

HRN

Stay Strong Plan

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

PRINCIPAL NAME (AKA)	OTHER NAMES	DOB:...../...../.....
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People that help to keep me strong: (family, friends, elders, carers)

I trust this person to give advice about my treatment _____

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

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

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

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

Detail of worries / current issues

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

Early warning signs of me getting sick are:

1.	3.
2.	4.

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

- 1.
- 2.
- 3.

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

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Goals I have today for changing worries – step by step:

Goals are things that we want to do differently. The steps to the goal help us to check how we are going. They should be do-able and measurable. Follow up with review and feedback.

Goal:

Step 1.

Step 2.

Step 3.

What would be good about making this change:

Think about: What will help? And who? And what has helped before? Change is your own choice. Everyone can make changes. Small steps can lead to big changes.

Goal:

Step 1.

Step 2.

Step 3.

What would be good about making this change:

Treatment goals for other Problems:

Other Problem (Diagnosis)	Goal and steps	Who will help

Other treatments that I am trying :

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

Who will help:

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

I sometimes get worries that I call

The diagnosis today is

Signed (Client) _____ Signed (Practitioner) _____