<input type="checkbox"/> Teaching children
<input type="checkbox"/> Going to country	<input type="checkbox"/> Hunting and fishing
<input type="checkbox"/> Health centre, health worker, doctor,	<input type="checkbox"/> Knowing about illness and treatment
<input type="checkbox"/> Medication	<input type="checkbox"/> Support
<input type="checkbox"/> Good diet	<input type="checkbox"/> Family
<input type="checkbox"/> Exerise	<input type="checkbox"/> Positive thinking
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____

Some of the worries I have are: (Tick or circle)

<input type="checkbox"/> Culture or spiritual worries	<input type="checkbox"/> Family or relationship worries
<input type="checkbox"/> Not many activites eg music, hunting, fishing, art and craft	<input type="checkbox"/> Feeling alone – not mixing much with others
<input type="checkbox"/> Not enough exercising	<input type="checkbox"/> Not working or trouble at work
<input type="checkbox"/> Not taking medication or treatment	<input type="checkbox"/> Gambling worries
<input type="checkbox"/> Physical Illness _____	<input type="checkbox"/> Not knowing enough about illness and treatment
<input type="checkbox"/> Hearing trouble	<input type="checkbox"/> Feeling anxious or nervous or jumpy
<input type="checkbox"/> Not eating well	<input type="checkbox"/> Violence or other problem behaviour
<input type="checkbox"/> Memory worry	<input type="checkbox"/> Not caring for self: trouble shopping, cooking, cleaning
<input type="checkbox"/> Sleep worry	<input type="checkbox"/> Feeling sad inside, no interest in doing things
<input type="checkbox"/> Marijuana, alcohol, cigarettes, other drugs	<input type="checkbox"/> Mixed up thoughts, paranoid thinking, silly thoughts
<input type="checkbox"/> Side effects of medicine: sleepiness, tight muscles, other	<input type="checkbox"/> Hearing voices or seeing things
<input type="checkbox"/> Too much energy, can't slow down, thinking too fast	<input type="checkbox"/> Self harm behaviour or thoughts of suicide
<input type="checkbox"/> Other worry _____	<input type="checkbox"/> Other worry _____

Detail of worries / current issues

Past worries: relevant family, medical, psychiatric and forensic history (trouble with the police or the law)

Early warning signs of me getting sick are:

1.	3.
2.	4.

If I know I am getting sick I will do these things to get help quickly:

- 1.
- 2.
- 3.

Progress toward previous goals: Previous care plan completed? ____ Previous care plan reviewed ? ____

HRN

Stay Strong Plan

DATE:...../...../.....

Goals I have today for changing worries – step by step:	
<p>Goals are things that we want to do differently. The steps to the goal help us to check how we are going. They should be do-able and measurable. Follow up with review and feedback.</p> <p>Goal:</p> <p>_____</p> <p>Step 1.</p> <p>Step 2.</p> <p>Step 3.</p> <p>What would be good about making this change:</p>	<p>Think about: What will help? And who? And what has helped before? Change is your own choice. Everyone can make changes. Small steps can lead to big changes.</p> <p>Goal:</p> <p>_____</p> <p>Step 1.</p> <p>Step 2.</p> <p>Step 3.</p> <p>What would be good about making this change:</p>

Treatment goals for other Problems:		
Other Problem (Diagnosis)	Goal and steps	Who will help

Other treatments that I am trying :	Who will help:
<p>1. Compliance strategies (Webster pack, dosette, depot)</p> <p>2. Life style changes (substance use, diet, exercise, smoking, time-out, go bush, job training)</p> <p>3. Cultural or spiritual activity or treatment (going to country, healer, church)</p> <p>4. Other services (counselling, other treatments, treatment for physical illness, investigations)</p>	

5. Medication plan (Dose, Frequency and route): see prescription for details

I sometimes get worries that I call

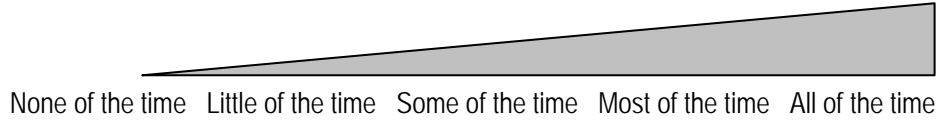
The diagnosis today is

Signed (Client) _____ Signed (Practitioner) _____

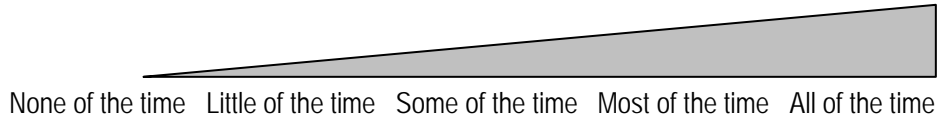
The following measures can be useful well being screening tools. The first is an abbreviated version of the Kessler K-10 scale

In the last four weeks how often did you feel?

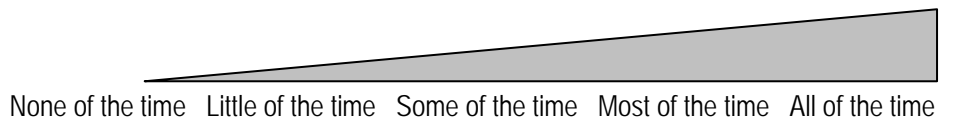
Nervous or anxious?



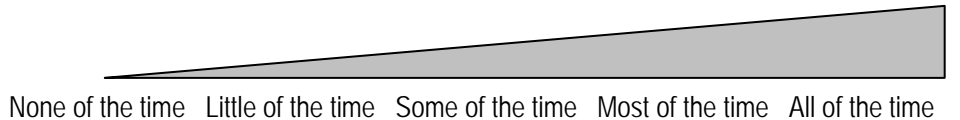
Hopeless (without hope)?



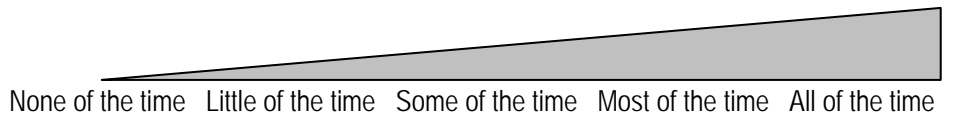
Restless or jumpy?



Everything was an effort?



So sad nothing could cheer you up?



Scores

1 2 3 4 5

Total Score

Risk of anxiety or depressive disorder
 5 – 11 Low or no risk
 12 – 25 Medium to High risk

Follow up indicated
 Follow up arranged

(5 item Kessler K10 well being scale)

Alternative three item outcome measure and screening tool for depression

1. During the past month have you often been bothered by feeling down, depressed or hopeless?
 Yes No

2. During the past month, have you often been bothered by having little interest or pleasure in doing things?
 Yes No

3. Is this something with which you would like help?
 Yes Yes, but not today No

If client scores yes to either 1 or 2 AND yes to 3 follow up for possible depression is indicated (Whooley version of PHQ 2) This care plan meets requirements for Medicare items 2710, 2712, 2713 and Team Care arrangements

HRN

Stay Strong Plan

DATE:...../...../.....

This page for practitioner use only

Mental state examination	
Appearance (Dishevelled? Well kempt?)	Affect (Happy? Sad?)
Behaviour (Agitated? Relaxed?)	Perception (Voices? Spirits?)
Conversation (Sensible? Confused?)	Cognition (Attention? Memory?)

Risk Assessment 1 = no apparent risk 2 = low risk 3 = some risk 4 = big risk 5 = very big risk														
Self Harm or suicide risk					Harm to Others					Vulnerability – cannot look after self				
1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Circle the number that matches your assessment of level of risk. Risk issues addressed by following actions:														

Outcome measures scores						
Kessler 10	or	5	HoNOS	LSP	Other	Other

Tick or circle other care planning interventions	
<input type="checkbox"/> Dosette or Webster pack offered today	<input type="checkbox"/> Client psycho education / illness information given today
<input type="checkbox"/> Carer psycho education given today	<input type="checkbox"/> Referral for counselling or further support organised today
<input type="checkbox"/> Adult Health Check in last 12 months (BP, Weight, urine check)	OR <input type="checkbox"/> Adult Health Check arranged today
<input type="checkbox"/> Liver/Renal/Thyroid/BP/Weight/Lipid check in last 6 -12 months	<input type="checkbox"/> New tests ordered today
<input type="checkbox"/> Mood stabiliser check in last 3 months or circle 'not applicable'	<input type="checkbox"/> New tests ordered today

Mental Health Care Team	Name
Carer	
Aboriginal Mental Health Worker/Health Worker	
General Practitioner	
Registered Nurse	
Allied Health	
Traditional Healer	
Registered Psychiatric Nurse	

Care Plan completed at Hospital Health Centre _____ Recorded on recall list

Date of next review _____/...../.....