HOUSING AND ACCOMMODATION SUPPORT INITIATIVE I EVALUATION

CARE PLANNING REPORT

GUIDE FOR NSW HEALTH AND HASI PARTNERS IN THE HASI DEVELOPMENT

SPRC Report 13/08

Social Policy Research Centre
August 2008

For a full list of SPRC Publications see, www.sprc.unsw.edu.au or contact:
Publications, SPRC, University of New South Wales, Sydney, NSW, 2052, Australia.
Telephone: +61 (2) 9385 7802 Fax: +61 (2) 9385 7838 Email: sprc@unsw.edu.au

ISSN 1446 4179

ISBN 978 0 7334 2667 4

Submitted: May 2007

Published: August 2008

Social Policy Research Centre

Karen Fisher, Ann Dadich, Kristy Muir and David Abelló

Authors

Ann Dadich and Karen R. Fisher

Contacts

Karen Fisher Social Policy Research Centre, University of New South Wales, NSW 2052, ph 02 9385 7813, email karen.fisher@unsw.edu.au

Acknowledgements

This research forms part of the program of research commissioned by the NSW Department of Housing and NSW Health from the Social Policy Research Centre and Disability Studies and Research Institute. Thank you to all the participants in the HASI Evaluation.

Suggested Citation

Dadich, A. and Fisher, K.R. (2008), Housing and Accommodation Support Initiative I Evaluation, Care Planning Report, SPRC Report 13/08, final report prepared for NSW Health, Submitted May 2007, Published: August 2008

Foreword

The progression of the HASI program in NSW has been impressive, in both its innovation and pace. This progression owes much to the strong commitment to the HASI program by the NSW Government and HASI partners.

The HASI program provides a platform to support mental health consumers on their individual journeys to recovery in the community. The key partners work closely with consumers, and where appropriate, their families and carers, under a psychosocial support model. The Program delivery is guided by the HASI Manual, which sets the tone and framework for active, functional partnerships between the agencies and individuals involved.

The University of New South Wales evaluation of the first stage of the HASI program found that it was an outstanding success. Some of the key outcomes that HASI was found to deliver include:

- 81% of participants had significantly improved family relationships since participating in the HASI program.
- 85% of participants remained with the same housing provider and reported numerous benefits associated with secure, affordable housing.
- A significant increase in community participation was reported by a vast majority of participants, including the establishment of friendships and participation in social and community activities, work and study.
- Over half of the participants reported improved physical health from access to appropriate resources.
- 68% of participants had improved symptoms, social and living skills, and a decrease in psychological distress.
- Hospitalisation rates, frequency and duration reduced for 84% of participants. Time spend in hospital and emergency departments decreased by 81%.
- 92% of participants regularly saw their mental health case manager and 89% were still in contact with their psychiatrists.

The full results of this research have been provided to the HASI partners, and inform decision making at all levels of program delivery. Practice issues and ongoing program development are managed through a variety of processes, in particular via the quarterly HASI practice forums. Full program evaluation is currently in development to ensure that HASI continues to meet its goals.

The HASI Care Planning Report provides a way forward in identifying practice issues and further strengthening care planning processes and practices to achieve optimal outcomes with the consumers involved in the HASI program.

Signed
David / Director-General

Contents

Executive Summary ..... **iv**

1 Introduction **1**
1.1 Overview of HASI One 1
1.3 Limitations of the Study 3

2 HASI One Care Planning Process **5**
2.1 Assessment of Consumer Need 6
2.2 Place 7
2.3 People Involved 8
2.4 Meeting Structure 8
2.5 Identifying Consumer Need 9
2.6 Accommodating Changing Consumer Needs 10
2.7 Care Plan Copies 11

3 Consumer Involvement in Care Planning **12**
3.1 Evidence of Consumer Involvement 12
3.2 Challenges Associated with Consumer Involvement 13
3.3 Strategies to Enhance Consumer Involvement 14
3.4 Summary 14

4 Other People Involved in Care Planning **16**
4.1 Case Managers 16
4.2 Family Members and Carers 19
4.3 Housing Providers 20
4.4 Other People 20
4.5 Summary 21

5 Care Plan Content **22**
5.1 Care Plan Template 22
5.2 Goals Identified in Care Planning 23
5.3 Timeframes for Care Plan Goals 25
5.4 Challenges Associated with Care Planning 26
5.5 Role of Care Planning in Recovery 26

6 Care Plan Implementation and Review **28**
6.1 Review Processes 28
6.2 Key Worker Practices 28
6.3 Challenges Associated with Implementation and Review 29

7 Contextual Factors **31**
7.1 Interagency Collaboration 31
7.2 Staff Turnover 31
7.3 Organisational Culture 32

8 Implications for the Care Planning Process **34**
8.1 Understanding Psychosocial Support 34
8.2 Organisational Support 34
8.3 Reflective Practice 35
8.4 Integration of Support 36

9 Conclusion **37**

References **38**

Abbreviations and Glossary

ADL	Activities of Daily Living
AMHS	Area Mental Health Service(s)
AHS	Area Health Service(s)
ASP	Accommodation Support Provider(s)
BASIS-32	Behavior and Symptom Identification Scale-32
CANSAS	Camberwell Assessment of Need Short Appraisal Schedule
Case manager	Mental health clinicians from Area Mental Health Services
Care plan	A scheme towards goal attainment that articulates aims, strategies and timeframes; ASPs refer to these as support contracts, Individual Care Plans (ICPs) and Individual Support Plans (ISPs)
Care planning	Development, implementation and review of a plan towards goal attainment
DoH	NSW Department of Housing
GAF	Global Assessment of Functioning Scale
GP	General practitioner(s)
HASI	Housing and Accommodation Support Initiative
HoNOS	Health of the Nation Outcome Scale
Key worker	Staff employed by Accommodation Support Providers who provide participants with direct support
LSP	Life Skills Profile
MHDAO	Mental Health and Drug and Alcohol Office (NSW Health)
MH-OAT	Mental Health Outcomes and Assessment Training
NGO	Nongovernment organisations
NSW	New South Wales
OT	Occupational therapists
SPRC	Social Policy Research Centre, UNSW
TAFE	Technical and Further Education
UNSW	University of New South Wales

Executive Summary

The Housing and Accommodation Support Initiative (HASI) is a program funded by NSW Health and NSW Department of Housing, in partnership with nongovernment organisations (NGO). HASI provides a stable, consistent and integrated hospital to community care system for people with mental illness and associated psychiatric disability. This is achieved through providing practical assistance, intensive psychosocial support, clinical care and secure housing, along with opportunities, options and hope to people who have a mental illness (referred to here as consumers).

Care planning

An individual process 'to assist the consumer to lead a fulfilling, meaningful life in the community, that meets his or her individual needs.'

Care planning involves working with the consumer to assess their goals and needs. The resultant plan includes specific goals to assist the consumer to work towards rehabilitation and recovery.

NSW Health and NSW Department of Housing, HASI resource manual, 2005:50

This report examines the care planning practices of NGO Accommodation Support Providers (ASPs) in HASI Stage One. Funded by NSW Health, it extends a comprehensive evaluation of HASI One completed by the Social Policy Research Centre (SPRC), University of NSW (Muir et al, 2007). It has been undertaken as a result of the recommendations from that evaluation, which indicated the need to review and evaluate care planning in more detail. Methods included fieldwork in three of the nine HASI One sites (Section 1.1), including interviews with 20 consumers who participated in HASI, other people directly involved in their care planning, as well as an examination of their care plans. The key findings are listed below.

Care planning has an important role towards recovery of HASI consumers in that it:

- Facilitates communication and provides guidance between consumers and the people who support them;
- Is a source of motivation for the consumer; and
- Helps to integrate support from a number of sources.

The research found that the involvement of consumers in HASI care planning varies. Some consumers are actively involved, while others are only vaguely aware of the process. The involvement of most HASI consumers lies between the two extremes.

Key workers from ASPs and mental health case managers sometimes find it difficult to encourage consumers to direct their own service provision. This is related to the consumer's wellbeing, a change in personal preferences, or the skill or experience of the key worker or case manager.

Key workers and case managers involved in HASI Stage One use innovative ways to manage the difficulties they and the consumers encounter. Examples include observing the consumer in their own home or in social contexts and encouraging new actions.

Some key workers find the comprehensive care planning guidelines from their ASP demanding and time-consuming. They reported that at times they felt that the formal

requirements reduced the time they have available to interact with consumers. Underlying this opinion is confusion about the purpose of care plans, what the care planning process attempts to achieve and how to apply assessment and outcome information.

Two of the three sites demonstrate strong partnerships between the ASP and the Area Mental Health Service (AMHS) in care planning. This is not apparent in the remaining site, where the AMHS did not appear to be engaged with the ASP in implementing HASI One. The active involvement of AMHS case managers in care planning is beneficial to the quality of HASI because:

- The role of key workers complements AMHS case managers' focus on clinical intervention;
- Key workers and case managers learn about the other support needs of consumers participating in HASI;
- Consumers regard case managers as credible sources of clinical information;
- Case managers are able to draw on their professional networks to augment the support services available to the consumer; and
- It ensures more consistent support between the ASP and the AMHS.

The variation in care planning practices between the three sites may be attributed to contextual factors, such as differences in:

- The degree of interagency collaboration, particularly between the ASP and the AMHS, which appears to be influenced by:
    - Staff turnover within the ASP and AMHS;
    - Limited sharing of consumer information despite consumer consent; and
    - Conflicting views about the roles of the AMHS and the ASP;
- Organisational culture; and
- Staff understanding of psychosocial support and community integration.

Consumers and key workers from all three sites recognised cognitive-behavioural benefits, as well as social benefits, from care planning. However, some consumers found it difficult to articulate any personal benefit associated with the process.

Care plan review meetings are used to formally appraise and develop the plans. Care plans are also reviewed and implemented between meetings. This is typically achieved through regular communication within the ASP to discuss consumer progress. Most consumers are aware of this process and the way it influences care planning.

Reflective practice in care planning is not universal within the three sites. The research team observed instances when key workers did not effectively translate care plans into daily practice by establishing and maintaining explicit links between a need, goal and strategy.

One in four of the consumers interviewed have the involvement of family members or carers in care planning. This is often the choice of the consumer. Some consumers

have benefited from involving family members and carers in the care planning process. The benefits have included:

- Providing emotional and practical support that can be incorporated into the care plan;
- Contributing valuable information to the care planning process, including the review meetings; and
- Motivating the consumer.

A number of consumers prefer that their family members and carers do not participate in the care plan review meetings. They fear having their goals co-opted by other people or of disappointing family members.

Housing providers are largely uninvolved in care planning, as it is a process focusing on psychosocial support goals. Housing providers are involved in other aspects of planning and HASI service delivery, for instance, client selection panels, Individual Support Plans and organisational planning processes.

A few consumers advised that they would prefer care planning to involve other people who are not part of the three-way HASI partnership model. Examples include members of the clergy, disability support workers from educational institutions and consumer support workers or consumer advocates. Some respondents, including consumers, case managers and key workers, cautioned against including too many people to prevent overwhelming the consumer.

To minimise the negative consequences of staff turnover on the quality of care planning, one ASP appoints coordinators whose role is to oversee the psychosocial support of a small number of consumers. This provides consumers with access to a familiar staff member and ensures continuity in the care planning processes.

Good practices observed in the HASI One care planning include:

- Understanding the principles and processes of psychosocial support in accordance with the NSW Government Action Plan: Framework for Rehabilitation for Mental Health (2002);
- Facilitating the active participation of consumers in the planning process;
- Leadership and organisational support;
- Reflective practice; and
- The integration of support from all sources.

1 Introduction

This report forms part of the evaluation of HASI One. While not part of the original evaluation framework (Morris et al., 2005), it follows from the finding that the development of consumer care plans differs across the nine sites implementing the initiative (Morris et al., 2005; Muir et al., 2005, 2006, 2007). The purpose of this study was to explore these differences and review the effectiveness of the different approaches. This was achieved through consultation with consumers and their respective key workers from the nongovernment organisation (NGO) Accommodation Support Provider (ASP). When appropriate, consultation was extended to other people involved in the planning process, including mental health service case managers and family members.

1.1 Overview of HASI One

Jointly funded by NSW Health and the NSW Department of Housing (DoH), HASI is a partnership between NSW Health, DoH and NGOs whose core business is supported accommodation. The program is designed to 'assist people with mental health problems and disorders requiring accommodation (disability) support to participate in the community, maintain successful tenancies, improve quality of life and most importantly to assist in the recovery from mental illness' (NSW Health and NSW Department of Housing, 2005: 4).

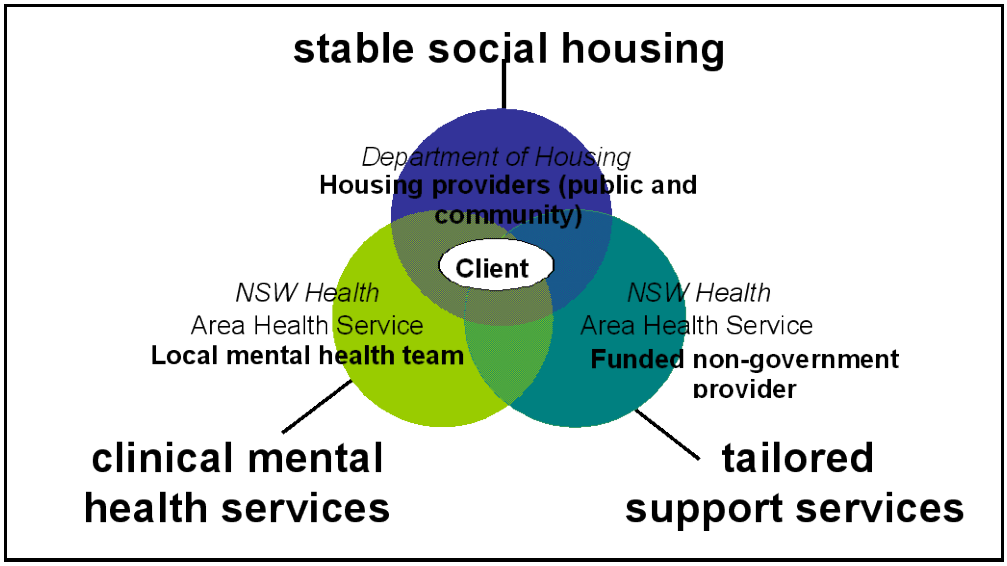
HASI is based on psychosocial support principles and has a recovery focus (NSW Health Department, 2002). From its beginnings in Stage One, the overall program provided permanent housing and long-term support for over 100 people with complex mental health problems and high levels of psychiatric disabilities. By the end of 2007 the program had over 1000 consumers across NSW.

HASI One covers nine locations within the following NSW Area Health Services (AHS): Greater Western; Hunter/New England; Northern Sydney/Central Coast; South Eastern Sydney/Illawarra; Sydney South West; and Sydney West.

These Areas are collectively supported by three NGOs: Neami, New Horizons and The Richmond Fellowship of NSW. Subsequent stages of HASI include other NGOs, as well as the three aforementioned (PRA, Mission Australia, Aftercare, Parramatta Mission, St Lukes, Uniting Care and On Track). HASI comprises a number of stages, below, with names related to funding processes. The research in this report pertains only to HASI One.

HASI funding stage	Level of Support	Maximum hours of support	Number of support packages funded	Progress
1	High	5 hours per day	100	Implementation complete
2	Low	5 hours per week	460	Implementation complete
3a	High	5 hours per day	126	Implementation complete
3b	Very high	8 hours per day	50	Currently being implemented
4a	High	5 hours per day	100	Implementation complete
4b: 'HASI in the Home'	Medium	3 hours per day	90	To be implemented (estimated late 2007)
	Low	5 hours per week	180	

The management and coordination of HASI involves a three-way partnership between DoH, the Area Mental Health Services (AMHS) and the ASP, as described in the diagram below (NSW Health and NSW Department of Housing, 2005:6). The consumer is central to this partnership, and may also choose to include their family or carer.



1.2 Methodology

The research examined consumer participation in accessing support; consumer inclusion in directing, developing and assuming responsibility for their own support and recovery; identifying consumer needs and goals; ASP care management activities; and integration of care management practices between the ASP, AMHS, housing provider and other service providers. It used a qualitative methodology.

The research team reviewed ASP care planning for 20 consumers supported in three HASI Stage One sites, by three different ASPs. The review was conducted using two methods – consultation with people directly involved in care planning, and an examination of ASP care plans for content.

The 20 consumers were randomly selected from three HASI Stage One sites, with the assistance of NSW Health. All of the consumers selected agreed to participate in the study; however, people who were unwell at time of fieldwork were substituted with other consenting participants from the same area. Participation involved an interview, permission to review the care plan, and authorisation to consult with other people involved in care planning. One consumer declined access to a family member involved in this process.

Semi-structured, open-ended interview schedules were designed to guide consultation with consumers, their key workers and other people involved in care planning. The questions addressed the research aim and objectives. The ASP care plans were examined for identified needs, strategies that were expected to lead to goal achievement, performance indicators and suggested timeframes for goal achievement.

The research material was analysed for thematic content. Themes were identified in relation to the study's aim and objectives. The themes were then compared and

contrasted between and within the sites. Interview material from different people involved in care planning was used to triangulate and verify the findings. To protect the identity of the people who participated in this study, the names of individuals, organisations and sites are not disclosed. The research findings are complemented with direct quotes to illustrate the care planning experiences.

It was not the purpose of this study to examine outcomes associated with ASP care plans, but rather, to examine care planning. Earlier reports from the evaluation of HASI Stage One include outcome findings (Morris et al., 2005; Muir et al., 2006; Muir et al., 2005; Muir et al., 2006). In the scope of this study, care plans developed by AMHS were not included. AMHS care planning is more directed at clinical, rather than social content, and variation between Areas relates to AMHS practices, rather than HASI program management.

In addition to the 20 randomly selected consumers, 22 other people were consulted including key workers, and, when appropriate, ASP managers, case managers and family members (Table 1.1).

Table 1.1: Respondents

	Number
Consumers	20
Accommodation Support Provider personnel	14
Area Mental Health Service case managers	5
Family members	3
Total	42

1.3 Limitations of the Study

To gauge the reliability, validity, and generalisability of the findings, particularly in relation to the remaining six sites of HASI One that were not part of the study, a number of methodological limitations must be considered. Six sites that implement HASI One were not part of this commissioned study. The randomly selected consumers participating in the study do not represent all consumers who are supported through this initiative. The study adopted a cross-sectional design. The respondents therefore provided a snapshot of care planning.

A qualitative research methodology limits the lifespan of the identified findings. The interpretive approach used to analyse the research material indicates that the findings reflect the interaction between the researcher and the respondents. They also reflect the research team's interpretation of these interactions. While every attempt has been made to adequately reflect the respondents' perceptions, the construction of themes from the research material could have missed some views.

A number of respondents struggled with recall when asked to reflect on care planning. They equated the formalised review meetings with care planning, and, for some consumers, the last meeting was held some six months ago. It was therefore difficult for these people to describe care planning; this was particularly the case for consumers who were unwell at the time of the fieldwork.

The lack of a common language around care planning was also a challenge. The use of different terms by the ASP to refer to the care plans and the way they are developed hindered this comparative study. It was not always apparent that ASP personnel were describing similar processes because of the language they adopted.

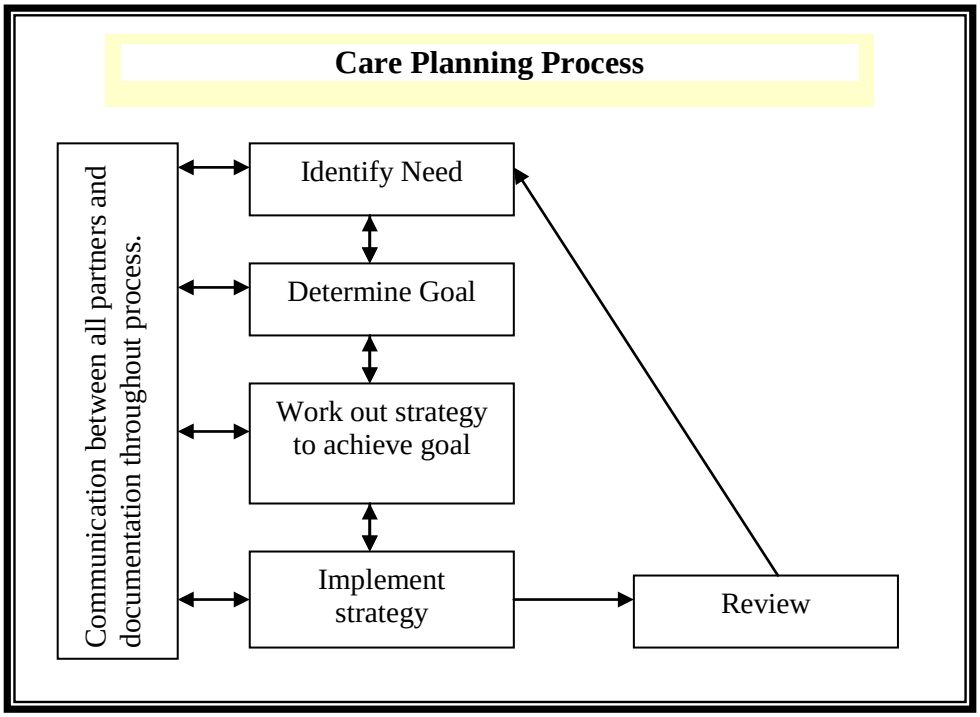
Summary

- This study reviews care planning practice and process undertaken in three NGOs involved in HASI Stage One. The methodology was interviews with 20 consumers and 22 other people involved in their care planning. It also included a review of their ASP care plans.
- The study is limited to a qualitative, snap-shot approach, with a small cohort. Some consumers could not remember participating in care planning.
- A lack of common language around care planning also presented challenges.

2 HASI One Care Planning Process

HASI One involves ASP care planning to facilitate consumer recovery.[1] The aim of an ASP care plan is 'to assist the consumer to lead a fulfilling, meaningful life in the community, that meets his or her individual needs' (NSW Health and NSW Department of Housing, 2005: 50). To achieve this aim, care planning commences with a comprehensive, person-centred, strengths-based assessment of consumer need. This process addresses a number of areas, including self-maintenance (self-care, home management, money management, shopping, medication management, as well as physical and mental health needs); productivity (education, employment or other meaningful activity); and leisure (social activities and recreation).

According to the HASI manual, the assessment is then translated into a care plan in consultation with the consumer, the key worker, the AMHS case manager and other people involved in care planning, such as family members or carers. This ensures alignment between the consumer preferences and needs, the ASP care plan, the AMHS case plan and the appropriate inclusion of family members or carers. The culminating ASP care plan specifies the ways in which the ASP key workers will support the consumer towards recovery. To monitor consumer recovery and relevance of the care plan, the manual suggests that ASP care plans be reviewed at least every three months (NSW Health and NSW Department of Housing, 2005). In practice, the implementation of the policy varies, as discussed through this report.



[1] Care plans are also referred to as support contracts, Individual Care Plans (ICPs) and Individual Support Plans (ISPs). For ease of clarity, they are referred to as care plans in this report.

2.1 Assessment of Consumer Need

In each of the three sites, ASP care planning commences with an assessment of consumer need. This is informed by the use of standardised measures. The ASPs do not consistently apply the measures, use them at the same frequency or involve the same people in this process. Case managers and other people are not involved in the assessment process in any of the sites. Key workers conduct assessments with the consumers, however they may use information from the mental health case managers to inform aspects of the assessment.

Key workers and consumers from two ASPs complete the CANSAS (Camberwell Assessment of Need Short Appraisal Schedule) every six months. In addition to the CANSAS, key workers in one of these organisations ask consumers to complete the BASIS-32 (Behavior and Symptom Identification Scale-32) annually, while the other ASP has key workers complete the GAF (Global Assessment of Functioning Scale) every six months.

To improve communication with AMHS case managers, the third ASP has adopted a modified version of MH-OAT. Consumer need is assessed every three months using the CANSAS, GAF, HoNOS and LSP. As one key worker explained, 'We use it because the [mental health service] uses them and it enables us to talk the same language as the case managers.' This process does not directly involve consumers, but rather, the key workers complete the care plan template in isolation.

Assessment measures identify consumer need and inform care planning. Key workers are typically trained in using and understanding the measures when they are appointed. Two ASPs provide internal training; the third, which uses a modified version of MH-OAT, uses training opportunities provided by the AMHS.

Key workers have mixed views about the value of the assessment measures. Some key workers stated that they ensure a comprehensive consideration of all life domains when developing a recovery plan. They also saw the assessment as a tool to facilitate communication between different agencies, as well as professionals from different disciplines. As two key workers stated, 'They're useful because they cover everything'; and 'We use them to back up what we observe, particularly when talking with [AMHS case managers].'

Other key workers said they were challenged by the formalities and regularity to which they are required to adhere. This is particularly so for the key workers in the ASP that requires them to complete four distinct measures, as the value of each is not always apparent to them:

> The assessment tools are in place, which is more paperwork. I'm not confident with the way they identify goals. The scores don't do anything for us. The numbers don't mean anything. We get similar results from four different assessments… It's a lot of time wasting.

A small number of key workers are not familiar with the rationale of the measures. One key worker stated, 'I never thought about the tools as informing practice.'

A number of consumers are equally unsure of the reason they are asked to complete the measures. Some supposed that it is part of standard practice:

> She got me to fill out paperwork. I don't know what it was about; just a routine form. I can't remember what it was… It's just what [the ASP] wants – I just conform. I think it's to help [the ASP] in some way.

A few consumers recognised the direct connection between the assessment measures and the care plan. One consumer stated that the measures he completed were beneficial because they provided a holistic overview:

> I fill out a survey to find out what I need… The goals are determined by the survey. It's time-consuming, but it's helpful cause you get an overall result. But I need help with it – I couldn't do it on my own.

2.2 Arranging the Care Plan

Armed with information on consumer needs, key workers typically convene a meeting with the consumer, the AMHS case manager and, where appropriate, family members or carers. One parent reported that it was never the key worker who organised the meeting; but rather, her and her husband – '[My husband and I] seem to be the ones who initiate the meetings.' Several key workers indicated that convening the meeting is not always easy. This is usually because of the limited availability of case managers and/or family members. As one key worker explained, 'Getting hold of the case manager for the review can be difficult, and that pretty much determines when the meeting's held.' Other key workers noted that health issues, transport difficulties and employment conditions impede family participation. When possible, these are overcome by telephone communication:

> [The consumer's] mother can't attend because of health problems… I speak with her on the phone and she's happy with the way things are going and the progress that he's made.

It therefore appears that the consumer does not necessarily nominate the meeting time; but rather, the key worker who juggles others' schedules arranges it. One consumer stated, 'They write down the date on the calendar for me.'

In preparation for this meeting, key workers encourage consumers to consider the goals they have achieved and those that they would like to pursue. As one key worker stated:

> I … let [the consumer] know that it's coming up. I … have time to chat about his goals, reflecting on previous goals, how is it going, what other goals does he want to achieve, is the status quo okay. He is not really goal-focused, but needs to be reminded – make him aware of how he is going.

2.2 Place

In each of the three sites, planning meetings are typically convened by ASP personnel and held in the consumers' home. Key workers said the familiar surrounds improve the comfort of the consumer. As one consumer confirmed, 'They all come to my place and we kick back with a coffee. It's good that we meet at my place – I'm more comfortable.' For a small number of participants, the meetings are held at the AMHS and convened by the case manager. This is to encourage consumer mobility, or

because of consumer preference. One consumer advised, 'My place is too small to have all those people. My place is better for one-to-one meetings, and I don't want a lot of people here.'

2.3 People Involved

At a minimum, a review of the care plan involves only the consumer. This was the case for only one consumer within the sample, whose recovery has progressed considerably; the consumer now receives minimal support from the ASP and AMHS.

At the other end of the spectrum, the care plan review involved up to seven people. These include the consumer; the key worker; the ASP manager; more than one case manager when the appointed case manager was resigning and was orienting his/her successor; and family members.

Two ASPs include a senior staff member in care planning. This person has extended experience with HASI One and is familiar with the consumers. The role of the ASP manager is to provide consumers with a familiar contact person, which is especially important when a new key worker or case manager had been assigned. They also oversee the planning process; contribute to care planning, particularly in light of their familiarity with local services and support networks; and provide key workers with professional development opportunities. One ASP manager stated, 'I love to know how it's all going, as I have limited contact. It's not compulsory for me to attend, but I like to, particularly when staff are new.' This ASP does not mandate the ASP manager's participation, in contrast to the other ASP, which does. Key workers appreciate the involvement of senior staff, recognising it as an opportunity for professional development. One key worker stated:

> [The manager] knows the clients and knows where they're at. She tries to attend all the reviews as well. She's a good communicator; she asks questions and seems happy with what we're doing. She provides general feedback; she's good with suggestions and resources.

Family members are not always aware why managers are involved in care planning. One family member stated, 'I don't know why two of them had to come.'

Managers are not involved in care planning at the third ASP. One consumer supported by the service would have preferred the manager to participate because of the manager's expertise and experience – 'I'd like [the manager] involved because he's good at psych assessments. I think he used to suffer from the same illness as me, so I can relate to him.'

2.4 Meeting Structure

The three sites share a common meeting structure. The convenor directs the discussion by firstly reviewing any existing ASP care plan and requesting feedback from the people present. The convenor asks whether identified goals have been achieved, the strategies that have been attempted, factors that facilitated and hindered goal attainment, and consequent outcomes or indicators that the goal has been achieved. This suggests a reflective process involving the people present at the meeting. Additional consumer goals are then identified and coupled with strategies to

ensure they are attained. As summarised by one key worker, 'We talk about previous goals, where they're at, and where they'd like to be.'

Consumers, key workers, case managers and family members suggested that the identification of consumer needs is a collaborative effort. Everyone who is present at a care plan review meeting contributes their views about current issues, how they should be prioritised, and how they should be attained. One consumer stated, 'They come here with the paperwork. They ask what I want to do. Like, I want to work on losing weight, cut down on smoking.'

For the key workers, consumer needs are initially identified by standardised assessment measures and complemented by reviews from the case manager and/or fellow key workers and in discussions between the key worker and consumer as they build rapport, as well as through involvement of family members or carers where appropriate. This suggests that consumer needs are typically identified prior to the meeting and developed in consultation with the consumer, and the family or carer. At times there appeared to be discrepancy in the rationales and approaches underlying this process, as a case manager stated, '[The key worker] has a fair idea of the goals, like, the plans are predetermined and then we meet to talk about how we go about it. The goals seemed already formed.'

Most consumers reported that they were consulted about their goals, and perceived the process as consultative. As one consumer stated, 'I feel involved in the planning.'

It was often difficult for consumers to explain specifically why they thought their contribution was valued at the meetings or provide examples. However, one ASP manager recognised great similarity in the goals that both consumers and key workers identified – 'Nine out of ten, the goals are the same.'

2.5 Identifying Consumer Need

A number of key workers suggested that the standardised assessment measures helped them discuss the content of the care plan with consumers. Responses on the measures enabled key workers to offer suggestions that would help consumers achieve their goals. This is of particular benefit when a consumer cannot identify these independently. According to one consumer, 'I often don't have enough ideas, so it's good that they give me goals.'

This raises questions about the extent to which key workers support consumers to formulate goals. A key worker alluded to this, stating:

> We have the assessment and then we get the results and then I will first address the things [the consumer] needs to work on. I have my ideas about his goals and then I ask him if he's interested, whether it's important, does he also have his own ideas. It's collaborative.

According to several key workers, balancing consumer preferences with those of key workers and case managers is often difficult, particularly when consumer wellbeing is at risk. To manage this, some key workers place parameters on the goals that consumers can pursue. For instance, the goals cannot be illegal or unethical and have to align with ASP policy. Other key workers use more subtle techniques to influence consumers as they identify their goals. A key worker stated:

> You just have to tread lightly, like, 'Couldn't you use some help with the cleaning?' But sometimes you have to get tough because of the complaints neighbours might make.

A case manager noted:

> We cajole, advise, suggest – but ultimately [the ASP] don't write… what [the] client doesn't want. We might think they have a hygiene issue, but if they don't identify it, it's not included in the [care plan] – it's just commented on.

Influencing consumer preferences is eased when the key worker and case manager have the opportunity to discuss care planning before the meeting. This allows them to share information about their respective assessments of the consumer and the strategies that might foster recovery. One key worker stated:

> [The case manager and I] have a chat before to decide what is the best way to go. We ensure congruency beforehand to identify what we will encourage and ensure that it's not discrepant. We come up with a similar plan.

This again raises questions about the extent to which workers support consumers to formulate their own goals.

Most consumers are satisfied with the way needs and goals are identified. The consumers respect the opinions of the key worker and the case manager, trusting that their primary needs will be addressed. As one consumer stated, 'They direct it, which is a good thing because they make sure that I take my medication and that the house is clean.'

Trust in the key worker and case manager is especially important for consumers who experience negative side effects from their psychotropic medication. One consumer affirmed, 'I don't know [which goals] I should do… The medication reduces my imagination. I sometimes find it hard to know my goals.'

2.6 Accommodating Changing Consumer Needs

Regardless of the length of time a consumer is part of HASI One, most of them were not aware of much change in the content and process of their care planning. Planning had not always altered despite changes in consumer recovery. As one consumer verified, '[The process] hasn't changed – they ask the same questions.' An ASP manager stated, 'Some clients don't identify with the forms. For those that have been with us for a while, I ask them to humour me.' This suggests a process that has limited flexibility, with restricted capacity to accommodate the changing needs of consumers.

The research team found one good example of variation within the planning process. One consumer, whose support needs have declined considerably, is encouraged to complete the care plan template independently. She noted, 'I have control over the new [care plan], like [goals such as] socialising with people more… The plan's gotten more advanced.'

2.7 Care Plan Copies

Many consumers reported that they are not provided with a copy of the care plan, despite being required to sign a form to demonstrate a commitment to recovery. One consumer recalled, '[The key workers] write them down on the paper and keep it at their head office and it stays there.' Consumers who remember their plan or trust their key worker are not concerned about not having a copy. Other consumers prefer to receive a copy. Some consumers could not remember whether they received a copy of not.

A number of case managers and family members also prefer to receive a copy. Although key workers advised that they would receive a copy of the updated case plan, they did not always provide one.

Many key workers offered a different perspective to the consumers, case managers and family members about who receives a copy of the care plan. They suggested that everyone who participates in care planning has the opportunity to receive a copy – 'I always ask if the consumer wants a copy of the plan.' Some of the conflicting perspectives might be explained by limited communication, or difficulty remembering if a copy had been received.

Summary

- Care planning is an ongoing process of planning and action, rather than just completing a care planning form.
- Training to understand the relationship between assessment processes, assessment findings, developing care plans and acting on goals assists key workers.
- Support and training on how to actively facilitate consumer participation in care planning processes assists key workers.
- Including ASP managers in care planning facilitates continuity of care in the context of staff turnover and increases the care planning skills of ASP key workers. Consumers, family and carers are more comfortable with this approach if the ASP explains why more than one ASP personnel is involved.
- Partnership between the ASP key worker and AMHS case manager has a positive impact on care planning and mental health case management.
- If all participants in care planning receive a copy of the care plan, effective communication and participation is improved.

3 Consumer Involvement in Care Planning

In accordance with HASI policy, the key workers interviewed for this study suggested that support provided by the ASP is consumer-driven. Services are specifically tailored to the needs of individual clients and wherever possible client choice is promoted and respected. (NSW Health and NSW Department of Housing, 2005: 7)

In the context of care planning, this study identified two important findings about consumer involvement: 'client-driven' is variably defined in practice – both within and between the three sites; and even when there is explicit adherence to this philosophy, it is not always easy to achieve. Evidence for these two findings is provided in the following section.

3.1 Evidence of Consumer Involvement

The three sites demonstrate disparate levels of consumer participation in care planning. At one end of the spectrum, some consumers in all sites are cognisant of their care plan and the active role they play in its development and implementation. They spoke of articulating their needs, the goals they would like to pursue and feasible strategies to attain these goals. According to these consumers, they identify their own goals and can challenge any goals suggested by other people with which they disagree. They could not give any explicit examples of this.

At the opposite end of the spectrum, other consumers are unaware of their planning and instead spoke of their weekly schedule of activities. This raises the question as to whether a care plan was developed, and about the communication of and participation in, this process with the consumer. Consumers in two of the three fieldwork sites evidence this. When asked about care planning, a couple of consumers presented their list of daily household chores that they were required to complete. The language used by these people suggests that, for the most part, these schedules were not consumer-driven:

> [The key worker] types up some notes and sheets of chores to do, a calendar of what's on when, and a weight chart… She also drew up a budget and a shopping list showing what I need. They help me with buying what I need. If I feel like chips or chocolate, they say, 'No, it's no good for you'… They have what's called a Visit List and it'll tell me what I'm doing. They change the list when they're short-staffed… If I don't like the times, I just ring them.
>
> Sometimes [the key worker] makes decisions for me.

Some key workers reported that in their experience active involvement is not feasible for all consumers in all instances. Poor or variable wellbeing and limited insight make it difficult for key workers to engage some consumers and encourage them to direct the recovery plan.

Some consumers appreciate clear direction from workers, including one participant who stated, '*I get told what to do all the time – I like that.*' This satisfaction might be partly explained by the positive reinforcement provided for achievement of goals, as a key worker and a consumer illustrate:

> [The consumer] enjoys what he eats; he likes sweet and fatty foods… I tell him about the consequences. He says it's a good idea [to modify his diet]. [He now] eats light cheese and he went without ice cream for six months… I praised him for the big change to reinforce our ideas. (Key worker)
>
> They give me praise when I've done my chores; it motivates me. (HASI consumer)

Not all consumers are content with directives. A few consumers thought they were belittled by the limited opportunities they had to direct their own recovery. As one consumer expressed, 'It's helpful, but sometimes I feel like a baby.' Discontent is not always relayed to the key worker or case manager. A few consumers confided their dissatisfaction to family members; others did not have this opportunity.

3.2 Challenges Associated with Consumer Involvement

Given the chronic and episodic nature of consumers' mental health conditions, consumer participation in care planning is not always easy to achieve. Most respondents are aware of the impact of mental health status on care planning. Poor wellbeing has the potential to stifle, if not obstruct care planning. One consumer said, 'It's hard to work on it when I'm not in the mood.'

Most key workers struggle with care planning when consumer mental health wanes. Some consumers are naturally motivated by court orders and the potential loss of child access – many consumers, however, are not. Their key workers grapple with finding balance between the pursuit of recovery and consumer lack of concern. As one ASP manager noted, 'It's hard if the client is unwell… When the client's unwell, I think it's pointless because they can't contribute and they don't know what's going on.'

Consumers who experienced delusions do not always share the same commitment to care planning as the people who work with them. One key worker conceded, '*[The* participant]'s quite delusional and hard to keep on track and focused.'

A particular concern is the ASPs' duty of care. When consumers experience poor wellbeing, key workers fear that consumers might be at risk of harm to themselves or others and that tenancies might be jeopardised. As one ASP manager suggested, this warrants greater worker-direction in care planning – 'Some clients have no idea what [care planning is] about. Some we have to make decisions for because of our duty of care.'

During review meetings, a few consumers report that they do not always understand the discussions between the key worker and the case manager. One consumer stated, '[The key worker and the case manager] said things that I didn't understand. But I'm not qualified to understand what they were talking about.' Another consumer said, 'My brain's not like their brains.' This suggests that people involved in the meetings do not always maximise the potential for consumer engagement and active participation.

Key workers are confronted by other challenges when care planning, such as consumer preferences changing or their motivation fading.

3.3 Strategies to Enhance Consumer Involvement

Some key workers have indirect strategies to manage the difficulties they encounter. They have ways to understand the needs of consumers and the goals that they might like to pursue. For instance, the key worker might change their approach to engage the consumer more effectively:

> You need to be really diplomatic 'cause some clients who are paranoid get worried when they see the form, like, 'You're all against me'… When she gets defensive, I just give her a blank one to fill out when she's ready.

Sometimes this involves observing the consumers in their own homes or in social contexts and praising particular behaviours:

> The planning is not isolated to the review meetings. The outings help me assess [the consumer's] social skills… It's an investigative process.

At other times, it involves greater innovation, like accompanying consumers to local services, or creating non-confronting situations to ease communication and ignite different interests:

> We just sit down for a chat, or go for long drives – I try to inspire him and trigger interest in something. Like, he recently mentioned golf and horse racing, so I'll pursue those with him.
>
> The planning is ongoing. There's not much formal planning, but informal stuff. Like, she'll identify some of her needs while I drive her home… She has to be the one who identifies the goals, otherwise there's no point.

Ultimately, key workers had to 'read between the lines' to 'find the carrot – the motivator that will interest the client'. One key worker for instance, gradually helped a consumer recognise the links between her limited ability to breathe and the cigarettes she smoked daily. This in turn, kindled the consumer's interest in reducing tobacco use.

3.4 Summary

In summary, consumer participation in care planning varies both within and between the three sites. At one end of the spectrum, consumers are actively involved in the process, while others, at the opposite end of the spectrum, are unaware of the process. Most people are situated between the two extremes. The impact of mental illness, and variability in wellness, also poses various challenges that result in care planning processes and approaches needing to be altered at times. Key workers utilise several strategies to facilitate greater consumer involvement, such as changes in approach and accompanying consumers to local services. These enable consumers to make relatively greater contributions to their care plan.

Summary

- The capacity of consumers to participate in care planning is often contingent on their current state of mental health.
- Key worker skills to engage and support a consumer to participate in care planning vary.
- Training to maximise consumer involvement in care planning improves the effectiveness of key workers.
- Care planning is an ongoing process to facilitate recovery. Some key workers report success where goals and strategies emerge from participating in social and community activities.

4 Other People Involved in Care Planning

While consumers and their key workers are the primary people involved in care planning, the process can also involve other people. This was the case for 11 consumers (55 per cent), all of whom had the involvement of their case managers. Five consumers (25 per cent) also involved (or had occasional involvement of) family members and one person involved a carer.

4.1 Case Managers

The active involvement of case managers is evident in two of the three fieldwork sites. Active involvement is typically demonstrated by case manager presence at the regular care plan review meetings as well as contact with the consumer and key worker between the scheduled meetings. Most respondents have a clear understanding of the distinct role of case managers in care planning. Case managers are thought to 'focus on clinical stuff'. More specifically, they help to ensure that the plan is realistic and achievable in accordance with consumer capacity and the side effects of prescribed medication.

The involvement of case managers is beneficial for four principal reasons:

1. Case managers contribute clinical information.

2. People involved in care planning provide case managers with additional information to improve their understanding of consumer issues. A consumer reflected, 'The three of us recently met, which was good because [the case manager] forgets some of the things I tell her… It helped us put our ideas together.'

3. The meetings strengthen the collaborative efforts of the consumer, the ASP and the AMHS. One key worker remarked, 'It's made a huge difference with our networks – [the case manager] turns up prepared, interested and raring to go..'

4. By forming a strong working alliance, both key workers and case managers have the opportunity to influence consumer change. They utilise each other's strengths and roles to manage changing needs, such as ill-health, that may arise.

Key workers and case managers in two of the fieldwork sites complement their skills to facilitate consumer recovery. One consumer for instance, aimed to use public transport independently – he found this difficult because of the chronicity of his delusions. The key worker provided the consumer with information about local bus services, while the case manager assisted the consumer with symptom management. As the case manager explained:

> I know that their goal is to get on this bus, so I reinforce this with [the consumer]; offer symptom management if he's supposed to be catching more buses but can't cause of delusions. We do symptom management pre-bus, and reality testing post-bus. It doesn't alter what I do, but when I do it, it becomes more timely.

Most consumers in these two sites appreciated this, recognising the benefits of cross-pollinating ideas – '[The ASP] and [the AMHS] work better together. The more people, the better the brainstorming and the better the result.'

A key worker from another site noted that care planning with the case manager also helps to ensure consistency. Workers supporting the consumer share the same goals and the same strategies to achieve these:

> We always work together. Her plan is similar to my plan. [The consumer]'s not receiving contradictory views; no different stories or different aims. We're following the one plan… [And] the reviews force us to chat; it gives us a reason to get together.

The involvement of case managers augments the services available to the consumer. By using their networks, case managers identify and engage appropriate healthcare professionals who can help consumers achieve their goals. Key workers reported:

> We rallied support from a GP… when the client wasn't interested in attending a liver clinic. We try every way that we can.

> [The consumer] wants to meet people but he doesn't leave the house. We got the OT on board to work with [the consumer] and we're now exploring options to get him out of the house.

A few key workers and consumers suggested that case managers have greater expertise in the management of mental health issues, relative to their key worker counterparts. Consequently, the advice of case mangers tends to have greater credence, which encourages consumers to take heed. One key worker advised, '[The case manager] reinforces goals like diet, [and] as an authority, it's important to have him there.'

A risk of this authority is the possible disregard of other viewpoints. For example, one key worker spoke about a consumer who wanted to consult a psychologist; however, the case manager did not agree with this request because of the participant's state of wellbeing,

> [One consumer] has a flat affect and is depressed a lot. He said he'd like to see a psychologist, but the case manager wasn't supportive of the idea because he said the schizophrenia caused the flat affect. It was really disappointing.

When case managers are actively involved in care planning and attend the regular review meetings, the research team found few instances of poor service integration. The few examples typically occurred at the inception of the initiative, when role clarity between key worker and case manager was less defined.

In the third fieldwork site, case managers have little, if any direct involvement in care planning. Seldom did they attend the regular review meetings or engage with the ASP. This is despite the fact that six of the seven consumers have an allocated case manager. Key workers and case managers in this site reported that this is primarily because of staff turnover. At time of fieldwork, three of the five case managers had recently become involved in HASI One; consequently, they had a limited understanding of the initiative and their role within it. However, case managers who have been in their role for an extended period do not appear to engage with the ASP. This is despite the efforts of one key worker who was requested to provide the nominated case manager with the HASI One contract between the ASP and the

AMHS to verify that each consumer is required to have an appointed case manager. This suggests a weak alliance between the ASP and the AMHS.

All three sites have examples of poor coordination between the ASP and AMHS. Care planning does not always involve case managers, sometimes because the consumer does not have an allocated case manager. According to one key worker, one consumer no longer needs a case manager because of extended recovery. Poor coordination between an ASP and an AMHS is also demonstrated when case managers consider their involvement in HASI One no longer necessary. Consequent to the efforts of the ASP, a couple of case managers stated that they were now redundant. As one case manager explained:

> There's not a lot of involvement since [the ASP] got involved… I'm not involved in any of the actions in the plan – he's very stable… [Case managers] got pushed out when [the ASP] moved in. I'm just the backup – I'm not a necessary party at these meetings. I just go out of interest.

A few case managers advised that the intensity and type of support they provide has altered. The active role of the ASP in facilitating psychosocial rehabilitation allows case managers to redirect their focus on clinical intervention and thus maximise their expertise. One case manager, for instance, stated, 'There's less of a need for me to be involved in daily issues, like housekeeping.'

With diminished involvement, some case managers indicated that they have the potential to end their role as designated case manager. The efforts of the ASP have made them somewhat obsolete. As indicated by one case manager, 'I really don't need to plan anything anymore; [the consumer] could be team managed.'

A couple of key workers feared this possibility. They suggested that 'team managed' translates into 'no accountability.' This is because no individual is assigned the role of case manager. This might suggest that some AMHS misunderstand the HASI model and the level of involvement from other people involved in care planning. It might also suggest that AMHS are under-resourced and do not have the capacity to commit to the initiative.

Some case managers who are involved in care planning are not clear about the role of the ASP within the HASI model. One case manager stated, 'I really don't know what they do… I don't how they interact with [the consumers], their training, their experience.'

Some key workers and case managers are challenged by the limited exchange of consumer information, even when consumers have consented to this exchange. As indicated by one key worker, '[The case manager] gets a copy of the plan, but I never receive theirs.'

These coordination and communication issues between the ASP and AMHS draw into question how well the HASI resource manual (NSW Health and NSW Department of Housing, 2005) has been translated into practice.

4.2 Family Members and Carers

The involvement of family members or carers in case planning is evident for nearly one-third of the consumers interviewed (30 per cent). According to most key workers, consumers are routinely asked about the possibility of family or carer involvement at the care plan review meeting. Some consumers would prefer greater family involvement – 'It'd be good if mum… came as [she] sees me regularly and remembers minor details that I can't remember.'

Most respondents view family and carer involvement favourably. Consumers appreciate the explicit demonstration of both emotional and practical support. One consumer noted, 'My parents are involved because they love me' while another stated, 'My sister produces the bills and the receipts to show that they've been paid.'

While most family members and carers continue to provide practical support, their involvement in care planning has changed. Some of their responsibilities are now managed by the key worker or case manager, which in turn improved familial relations. For instance, one family member noted:

> It's taken a lot of pressure off the family. She can talk to the family, [the key workers] or [the case managers]… I don't have half as much to do now. I just get the bills and pay them, drive to a Body Corporate meeting or go on her behalf. I don't have to check her medication and housekeeping. Life is now 100 per cent better.

By participating in care plan review meetings, family members and carers remind others involved in the process of important information that they might have disregarded. This enhances the feasibility of the care plan. One mother explained, 'I look at the practical issues – transport, what type of people [will be at the outing], who will meet her [when she arrives]. The others tend to overlook these.'

Key workers also noted the importance of supplementary information from family members and carers. They appreciate the unique insights family members and carers offer; these enhance their understanding of the consumer and enable them to provide appropriate support in a timely manner. As stated by one key worker, 'We use their collateral information and we tell them when we've noticed signs of deterioration; so it helps with early intervention'.

The key workers identified other benefits associated with family and carer involvement; particularly at the care plan review meetings. For instance, practical support from family members and carers are readily negotiated and incorporated into the plan. One key worker explained, 'It's good for [the carer] to be there because when shopping days are changed and more money is required, this can be done straight away.' Family members and carers also motivate the consumer, reminding them of their recovery thus far and fuelling an interest in further progress. A key worker commented, 'It's a good reminder for [the consumer] to see how far he's come, particularly when his mum can recall how things used to be.' Finally, by witnessing consumer recovery, family members and carers have their confidence in and relationship with the ASP and AMHS strengthened.

Family and carer participation in care planning can also be tense in some instances. According to some consumers, family members and carers are sometimes a source of

'pressure.' They impose their views and preferences, which in turn, may sway care planning. Key workers also recognised this. One for instance, stated, 'Mum hasn't been involved because she's a bit demanding and overbearing, but she means well. [The consumer] feels like a child when she's there.'

Not all family members are satisfied with their level of involvement. Two for instance, suggested that they are the ones who drive the meeting because the key workers and case managers demonstrate little initiative. The family members felt the key worker often fails to suggest practicable goals and appropriate timeframes in which to achieve them. One reported, 'The ideas seem to come from me'. Another said, '[They] haven't [set timeframes and] said, "In a week's time… in a month's time" – nothing's been achieved. There's little follow up.'

Consumers whose family members or carers actively participate in care planning are mostly satisfied with this participation. As one consumer concluded, '*Mum gets fussy* about the house; that makes it hard. But I prefer it that she's there.'

Other consumers whose family members and carers do not participate in the care plan review meetings prefer that family members or carers remain uninvolved. They fear interference and having their goals co-opted by others – 'I don't want Mum or Dad involved because they disagree with what I want to do, like TAFE and go to church.' One consumer does not want to disappoint her family members, should she be unable to achieve the identified goals – 'It's better that [Mum is] not part of it… I don't want to disappoint her.'

4.3 Housing Providers

Within all sites, housing providers do not participate in care planning, as it is a specific process focusing on psychosocial goals. Housing providers in all three sites are typically contacted after a care planning meeting if a tenancy-related goal has been identified. For example, during care planning, one consumer contemplated a transfer to another place of residence because of the insecurities she experienced. She felt unsafe because people in the local area used illicit substances. To quell her concerns, the key worker contacted the housing provider after the review meeting to request that the door locks be changed. Since this, the consumer no longer wants to relocate. Housing providers are involved in other aspects of planning and HASI service delivery described in NSW Health and NSW Department of Housing (2005).

4.4 Other People

A few consumers advised that they would prefer the process to involve others who are not part of the three-way HASI partnership. One consumer for example, suggested a disability support worker from TAFE, while another wanted the involvement of a pastor. Having other people involved in care plan review meetings has the potential to enhance brainstorming efforts and support around goal achievement.

Some respondents reflected that it is important to find balance between representativeness and overcrowding. As noted in section two, the care plan review meetings sometimes involved up to seven individuals. These included the consumer; his/her key worker; the ASP manager; two case managers – which would occur when the appointed case manager was resigning and orienting his/her successor; and two

family members. This sometimes overwhelmed the consumer, whose interests were at times lost in the conflict of personalities. As one family member explained,

> You need one person from [the ASP] and one person from [the AMHS] to push that line – 'What do you want to do?' There are too many egos clashing. We need to let [the consumer] steer this. There are too many people involved. Maybe a consumer representative would be helpful – someone to advocate on their behalf.

Consumer representatives are not part of care planning in any of the three fieldwork sites. A few consumers suggested that the participation of people they could identify with and relate to would be particularly advantageous in their recovery. It would provide opportunities for advocacy as well as positive role modelling. Two consumers suggested:

> Having a consumer representative might be good to share experiences and be a role model. But you'd have to make sure that they weren't good friends [with the consumer], because it might ruin the friendship.
>
> It'd be good to share what we've done with other consumers and learn from their positive experiences.

4.5 Summary

This section has explored the representation of different people involved in care planning. The process typically involves the consumer, the key worker and the case manager. The participation of case managers is not typical in one site. One in four consumers interviewed have family members or carers involved in care planning. While most consumers are content with this, recovery might be enhanced through the involvement of other people who are not part of the HASI partnership, including consumer representatives. The additional involvement of others should be balanced with the consumers' needs and preferences.

Summary

- Key worker and case manager skills are complementary in supporting the consumer in care planning processes.
- Partnership between the key worker and case manager has a positive impact on the experiences and outcomes for the consumer.
- The HASI resource manual is not always translated into practice, to the detriment of relationships, communication and consumer outcomes.
- For some consumers, the involvement of family members, a carer, a specialist rehabilitation worker and a consumer representative, can add significant value to care planning.

5 Care Plan Content

5.1 Care Plan Template

The care plan templates used by the three ASPs differ in both layout and content. One ASP uses a structured care plan with explicit reference to the assessment forms that are used to identify consumer needs. It directly links the needs assessment with the recovery plan. For this ASP, three other forms complement the care plan, including a recovery plan (identifies early warning signs indicative of mental illness), an individual plan (for the consumer), and a plan to manage substance use (used as applicable).

Another ASP uses a care plan template that includes references to accommodation, self-care and social skills. The third ASP uses a less structured template, inviting respondents to explore support needs, goals, actions and the role of different people in the recovery process.

While it is not the purpose of this study to evaluate the ASP care plan templates, layout and content can influence the degree of consumer participation and thoroughness of the plan. For instance, the identification of particular domains, and the order they are presented, guides care planning but also reduces consumer-direction. One consumer for instance, suggested that some topics were forbidden. He is not always able to discuss with his key worker matters that interest him. He said, 'There seems to be topics I can't talk about, like spirituality and friendships with the workers… The time given to me is strictly business.'

Conversely, the identification of particular domains can guide comprehensiveness. Some key workers who use the structured template appreciate its completeness; it helps them to remain aware of all facets of consumer wellbeing.

Key workers are sometimes overwhelmed with the detail required by a structured care plan template, particularly when four forms need to be completed. They report that time allocated to form completion detracts from quality time with consumers. One key worker asserted, 'There should be a lot more contact [with consumers]… We just need one plan – a service user's plan – not four.' It was unclear how the different forms complement each other and key workers or consumers could not describe the way the different documents informed and guided consumer recovery.

Key workers who use a care plan template that is relatively less structured recognise the need to keep the process straightforward and uncomplicated. One key worker noted, 'We just need to keep it simple … You can't spend too much time on paperwork.'

The way that care plan templates translate into consumer recovery is difficult to gauge. This is because all three sites have recently modified the documents they use to improve service delivery. One ASP makes greater use of MH-OAT to strengthen service integration with AMHS. The other two ASPs modified the forms they use because staff turnover has introduced new disciplines and experiences into the team.

5.2 Goals Identified in Care Planning

Care plans include maintenance goals and development goals. The former involve short-term objectives that preserve tenancies and reduce hospital admissions. The latter involve long-term goals that encourage psychosocial development. In all sites, most care plans include both maintenance and development goals. For instance, a plan could include housekeeping, educational and social networking goals. As one consumer commented:

> [The care plan] helped me to go to the Leisure Club, GROW, a church that I feel comfortable at, and my friend's place without their help… It helped me get things done around the house, like washing dishes and clothes, shopping… I waste time if I don't have a goal.

Consumers with maintenance goals have typically experienced poor wellbeing for extended periods. Delusions and lack of interest for example, make it difficult for some consumers to identify areas for personal growth. They were content with the status quo and were not eager to change. This could also reflect the possibility that consumers had goals but did not articulate or perceive them as such. These include household maintenance, financial management and pursuing work. Like higher order goals, these goals are also important. One consumer stated:

> I don't want any goals – I just stay in the present. I just have a general picture. My aim is to work with [the ASP] and maintain my nice home. My aim is to manage on a pension and maybe earn a bit of money. Their friendship helps me achieve these… I haven't got aims. Finding [the ASP] and this place is all my dreams come true.

Poor consumer wellbeing makes it difficult for key workers and case managers to engage the consumer for extended periods. In these cases, key workers are not always able to identify opportunities for psychosocial rehabilitation. As two key workers explained:

> [The consumer]'s goals aren't really tangible. He seems content with what he's doing. When his mood is flat, it's hard to do anything with him. It's hard to work out what his goal is. It's also a challenge to understand what he means by some of the things he says… He gets caught up in the moment and makes promises that he won't keep.

> I feel like we've come to the point where it's maintenance. It's as far as [the consumer] wants to go. I think it's about acceptance. The next goal for her was HASI Two. We were reducing support and she deteriorated, so it's not possible. Having daily contact with someone to get her day started makes a huge difference to her. She continues her day after we've left. No goals have been identified except for a few short-term ones… She lacks the motivation and these have been on the To Do list for about a year. It's 'cause of her negative symptoms.

The consumers of these key workers affirmed this difficulty; they suggested that maintaining focus on long-term case planning is a challenge. For this reason, they primarily work towards achieving the daily tasks they are assigned. These include

showering, eating regular meals, completing household chores, keeping medical appointments, and budget management. As one consumer noted:

> I've got a housecleaning project. They've written down what I have to do and the date. [The key worker] came to assess the house and look at each room and she works out what needs to be done. She worked out the date as well. There's a lot of work. I don't want to clean the walls – that's a horrible job… But I guess I have to do it, otherwise you live like a pig.

Given the poor wellbeing experienced by some consumers, a few key workers are concerned that the focus on psychosocial outcomes within HASI does not accommodate the needs of these consumers. They argued that maintenance within care plans is undermined as there is increasing pressure to demonstrate consumer change. Two key workers noted, 'It's too focused on change' and 'There's pressure to show outcomes – but you can't impose change. I just advocate what the client wants at the team meetings.' Workers with these views do not appear familiar with setting incremental goals.

A family member suggested that key workers need to engage more effectively with the consumer, rather than the paperwork:

> Listening skills, empathy, trust – they're the necessities. All [the key workers] worry about is the inputs and outputs because of the damn funding. Managers need to worry about the funding, not the workers.

A couple of ASP personnel noted that funding contracts should not be contingent on consumer change, but rather organisational operation and the organisational responsiveness:

> The units of service make us accountable, so the [care plans] shouldn't be part of the funding agreement. The important thing is identifying the client's needs and the staff needs… [But] under the funding agreement, clients have no choice about having a [care plan]; that's not client-centred… We need to accept that the client might not want a [care plan] if we're really client-focused.

Consumers who have experienced recovery for an extended period typically pursue development goals. Their care plans reflect ways to increase access to community services, strengthen support networks, and become increasingly independent. One consumer, for instance, worked with his key worker to gradually familiarise himself with using public transport. He now does this independently and is able to travel to his place of employment.

Another consumer worked with her key worker to reduce dependence on the ASP and make greater use of the local community. This includes pursuing a TAFE course and commencing voluntary work. She has always regarded herself as a 'go-getter', eager to improve her wellbeing and be an active participant in her own recovery. She therefore suspected that, even without a care plan, she probably would have achieved her goals. During the recovery, this consumer was sometimes frustrated by the gradual withdrawal of ASP support; she feared that the safety net provided through

HASI might no longer exist. In hindsight, she now appreciates that recovery is a process towards greater independence – 'It really annoyed me at first – I didn't understand that they were doing it for my own good.'

Some consumers doubted whether care planning is pivotal to recovery. They indicated that psychosocial development would have occurred even without a care plan. One consumer stated, 'I'd probably do the same things without the plan.' This was largely attributed to their desire for change. Some ASP personnel concurred with this view – '[The consumers] typically identify things they were going to do anyway, with or without the form… I don't think their lives would differ without it.' These views do not acknowledge the reflective value of care planning or the processes of care planning, such as rapport building between consumers and key workers; incremental development of goals through discussions and expressions of interest and actions; and the formalisation of these processes in plans and reviews.

5.3 Timeframes for Care Plan Goals

Most of the HASI One care plans do not include timeframes for goal attainment. Literature highlights the importance of target dates in care planning, suggesting that timeframes reflect the quality of the identified goals (Brown and Brown, 2003; Rapp and Goscha, 2006; Tondora, Pocklington, Gorges, Osher and Davidson, nd). Despite this evidence, target dates are not always included in the plans. If a timeframe for goal achievement is suggested, it is sometimes unspecific – examples include, 'ongoing' and 'next review meeting.' As one ASP manager noted, 'The goals are worked toward within three months; then they roll over.'

This frustrated one consumer who prefers greater structure. Not only does he want to know where he is going, but also, when he could expect to get there – 'I … want to know when we're going to get started.'

Several key workers find it difficult to set target dates for two reasons. Either, key worker skills and experience in setting incremental care planning goals may be limited, or consumers are too unwell to achieve goals. Some consumers find it difficult to engage with the plan for extended periods. They have reduced motivation and interest in the process. As one key worker explained, 'There's no timeframe identified. It's a bit hard 'cause you don't know how motivated [the consumer] is.' Consumers affirmed this sense of difficulty around putting timeframes on goals – 'All you can do is plan a day ahead and see what happens.'

Other consumers are overwhelmed by the prospect of having deadlines by which to achieve their goals. According to some key workers, unspecific timeframes are therefore more palatable – 'Dates can freak people out. If it's too specific, there's too much pressure.' While the limited use of target dates might compromise the value of a care plan, some key workers advised that this approach is relatively more consumer-driven. It allows for change when the consumer is ready. Again, workers with these views do not seem familiar with incremental planning, which emphasises small achievable steps, within a timeframe tailored to the consumer's wellbeing and capacity.

5.4 Challenges Associated with Care Planning

Sometimes care planning is not implemented. This is typically due to challenges accommodating change in consumer preferences, consumer wellbeing, and staff turnover. Two key workers noted:

> [One consumer] is more difficult due to his low motivation. Doesn't know what he wants to do. He doesn't want to do what he identifies. It's difficult but you just keep plugging away. We try to encourage him to develop regular sleep patterns. I help with the dishes; not do it for him. We approach it as a team. Praise him when he's well.
>
> [If a care plan gets stuck,] it usually means that the client's unwell or the goals are old or not relevant or they change case manager or key worker, so the client is left in limbo for awhile. We have to quickly organise a meeting to explain to the client what's going on.

When this occurs, key workers are able to make care planning more practicable for consumers. In addition to praise, key workers refine the care plan with the consumer (and other people involved) to ensure it meets current needs. They also segment consumer-driven goals to ensure they are achievable:

> When stuck, I break it down further or leave it for a while and then return to it later. [One consumer] needs to eat healthy [sic]; there was a stage when he didn't buy fresh fruit and vegies. But I gave him a recipe to try and I encourage other staff to work with him on this.

5.5 Role of Care Planning in Recovery

Most respondents indicated that care planning has an important role in consumer recovery. They cited three primary reasons for this – care planning facilitates communication, provides guidance, and stimulates motivation. Each is addressed in turn.

Care planning enables key workers, consumers and other participants to engage in dialogue about recovery. One consumer explained, 'It helps me put what I want into conversation.' Care planning provides a common language to identify goals and strategies towards goal attainment. One key worker noted, 'We know where we're going… It makes it clear… It makes the big picture more obvious and reduces an ad hoc approach.' By encouraging discussion about various life domains, it also helps to ensure that consumer's aspirations are identified. One key worker recalled, 'Without the [care plan] there is no direction because [the consumer] wanted to go to TAFE for a long time but didn't tell anyone until the meeting.'

A clear, 'black and white' care plan guides psychosocial development. This development is demonstrated by significant change (starting a job, TAFE course or joining a social or community group), or stability (a stable tenancy or reduced hospital admissions). Some consumers recognised the importance of stability for their confidence, sense of self-worth and insight. One consumer stated, 'I've established my own life… I have a weekly plan to make sure that I have three meals a day and that I do my chores each day. It guides each day of the week for me.' A key worker noted,

> She's become more aware of what she wants to achieve, like, she followed up where the courses were. She identified that she wants to be a better mum, so she enrolled in a short parenting course – she got herself involved and she completed it. She's more aware of what is an unhealthy relationship, because previous boyfriends used her. She's got greater insight.

Finally, care planning motivates consumers. By providing an overview of the past, the present and the future, consumers are reminded of their capacities and their potential to develop further. One consumer stated:

> I'm able to achieve my goals now. It motivates me – helps me go further. It reminds me of where I've come from. You never think you're going to get far, but it's helpful to tell me what I've achieved.

Summary

- Incremental planning that involves setting short-term, achievable goals can promote consumer recovery, even when the consumer's mental health is unstable.
- Care planning needs to be flexible and responsive to the consumers' needs, preferences and wellbeing.
- Establishing timeframes around care plan goals, that are sensitive to consumers' needs and preferences, adds to the quality of the care planning process and sets achievable and measurable outcomes.
- Challenges associated with care planning are the skills and experiences of the key worker and consumer wellbeing.
- Care planning can be a valuable record of consumers' progress over time and provide a source of motivation.

6 Care Plan Implementation and Review

Across the three fieldwork sites, the implementation and review of care plans is not exclusive to the formalised meetings between consumer, key worker and other people involved in the process. The care plans are implemented and reviewed between meetings. Given the regular contact between key workers and consumers, key workers primarily facilitated these processes. Some of their care planning practices are examined in the following section.

6.1 Review Processes

Care plans are formally reviewed every six months in two sites, and every three months in the third site. This process typically involves the completion of standardised measures to assess consumer needs, followed by a meeting between the consumer, the key worker and other people involved in care planning.

While most consumers are content with the regularity of formal reviews, others would prefer it be more or less frequent. One consumer stated, 'Every three months would be better, cause too much changes in six months. It might also speed things up', while another said, 'The reviews should be every year 'cause I need time to get my shit together.'

Between the formal reviews, key workers in all three sites participate in regular team meetings to discuss consumer progress and contribute to the implementation and review of care plans. These weekly forums are important in care planning. Given the rotating nature of their shifts, key workers do not always have the opportunity to meet with the consumers to whom they are assigned; the meetings therefore provide an overview of consumer progress and significant change, and armed with these insights, key workers can modify care plans accordingly. As one key worker stated, 'We have weekly meetings to review the clients. I get to know what the others are aware of.'

Key workers used other ways to share information about the consumer. One ASP maintained a communication book, while another held daily handover meetings. Consumers are not always aware of the information exchange between key workers.

6.2 Key Worker Practices

A number of key workers suggested that the value of a care plan is found in the way the document translates into daily practice. As one key worker stated, 'It's about how you practice and how you act – not the document per se.' The care plan provides an opportunity to 'formalise what is done daily… by the team.' The research material suggests that several factors help to translate the care plan into daily practice. These include professional skill, commitment, and working alliances with both the consumer and other agencies. As one key worker commented, 'It's only as effective as the rapport that you have with a client, the services that are involved, and the personalities of the staff involved.'

Key workers implement and review care plans with consumers in different ways. At one end of the spectrum, key workers work with consumers to establish explicit links between identified goals and strategies towards their achievement. These individuals described a reflective process. They remind consumers of their needs, the goals they

wanted to pursue, and the rationale for these goals. They then encourage consumers to act on the strategies they agreed upon. For example, key workers reported:

> Every time I'm with [the consumer], I discuss his goals… When we go and visit him, we talk about the progress he's making. We encourage and praise him, give him information that he might be interested in; we encourage him to use the Internet and the library.
>
> In the last few months, [the consumer has been] working on being positive. Negative thinking was identified in [the care plan] and it's improved because it impacts on his illness. I ask him to tell me three positive things that happened that day, and how he contributed to that. He identifies them himself now. Like, he said, 'If I go to hospital again' as opposed to, 'When.' I had to stop him to point out what he had just said; it was such a big change for him, and he didn't even realise it.

According to these key workers, consumers appreciate the reflective links between need, goal and strategy. It provides the consumers with direction and hope for change. Only a small number of consumers commented on these links. They tended to be people who had experienced an extended period of recovery.

6.3 Challenges Associated with Implementation and Review

According to a number of key workers, translating care plans into practice is not always easy. In addition to the difficulties of consumer lack of interest, and goal changes, consumers would sometimes exaggerate their predicament.

Further to this, some key workers advised that explicit links between need, goal and strategy could be threatening to consumers. By inviting them to reflect on personal progress, they might be reminded of goals they had failed to achieve. A key worker noted, 'The process can be confronting because they don't like to see that they haven't made progress; they don't like to hear that they might jeopardise tenancy.'

Reflective practice does not seem to be a dominant part of the care planning process for some key workers. Consumer comments seldom evidenced awareness of reflective practice. For the most part, they spoke of being 'reminded' of tasks they had to complete. As one consumer recounted, 'They encourage me – they check my housework, take me shopping, check my medication; they're supportive.' The reminders and the encouragement are not always linked to the care plan. Similarly, another consumer wanted to reduce the number of cigarettes he smoked daily. According to the consumer and key worker, while key workers regularly inquire about his progress, seldom do they explicitly link the goal to his care plan.

Reflective Practice

The creation of a habit, structure or routine around examining experience.

Amulya, nd; Shepherd, 2006

A few misinformed or uncertain consumers provided further evidence of the limited use of reflective practice. As suggested by the following excerpt, these individuals do not have a clear understanding about the purpose of the care plan or the tasks they are encouraged to complete – 'It might waste my time but I guess it's got to be done; otherwise you might be taken off the program.'

Similarly, some family members are puzzled about the distinct roles of the key worker and the case manager. The limited ability of family members to make connections between distinct parts of the support system suggests that perhaps the workers supporting the consumer on their recovery do not always discuss with family members the way the care plans are translated into practice.

Summary

- Regular key worker review meetings with ASP staff to discuss consumer progress and challenges have helped to promote continuity of care for consumers.
- Care plans are most effective when implemented using reflective practice, which involves establishing explicit links between identified goals, strategies and the rationales, and incorporating the goals into daily interactions with the consumer.
- Discussion with consumers, and when appropriate, families and carers, about developing, implementing and reviewing care plans, enhance their understanding and engagement in the care planning process.

7 Contextual Factors

A number of contextual factors influence the effectiveness of care planning, including interagency collaboration, staff turnover and organisational culture.

7.1 Interagency Collaboration

Some AMHS are not actively engaged in the HASI One partnership. This is most apparent in one fieldwork site where case managers are seldom involved in the care plan review meetings discussed in Section 5. This might be partly attributed to staff turnover among case managers. However, according to one key worker, it might also be a consequence of increased caseloads, 'Access to case managers at [one AMHS] is perceived as very difficult at [the ASP], and my own experiences [with the AMHS] have not been encouraging.'

The weak alliance between the ASP and the AMHS is associated with a number of consequences. Key workers are compelled to be hyper-vigilant of symptomatic change among consumers. The explicit role of the ASP is not clinical intervention; this therefore has the potential to place consumer recovery at risk. Three of the seven consumers are largely unaware of the care plan, and instead spoke of the weekly activities schedule during the course of the interview – this compares with only one consumer from the two remaining sites. Many of the goals that consumers in this site are working towards are maintenance goals as opposed to development goals. A comparison of this site with the remaining two emphasises the importance of the ASP-AMHS partnership in supporting consumer recovery.

7.2 Staff Turnover

The three fieldwork sites experience high staff turnover among key workers. Seven of the 14 interviewed key workers (50 per cent) have been appointed since the completion of fieldwork for the longitudinal evaluation of HASI One (11 months earlier). Staff turnover is most evident in one site, where four of the five key workers have been appointed since the completion of fieldwork for the evaluation project.

Respondents who referred to key worker turnover spoke negatively of the associated effects. They advised that it disrupts team dynamics within the ASP, consumer-key worker relationships and interagency collaboration. It takes time for recently appointed key workers to become familiar with and adjust to the HASI model; the ASP's understanding of the model; the consumers they will support; the key workers they will work with; as well as the other people involved in HASI One. This delays care planning and consumer ability to attain goals.

A number of consumers are particularly aware of the difficulties associated with staff turnover among key workers. After having established a trusted rapport with a key worker, these consumers are often required to commence the process again with a new key worker – a process that could be both frustrating and tiring. One consumer stated, 'It's hard to get used to other workers – they're always bloody changing'; another advised, 'So many of the workers are gone… I've had a few workers. They all have different ways of working.'

As the second excerpt suggests, turnover among key workers also increases variation in the styles of service provision. Key workers have different ways of supporting

consumers and different understandings of consumer capacity. It is sometimes difficult for consumers to understand the expectations placed on them. One consumer reflected,

> Different workers have different housecleaning standards. [One key worker] was very meticulous. She was offended by the cigarette smell and she'd make a fuss about it. She was hard to take. I used to spray the whole place before she came. She liked it, but the other workers hated it.

Personnel from the ASP also recognise the problem of variation in service provision. One key worker for instance, suggested, 'It's hard for so many staff to support a client in a consistent way; maybe there should be a core group of staff who work with the same clients.'

To minimise such variation, one ASP appoints coordinators whose role is to oversee the psychosocial rehabilitation of a small number of consumers. Personnel who have been employed by the ASP for an extended period typically hold these positions. Coordinators have nominal contact with consumers and are required to contribute to care planning and participate in review meetings. This provides consumers with access to a staff member they are familiar with, regardless of key worker turnover. It also ensures continuity in the planning processes, described in Section 2.

7.3 Organisational Culture

Organisational culture also influences care planning. The three ASPs involved in HASI One understand and apply the model in unique ways. Although policy clearly guides service operation (for instance, the selection, review and exit of participants) (NSW Health and NSW Department of Housing, 2005), the ASPs interpret key concepts, like psychosocial rehabilitation and community integration, differently.

Two of the three ASPs develop opportunities to facilitate psychosocial rehabilitation. These organisations arrange regular activities and outings to engage consumer interest and strengthen support networks. In turn, these activities influence care planning. They provide consumers with the opportunity to identify their likes and dislikes, and thus, the activities they would like to pursue. Consumers also have access to activities that might otherwise not be available due to geographical distance or financial constraints.

The third ASP does not organise regular activities and outings for consumers. Instead, it attempts to network consumers to external services. According to one key worker, consumer participation in social activities is not deemed a priority, lest tenancies are jeopardised:

> [The ASP manager is] more interested in maintaining clients rather than progressing them. Maintaining tenancy, for instance, was a priority over community integration, improving social skills, becoming more physically active, working, addressing the effects of negative symptoms and trying to improve independent living skills. There was very little rehab happening… outings for example… were stopped… because [they were seen] as an unnecessary distraction from keeping their homes clean.

In addition to variation between the ASPs, there is also variation within an ASP. This is partly consequent to the rapid growth of HASI. One key worker with extended experience with the initiative recognised considerable change since the model expanded into its second and third stages. More specifically, the swift expansion of HASI within one ASP necessitated the employment of additional staff; and, to ensure that all shifts were adequately staffed during the recruitment phase, it also required key workers to support consumers funded by different HASI stages. The appointment of new staff and the sharing of staff across different HASI stages, has diluted the culture of the organisation and its understanding of psychosocial rehabilitation. As the key worker explained, 'We're losing the focus on psychosocial rehab with the expansion of HASI. It's getting diluted and there's confusion between doing things with clients as opposed to for clients.'

Summary

- Collaboration between the ASP and AMHS improves consumer outcomes.
- Clear definition of the roles of ASP and AMHS personnel improves the effectiveness of the partnership to meet consumer needs.
- ASP key worker and AMHS case manager turnover presents a significant problem for all partners. It disrupts team dynamics, consumer relationships, interagency collaboration and care planning.
- The appointment of a coordinator within the ASP who is involved in care plan reviews can minimise the disruption caused by key worker turnover.
- A shared understanding of key concepts, such as psychosocial rehabilitation and community integration ensures a consistent approach among people involved in care planning.

8 Implications for the Care Planning Process

This research has implications for care planning in HASI One. It highlights the components of good practice, which have the potential to guide future care planning. These components include an understanding of psychosocial support, organisational support, reflective practice and integration of support.

8.1 Understanding Psychosocial Support

NSW Health (2002) states that mental health rehabilitation is comprised of two service provision components; namely clinical rehabilitation, which is the domain of AMHS, and accommodation support, which is the domain of ASP.

Care planning and goal attainment is facilitated when ASP personnel and other people involved in care planning hold a shared understanding of psychosocial rehabilitation. They help the consumer to identify strategies towards incremental advances that are consumer-driven, appropriate, timely and flexible. As one key worker explained, 'The goal setting process is merely a guide – after all, how do you plan living?'

Of particular importance is a demonstrated ability to balance psychosocial rehabilitation with disability support. Some consumers experience complex and chronic mental health issues; thus, the capacity to balance these constructs in a manner that will not jeopardise rehabilitation is imperative.

It is important for ASPs to have a clear understanding of psychosocial rehabilitation and its relationship to clinical intervention. People who are actively involved in care planning need to communicate regularly to ensure that they hold a similar understanding of psychosocial rehabilitation and its role in recovery.

Psychosocial rehabilitation

While the nature of the process and the methods used differ in different settings, psychosocial rehabilitation invariably encourages persons to participate actively with others in the attainment of mental health and social competence goals.

The process emphasises the wholeness and wellness of the individual and seeks a comprehensive approach to the provision of vocational residential, social/recreational, educational and personal adjustment services. (IAPRS, 2000)

8.2 Organisational Support

Good practice is also observed in the sites where the ASP actively supported case planning founded on psychosocial rehabilitation. This involves:

- Orientation and guidance for key workers, particularly during induction;
- Policy that clearly articulates the role of the ASP in facilitating psychosocial rehabilitation in collaboration with other people involved in care planning;
- Care plan templates that are clear for both the personnel and consumers;
- Professional supervision for key workers that encourages reflective practice;

- Maintaining consumer-key worker relationships, despite staff turnover – strategies that help to achieve this include the appointment of ASP personnel to coordinator roles, and assigning small teams of key workers to support a group of consumers;
- Regular opportunities for team discussion to consider consumer progress and the translation of care plans into practice; and
- Manageable workloads that encourage rapport-building between key workers and consumers.

Another important demonstration of organisational support is the provision of ongoing training opportunities in care planning. The three ASPs provide training in the use and interpretation of assessment tools. Yet, a number of key workers identified the need for further guidance. This is particularly the case when training is accessed from an external organisation, rather than tailored to the needs of the ASP. They advised that they would benefit from training on developing and implementing care plans; facilitating care plan review meetings; and promoting psychosocial rehabilitation among consumers, particularly those with challenging mental health issues and those with limited interest in development. Key workers reported:

> Additional training is needed on how to quiz people, how to rephrase questions appropriately, how to identify aims, how to develop rapport… It's not just the document itself; it's how you use it and how you translate aims into structure and then outcomes.
>
> Training would be useful on how to motivate clients, how to increase client awareness, how to instil hope, how to reaffirm the attainability of recovery, how to affirm that recovery is a process, what to do when you can't facilitate change, how to overcome barriers, helpful strategies to achieve goals.
>
> It might be good to get training in developing and implementing [a care plan]… and chairing meetings – how to keep a meeting focused and how to manage the egos; facilitation skills would be useful too. But it wouldn't be that useful cause the client's not there.

8.3 Reflective Practice

Reflective practice is evident in the care planning of some key workers. The habitual examination of consumer need, identified goals and strategies towards goal attainment has the potential to foster long-term psychosocial rehabilitation. It also promotes consumer participation, as consumers are encouraged to consider their current situation and opportunities for personal development. Reflective practice is not universally performed within the three fieldwork sites. The links between need, goal and strategy sometimes waned.

Respondents do not always understand the purpose of care plans, the process of care planning, and the significance of participation from all people – particularly consumers. This is especially the case when care planning is regarded as routine paperwork, rather than as a part of recovery that required reflection before, during and after the care plan was prepared and implemented.

Some of the challenges that surround care planning, like lack of consumer interest and a change in consumer preferences, might be overcome if relevant literature (Berzins,

2006; Brown and Brown, 2003; Rapp and Goscha, 2006; Tondora et al., nd) is used to inform ASP practices.

8.4 Integration of Support

Good practice is observed when care plans clearly articulate the role of the consumer, the ASP, the AMHS and other people in facilitating psychosocial rehabilitation. The plans identify additional community-based services and support systems that will be accessed to promote consumer development and wellbeing. In two of the three sites, these include activities that are organised by the ASP, as these are found to generate enduring support networks and promote the development of social skills.

One of the three sites demonstrates weak partnerships between the ASP and the AMHS. Additional strategies need to be identified to ensure that the principles of the HASI model are implemented in practice. The significance of this issue is heightened by staff turnover and the varied understandings of the model that new workers are likely to have.

Summary

- Not all HASI partners hold a shared understanding of psychosocial rehabilitation, which has negative consequences on collaboration.
- Balancing psychosocial rehabilitation and disability support is challenging, but important to achieving consumer outcomes.
- ASP key workers' care planning practice benefits from training and support.
- Setting incremental goals and using reflective practice are critical in effective care planning. These concepts are not understood or used by some key workers.
- Care plans are most effective when they articulate the roles of all participants.

9 Conclusion

This study examined the differences between ASP care planning practices in three of the nine sites implementing this initiative, and reviewed the effectiveness of the different approaches. Care planning is a useful means of mapping, implementing and achieving psychosocial rehabilitation. It provides key workers and case managers with direction to reduce role duplication; it also assists consumers and family members by documenting goals towards recovery, verifying progress, and providing hope for future growth.

The three fieldwork sites demonstrate considerable variation in the development and monitoring of care planning. Some consumers recognise links between care planning, their involvement in the process, and recovery; others do not. This suggests that some HASI participants were only marginally involved in the care planning process, and indicates variable knowledge and skill across ASP key workers associated with care planning. Improvements to the care planning process could therefore provide more opportunities for consumers to control their experience of psychosocial rehabilitation.

The findings have implications for care planning in HASI Stage One. They highlight components of good practice, which include an understanding of psychosocial rehabilitation in accordance with NSW Health (2002); organisational support; reflective practice; and integrated support.

Summary of strategies to enhance care planning

- A shared understanding among ASP and AMHS personnel about care planning processes, psychosocial rehabilitation and roles of the partners facilitates effective collaboration.
- Active consumer involvement in care planning is central to the HASI model.
- Reflective practice by ASP staff in care planning improves understanding about the quality and progress of the process.
- Clear documentation of care planning, with copies retained by all participants, facilitates effective communication.

References

Amulya, J. (nd), *What is reflective practice?*, Center for Reflective Community Practice, Massachusetts Institute of Technology, MA. http://crcp.mit.edu/documents/whatis.pdf.

Berzins, K. M. (2006), *Implementing a recovery approach in policy and practice: A review of the literature*, University of Glasgow, Glasgow, Scotland.

Brown, I. and R.I. Brown (2003), *Quality of life and disability: An approach for community practitioners* (Second ed.), Jessica Kingsley Publishers, London.

International Association of Psychosocial Rehabilitation Services (IAPRS) (2000), *Principles for Rehabilitation.*

Morris, A., K.R. Fisher, D. Abelló, K. Norris, K. Sutherland, S. Yallop, et al. (2005), *Housing and Accommodation Support Initiative (HASI): Evaluation plan*, Feb., SPRC (Social Policy Research Centre), Sydney, NSW.

Morris, A., K. Muir, A. Dadich, D. Abelló and M. Bleasdale (2005), *Housing and Accommodation Support Initiative (HASI): Report I summary*, Aug., SPRC (Social Policy Research Centre), Sydney, NSW.

Muir, K., A. Dadich, D. Abelló, M. Bleasdale and K.R. Fisher (2006), *Housing and Accommodation Support Initiative (HASI): Report III summary*, Jun., SPRC (Social Policy Research Centre), Sydney, NSW.

Muir, K., A. Dadich, D. Abelló, M. Bleasdale, A. Morris and K.R. Fisher (2005), *Housing and Accommodation Support Initiative (HASI): Report II summary*, Dec., SPRC (Social Policy Research Centre), Sydney, NSW.

Muir, K., K.R. Fisher, A. Dadich, D. Abelló & M. Bleasdale (2007), *Housing and Accommodation Support Initiative Evaluation: Final Report*, report prepared for the NSW Department of Health, September, SPRC Report Series 14/07 and www.health.nsw.gov.au/pubs/2007/hasi_evaluation.html

NSW Health and NSW Department of Housing (2005), *The Housing and Accommodation Support Initiative (HASI) for people with a mental illness: Resource manual (draft version 1.7)*, Sep., NSW Health and NSW Department of Housing, NSW, Sydney.

NSW Health Department (2002), *NSW Government Action Plan: Framework for rehabilitation for mental health*, Aug., NSW Government, Sydney, NSW.

Rapp, C. A. and R.J. Goscha (2006), *The strengths model: Case management with people with psychiatric disabilities* (Second ed.), Oxford University Press, New York, NY.

Shepherd, M. (2006), 'Using a learning journal to improve professional practice: A journey of personal and professional self-discovery', *Reflective Practice*, 7 (3), Aug., 333-348.

Tondora, J., S. Pocklington, A. G. Gorges, D. Osher and L. Davidson (nd), *Implementation of person-centered care and planning: How philosophy can inform practice*, Department of Psychiatry, University of Illinois, Chicago, IL. http://www.psych.uic.edu/uicnrtc/cmhs/pcp.paper.implementation.doc.