

## **Appendix 1: Care planning maps**

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These maps are suggested tools for a client and a keyworker to work through together to improve the quality of their care planning. They transform care planning into an interactive and motivational process which both defines the main elements of the care package and improves treatment retention. It is suggested that in using maps to do care planning a keyworker goes through the four steps and four accompanying maps outlined below. Thus the “self map” is used as the initial step to assist the client in exploring personal strengths. This is followed by the “goals map” that assists identification of specific goals to work on in relation to particular problems. Care plans are further developed with the next two maps “care planning (examining goal)” and “care planning (taking action)”. The results of work done in the maps can then be recorded as part of the care planning record.

Mapping serves two major functions in the care planning process. Firstly, it provides a visual communication tool for clarifying information shared between client and keyworker. Mapping can enhance communication with a client whose cognitive awareness is blunted (due to acute or chronic effects of drugs) and can be used in tandem with whatever therapeutic orientation or style a keyworker may follow. Secondly using mapping during care planning sessions provides a model for systematic and “cause-effect” thinking and problem-solving, which clients begin to adopt.

Mapping skills are best developed through repeated practice. Just as keyworkers develop their own personal style, those who become comfortable and experienced with the mapping techniques discussed here will develop their own unique ways of using this tool. Although mapping may seem complicated at first glance, the system quickly begins to feel familiar and straightforward. We encourage novice mappers to practice by mapping their own experiences, feelings and thoughts and develop maps for any presentations they may make.

In the short term, keyworkers using these maps with a client can expect at least two measures of success. Firstly, maps should help with problem definition. Maps should systematically highlight issues for the client in terms of causes, consequences and solution options. In this regard, it shares something with solution-focused approaches to working with a client. Secondly, maps should provide easy-to-read summaries of a care planning session that can be useful both for quick recall of issues and reviewing a case in clinical supervision.

1.1.1 Summary

# Care planning

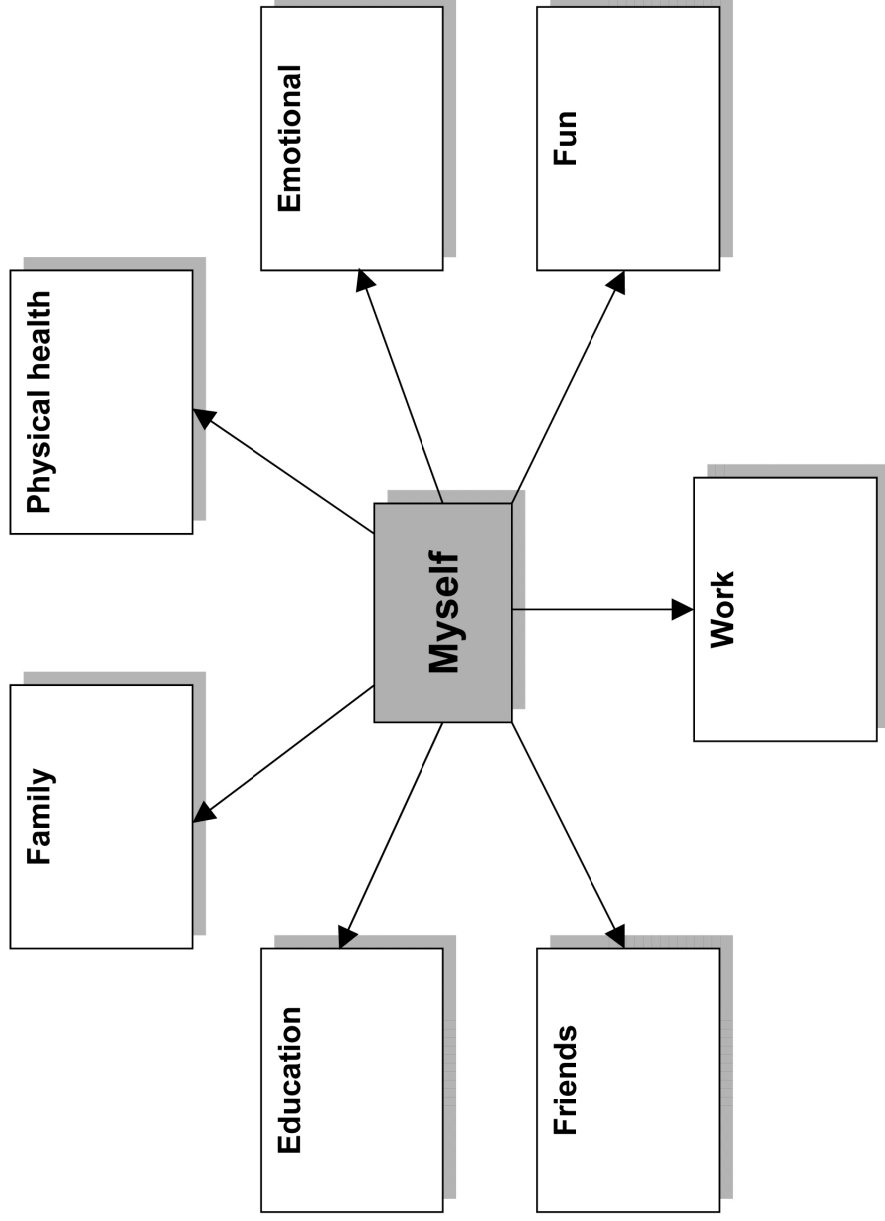
**Steps** **Primary maps**  
(used for all clients)

<b>Step 1:</b> Explore strengths and problems	<b>1. Self map</b>
<b>Step 2:</b> Identify goals	<b>2. Goals map</b>
<b>Step 3:</b> Develop plans	<b>3. Planning map</b>
<b>Step 4:</b> Commit to specific actions	<b>4. Action map</b>

# Care planning (examine self)

Client name:

Date:



1.1.3 Map 2: Step 2

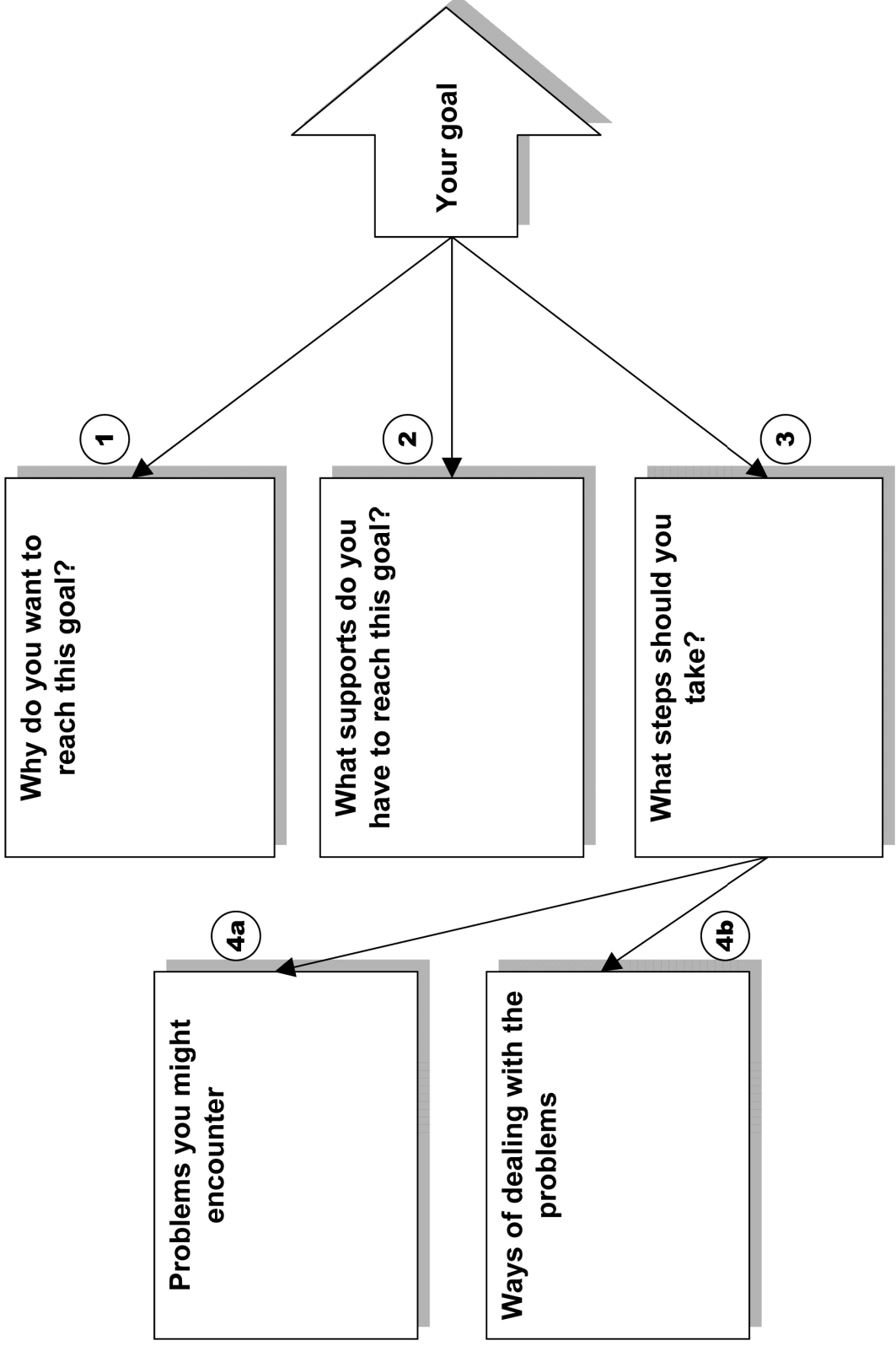
# Care planning (select goals)

Client name:  
Date:

<p>Which areas should be treatment targets? Check the six most critical areas and then fill in the boxes</p>	<b>State the problem</b>	<b>What's the specific goal?</b>
<ul style="list-style-type: none"><li>(a) Employment and support</li><li>(b) Family relations</li><li>(c) Peer relations</li><li>(d) Legal and criminality</li><li>(e) Medical and health</li><li>(f) Psychological and emotional</li><li>(g) Alcohol use</li><li>(h) All other drug use</li><li>(i) Gambling</li><li>(j) AIDS-risky needle use</li><li>(k) AIDS-risky sex</li><li>(l) Housing and living situation</li><li>(m) Academic and vocational skills</li><li>(n) Sexual behavior</li><li>(o) Financial management</li></ul>	<b>1</b>	
	<b>2</b>	
	<b>3</b>	
	<b>4</b>	
	<b>5</b>	
	<b>6</b>	

# Care planning (examine goal)

Client name:  
Date:



# Care planning (take actions)

Client name:

Date:

What's the specific goal?
Here are the <b>actions</b> I will take to get me to this goal:

What will you do?

Beginning when?

1	↑	
2	↑	
3	↑	
4	↑	