Implementation of A Practical Guide for Working with Carers of People with a Mental Illness

Inpatient & Community Mental Health Service Pilot: Report June 2018

ACKNOWLEDGEMENT

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EXECUTIVE SUMMARY

This project examined the effectiveness of implementing *A Practical Guide for Working with Carers of People with a Mental Illness* (hereafter referred to as *the Practical Guide*) to support mental health services to enhance their engagement with carers. The pilot project was undertaken with four metropolitan inpatient adult mental health services (from July 2017) and with four adult community clinical mental health services (from February 2018 over four months). We found that the Practical Guide, in combination with a co-design approach, was a useful tool to support improved staff engagement with carers of people using mental health services.

The following outcomes were observed:

- Increased staff awareness of the importance of engaging with carers and families
- The identification, development and implementation of strategies, process and resources that support carer inclusion as consistent with standards and legislation
- Increased provision of support and advice to carers.

At the start of engagement with each site, staff completed a checklist of practice activities under each of the six partnership standards. From checklists, it is possible to identify existing strengths in carer engagement, and areas in which engagement with carers could be improved.

Existing strengths in carer engagement commonly identified by staff across sites:

- Standard 2: Staff are aware of policy that requires them to work with carers; staff convey hope when working with carers
- Standard 3: Consumer consent to share information with the carer is sought; agreement is reached with the consumer about the level of information to be shared with the carer
- Standard 6: A range of carer support services is available

Areas for improvement in carer engagement commonly identified by staff across sites:

- Standard 1: Carers are routinely identified; special circumstances of carer recorded; there is a documented procedure for welcoming carers
- Standard 2: Staff are carer aware and trained in carer engagement strategies – training is delivered by carer trainers or carers as part of the training delivery team
- Standard 3: Policy and procedure regarding confidentiality and sharing of information – consent to share information is regularly revisited with the consumer; opportunities are provided to carers to discuss the care and treatment of the consumer; practice guidelines re information sharing are in place; carer contact is clearly identified in the consumer's file; staff training includes carer best practice for information sharing and confidentiality

- Standard 4: A carer champion is identified; carer peer/consultant roles are in place
- Standard 5: A carer introduction to the service and staff is available; an early appointment is offered to the carer to hear their story/history; carer information packs provided to new carers at first meeting, cultural and language needs of carers addressed; feedback is sought from carers as part of quality improvement activities

Resources developed at each site depended on the priorities of the service. The range of resources implemented across services included:
- Carer engagement e-learning modules
- Introduction to services letters (community and inpatient)
- Service statement of commitment to carers – fact sheet and poster
- Carer engagement checklist – admission (community)
- Carer welcome procedure (inpatient)
- Who is a carer/next of kin fact sheet
- Starting conversations with consumers about consent – clinician guide
- Information sharing – clinician guide
- Consumer and carer list of useful questions
- The provision of on-site carer support groups, counselling and/or carer peer support
- Confidentiality training offered by the Office of the Chief Psychiatrist in response to feedback from the project

Once resources and activities at most of the sites were rolled out, staff checklists were completed again. The tight timeline for the project meant that at some sites, post-intervention checklists were completed prior to fully implementing the initiatives. However, checklist findings indicated that staff still perceived an improvement in carer engagement across each of the six standards[1].

Combined Inpatient and Community Mental Health Services: Pre and Post Intervention
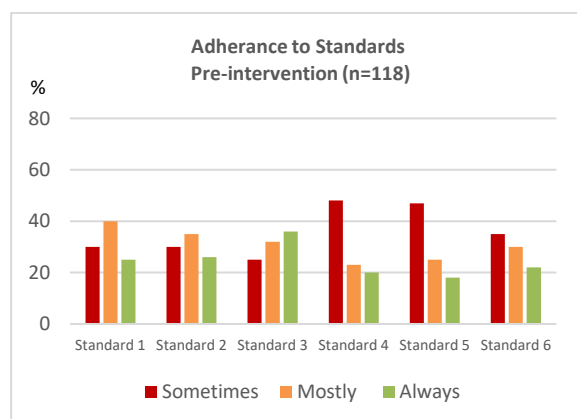
FIGURE 1: COMBINED SITES PRE-INTERVENTION   FIGURE 2: COMBINED SITES POST-INTERVENTION
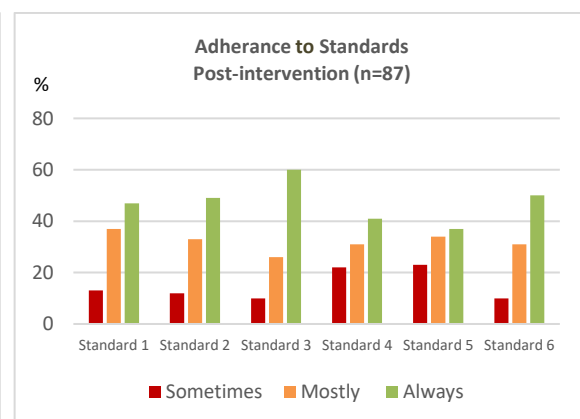
[1] Totals will not add up to 100% due to questions left unanswered in the checklist

There was consistency across all inpatient and community sites regarding areas identified for improvement, resources implemented and pre- and post-checklist findings.

Key learnings of the pilot project comprised:

Project design:
- Continue use of *the Practical Guide* to enhance service engagement with carers
- Continue the use of a strength based and co-design approach, as well as external facilitation by a peer (a fellow clinician)
- Consider longer engagement with each service (for eight to ten months) to provide more opportunities for staff to implement changes and to test initiatives

Adapting resources to meet service needs:
- Maintain the staff checklist adaptations that give a more strength-based focus and include cultural considerations. Consider further adaptations to the length and timing of the checklist
- Consider how to support clinicians to complete the carer engagement e-learning modules
- Identify two carer champions at each site
- Consider how to maintain the Carer Champion Network sustainably
- Support the development of a young carer toolkit

Responding to service specific needs:
- Maintain a focus on building and maintaining relationships with staff
- Consider working with a whole service or area
- Work with existing site-based carer and consumer engagement processes when possible
- Consider common challenges faced by mental health services
- Consider strategies that facilitate cultural change
- Advocate for the inclusion of systems approach training for mental health clinicians at foundation level and beyond
- Consider common carer engagement issues
- Consider ways to build engagement with carers with Aboriginal and Torres Strait Islander (ATSI) and Culturally and Linguistically Diverse (CaLD) heritage

Gains made during the project are encouraging steps towards best practice. There is still a significant gap between policy requiring carer engagement and practice. Cultural change is required to embed meaningful engagement with family and friends in a caring role (Martin, 2017).

Experience from the UK makes clear that cultural change takes time. Many services made ongoing changes towards implementation of the Triangle of Care over several years, allowing for multiple initiatives (Cummins, 2013).

Moving forward, all services could continue to build engagement with carers through developing action plans to implement strategies such as:

Standard 1: Carers and the essential role they play are identified
- Consider how to identify and respond to any special circumstances experienced by the carer
- Routinely involve carers in treatment, support and discharge planning

Standard 2: Staff are carer aware
- Carers to deliver training regularly as part of staff development
- Encourage staff to complete carer engagement e-learning modules
- Include carer engagement e-learning modules as part of induction

Standard 3:   Policy and practice protocols regarding confidentiality and information sharing are in place
- Add 'review consent to share information' to client three monthly reviews
- Offer staff training in carer best practice for information sharing and confidentiality
- Ensure that policy is supported by effective protocols

Standard 4: Defined staff positions are allocated for carers
- Consider carer consultant and/or carer peer worker roles for the service
- Promote local carer champions

Standard 5: A carer introduction to the service and staff is available
- Develop carer information packs to be provided to new carers at first meeting
- Offer early appointments to carers to hear their history with the consumer and any relevant information and concerns
- Seek carer feedback regarding the service as part of quality improvement activities

Standard 6: A range of carer support services is available
- Regularly consider carers needs

RATIONALE

This project seeks to address concerns arising out of the mismatch in policy and practice regarding the engagement of family members and carers by mental health services.

Family and carer engagement is embedded in mental health policy, standards and legislation

The benefits of partnerships between mental health service providers, consumers and family and friends in a caring role are acknowledged internationally (WHO, 2004), nationally (*National Standards for Mental Health Services*, Commonwealth of Australia 2010) and within Western Australia (Government of Western Australia: Chief Psychiatrist, 2015; Mental Health Act 2014; Waters, 2016).

For example, Principle 14 of the *Mental Health Act 2014* requires clinicians to respect the right of a consumer to include the people close to them in their treatment. The *Clinician's Practice Guide to the Mental Health Act 2014* states that "the default position is that it is important to involve significant people in the patient's life" (Government of WA: Chief Psychiatrist, 2015, p.22). This is in acknowledgment that, "Family members are in a good position to contribute to the recovery of the patient and the Act obliges clinicians to involve them" (p.22).

Family and carer engagement is not routinely embedded in practice

However, there is still a significant gap between policy and practice in the provision of consistent, meaningful and sustained family inclusion in mental health services (Martin, 2017). Multiple reasons for this gap in practice have been identified (Easson et al 2014; Rose et al, 2004; Martin et al, 2017). For example, some family members seeking advocacy report that some staff fail to respond to requests for meetings or information, either in person or over the phone, and that certain professionals appear reluctant to involve family members/carers.

Mental health service staff have identified the following challenges to family engagement:

- Concerns around consumer confidentiality when sharing information
- Aspects of the service delivery model not supporting family engagement
- The needs of family members can be overwhelming
- A lack of relevant materials/information/support to provide to family members
- A lack of skills and experience in working with family members
- Family engagement is not perceived as part of practice and can be complex
- Families resist involvement, due to exhaustion, or cultural or social beliefs about mental illness
- Concerns that involving family members may not be in the best interests of the consumer

In Western Australia, the relatively recent introduction of mental health legislation that explicitly requires the involvement of family members and others in a caring role is an additional factor to be considered when identifying systemic barriers to carer engagement.

The ongoing systemic barriers to greater family engagement identified by staff and carers have led to conclusions that while training, education and policies are necessary, they are not of themselves sufficient to allow new practices to emerge and be routinely embedded. Martin et al (2017, p. 484) concluded that "widespread culture change is necessary to systematically embed meaningful involvement of both families and service users in the delivery of mental health services". This requires a safe space for staff to identify and voice their concerns. "Exploring and acknowledging such concerns through open, yet non-judgemental communication could facilitate the establishment of a therapeutic alliance between staff, families and patients" (Eassom et al 2014, p. 8).

Evidence based tools to enhance carer engagement in mental health services already exist
1. Triangle of Care, and
2. Co-design

1. The *Triangle of Care* (Carers Trust 2010) describes service providers, consumers and carers working together in partnership. "The Triangle of Care model provides a practical framework that, if implemented, will meet the criteria of state and territory mental health legislation, carers' rights legislation, quality and safety guidelines and state and territory policies" (Mind Australia and HelpingMinds, 2016, p.9*).*
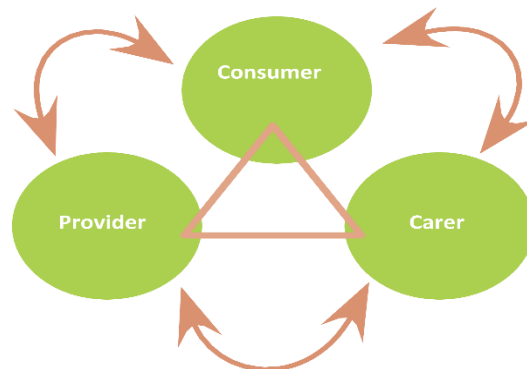
FIGURE 3: THE TRIANGLE OF CARE

Staff involved in implementing the Triangle of Care report that the most sustained changes emerge from a cultural change process and that the completion of checklists (similar to those utlised in the *Practical Guide*) is a very effective means to commence this process (Cummins, 2013).

Within the UK, the Triangle of Care is now an accreditation standard, currently adopted by 36 National Health Service (NHS) trusts to indicate a commitment to engagement with

carers (Carers Trust, 2018). As part of the process, a group of 'critical friends' must be engaged. This group of friends is comprised of people with lived experience in a caring role along with others who are users of the service.

A Practical Guide for Working with Carers of People with a Mental Illness (Mind Australia and HelpingMinds, 2016) is based on the *Triangle of Care* (Carers Trust, 2010) implementation model. The *Practical Guide* was developed collaboratively by an alliance of carer and consumer mental health peak bodies and services providers, in recognition of the importance of carers as critical partners in providing care for and fostering recovery of people with mental health issues.

Six partnership standards are provided within the *Practical Guide* to "improve outcomes for consumers by combining the knowledge and skills of staff with the knowledge and lived experience of family and other carers" (Mind Australia and HelpingMinds, 2016, p.11*).*

FIGURE 4: THE SIX PARTNERSHIP STANDARDS

The content within the *Practical Guide* has been adapted to ensure consistency with Australian mental health standards, policies and legislation. Also included with the *Practical Guide* are case studies providing examples of applying the Partnership Standards to particular mental health service settings typically available within Australia.

Additional resources include six e-learning modules, each exploring one of the partnership standards outlined in the *Practical Guide*. Each module contains readings as well as videos

of the experiences of carers, consumers and service providers. The modules can be undertaken one at a time, and each takes around ten minutes to complete. https://helpingminds.org.au/health-professionals/

2. Co-design. The Practical Guide Project used a co-design approach by engaging consumers and carers as well as service providers in the design of resources and activities. Co-design at its simplest refers to a collaborative design process (Burkett, n.d.).

Throughout the NHS, Experience-Based Co-Design (EBCD) has been in use in the UK for over ten years. "EBCD is a collaborative approach that aims to improve health care services by enabling service-users, carers, and staff (ground-level and management) to collaborate together to co-design better services" (Larkin, Boden and Newton, 2015, p. 2).

Concerns regarding co-design included staff feeling that co-design activities were just additional, non-core tasks to be carried out in addition to an already exhausting workload; projects failing to be sustained when external facilitators handed over responsibility to internal working groups; lack of budget allocated to support consumer and carer involvement; a failure to implement changes that required cross-department or system wide collaboration.

In summary, while there will, and should be, variations in the design of any particular co-design project, a codesign approach is characterised by attempts to acknowledge and address power differentials between service users and service providers; to support consumers and carers to participate in co-design; to provide training and support to staff to assist them to be open in their self assessments of their service, and to better understand the value of a lived experience perspective; to achieve practical solutions; and to embed co-design into future decision-making processes (Burkett, n.d.; Slay and Stephens, 2013).

METHODOLOGY

Based on the guiding principles of *Better Choices. Better Lives.* (MHC 2015), conclusions from the academic literature, and the extensive experience of co-design in the health and mental health services in the UK, a co-design methodology was adopted for this pilot in which clinicians, carers and consumers of mental health services were partners in the activities undertaken as part of the pilot projects. We adopt a definition of co-design offered by Roper et al (2018) where people involved in the project work together to identify the problems, to develop solutions and to test them.

Based on the ongoing success of the Triangle of Care, a decision was made to pilot the *Practical Guide* (Mind Australia and HelpingMinds 2016) as a tool to support mental health services to enhance their engagement with carers. The project was undertaken first with four metropolitan adult inpatient mental health sites (from July 2017) and then with four metropolitan adult community mental health services (from February 2018).

Working with carers and consumers
A total of eleven people (seven with carer lived experience, six with consumer lived experience) were recruited and paid to participate in the project. Working with local staff, recruitment flyers were designed and promoted on site, distributed through staff networks and advertised on Facebook pages. The project budgeted for consultation and development time to work with the participants to identify issues and to co-design prototype solutions. The consumers and carers had experience of using mental health services but were not necessarily current users of the services involved in the pilot.

We met with the carers and consumers in locations that best suited them and provided transport where required. Face to face sessions with carers/consumers with Aboriginal and CaLD heritage identified a range of barriers experienced by members of their communities in engaging with mental health services. Discussion was held around ways that engagement could be enhanced. These suggestions have been included in the key learnings section of this report.

In another session, we worked with a carer and a consumer who was supported to attend with their community support worker. In this session, the importance of the visibility of the Carers Charter (Carers Recognition Act WA, 2004) was emphasised with the need for discussion in services on the impact of treatment and care planning on carers and their ability to sustain their role. The development of a checklist of questions for both carers and consumers to take into appointments was considered particularly useful and this was developed in further sessions for all practitioners in each of the services to make available (See Appendix 2: Toolkit of resources).
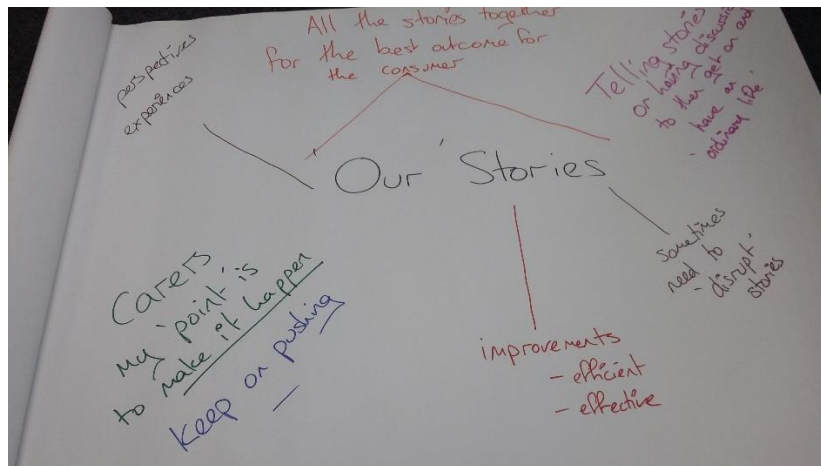
FIGURE 5: BRAINSTORMING 'OUR' STORIES

Another example of the valuable role of carer consumer consultancy was feedback provided on a new document that had been drafted - guidelines for clinicians on conversations (with consumers) about consent to share information. The feedback re-designed the document to one that could be used in meetings with consumers. The new version of the document helps clinicians start conversations with consumers and can be used in meetings with consumers to help them understand consent to share information.

Working with clinicians

The project officers adopted an asset-based approach, building on the existing capabilities, reciprocity and mutuality. They facilitated rather than delivered the project (Slay & Stephens, 2013). A peer approach was enhanced by the project officers having clinical backgrounds and bringing lived experience as a carer to their work with the service providers. The peer approach assisted in creating 'shared power' and partnership (Mental Health Australia 2017). The project officers, as external facilitators with clinical experience were positioned as supportive peers rather than 'experts', 'auditors' or 'evaluators'. This provided a safe space for other staff to acknowledge their own caring experience which was part of the approach to breaking down the divisions between the 'expert' professional and service users.

We also assessed our data gathering tool, the staff checklist in *the Practical Guide*, to ensure it supported staff to provide accurate answers. It was decided that asking staff to agree that their service was 'significantly under-performing' was asking too much of staff working in a high-risk service. The categories of the checklists were modified to encourage honest reporting of the need to improve performance, without requiring staff to admit that they were not abiding by mandatory legislative requirements.

Red	indicates significant under-performance and a need to develop action plans for improvement.
Orange	indicates achievement of the activity some of the time but that improvement is required.
Green	indicates positive achievement of the activity the majority of the time.

FIGURE 6: THE ORIGINAL SCALE IN THE STAFF CHECKLISTS

Red	indicates this practice may be occurring sometimes but is generally not consistent of documented.
Orange	indicates this practice is occurring most of the time but documentation could be further developed.
Green	indicates this practice is always carried out and consistently documented.

FIGURE 7: REVISED SCALE IN THE STAFF CHECKLISTS

At the start of the project, senior management of the three Perth metropolitan area health services were contacted and invited to participate in the pilot. Positive responses were received from all area health services with senior mental health managers deciding on the participating sites. The number of sites and the amount of time allocated, was determined by the resources available to this project.

Once the sites were confirmed, the project manager and/or project officers met with management of each of the mental health services and within these meetings carer champions were identified. The project was then presented and checklists completed in team meetings within the service. In each of the presentations, the project officers shared the Triangle of Care model to demonstrate the shift required in how carers are to be recognised in partnership with consumers and service providers. The carer champion facilitated the later completion of the checklist for staff not at the meeting.

The collegial approach taken during the completion of the checklists made room for discussion between staff. This meant there was also the opportunity to discuss and challenge views that were barriers to working in partnership with carers. By engaging with staff as peers, and demonstrating empathy, staff were supported to reflect on their practice and to complete the checklist accurately. The checklists were completed anonymously and at no point are individual responses identified or revealed. Individual staff were able to keep their responses private from others. The only exclusion to this was when Carer Champions collected checklists from staff who had been unavailable for the staff meeting.

Completion of checklists at the start and end of the project served several purposes. Importantly, completing the checklist at the beginning of the project helped to orient staff to practical ways that they and their service could enhance their engagement with carers. This also gave them the chance to review their current level of engagement with family and friends in a caring role. Compiling the checklists across the service provided an overview of the service, to identify areas of strength and opportunities to enhance their practice.

Checklist completion at the end of the project gave staff the opportunity to reflect on any changes made to their practice and to the way the service is operating, and to consider next steps in sustaining and further enhancing engagement with carers.

Figure 8 provides a visual representation of the co-design methodology used in the Practical Guide Project.

Analyse existing information
- Literature review - barriers to carer engagement in mental health services; co-design; Triangle of Care
- Scan of Western Australian mental health standards, policies and legislation

Commence engagement
- Recruitment of carers and consumers
- Discussions with senior management to confirm sites
- Site visits and identification of carer champions
- Agree on site specific engagement strategies

Gather and share information
- Provide copies of the Practical Guide to staff
- Provide access to the online videos
- Completion of pre-intervention self assessment checklists by staff
- Meetings with carers and consumers to share stories
- Gather evidence to corroborate self assessment checklist results

Co-design solutions
- Share checklist findings and determine priorities with sites
- Assist with the provision of information and the development of resources
- Workshop proposed solutions with carers and consumers
- Host a Carer Champion network meeting

Test solutions
- Completion of post-intervention self assessment checklists by staff
- Gather evidence to corroborate self assessment checklist results

Sustain the solutions
- Agree a method for sharing resources and tools with all sites
- Share checklist findings and recommendations with all sites
- Share checklist findings and recommendations with senior management
- Completion of a final self assessment checklist after an agreed date

FIGURE 8: PRACTICAL GUIDE PROJECT CO-DESIGN METHODOLOGY

EVALUATION METHODOLOGY

The effectiveness of *The Guide*, in conjunction with the co-design approach, as a tool for supporting improved carer engagement was determined through:

- Results captured by the completion of the pre and post intervention staff checklists,
- the development and implementation of resources and procedures
- the usefulness of the resources as determined by carers and consumers
- the correlation of the staff checklist results with substantiating evidence
- the willingness of staff to maintain their participation.

Prior and post intervention, staff at each site completed a staff checklist regarding their perceptions of the extent to which their service was compliant with the six partnership standards included in the *Practical Guide*. Self-reported data can be subject to bias (Short et al., 2009). The Project Officers sought to overcome this in several ways, based on the methodology adopted in the UK by NHS Trusts in their implementation of the Triangle of Care, and based on the transparency of the co-design approach which offers opportunities for peer interactions and learning.

Staff sometimes questioned each other and the project officers while completing the checklists. For example, people asked each other for evidence of certain practices, such as the existence of procedures or resources. This is an example of peer learning and is similar to the manner in which culture influences practice in service settings. "Practitioners evaluate their professional practice in a formative and collaborative way on a daily basis. Such experiential learning is pervasive…" (Stabler 2014, p. 10).

The findings from the post-intervention checklists were mapped against the initiatives that implemented. In general, improvements in checklist findings related to an implemented initiative. That is, the perceptions of staff as measured by the checklist were matched to a change in service delivery.

KEY LEARNINGS

SUMMARY

This pilot project involved implementing *the Practical Guide* within four inpatient and four community mental health services across the Perth metropolitan region. Overall, findings showed that *the Practical Guide* was a useful tool to help the mental health services enhance their engagement with carers.

Key learnings comprised:

Project design:

- Continue use of *the Practical Guide* to enhance service engagement with carers
- Continue the use of a strength based and co-design approach
- Consider engagement with each service for eight to ten months
- Continue utilising project staff with clinical experience as peers

Adapting resources to meet service needs:

- Maintain the staff checklist adaptations that give a more strength-based focus and include cultural considerations. Consider further adaptations to the length and timing of the checklist
- Consider how to support clinicians to complete the carer engagement e-learning modules
- Identify two carer champions at each site
- Consider how to maintain the Carer Champion Network sustainably
- Support the development of a young carer toolkit

Responding to service specific needs:

- Maintain a focus on building and maintaining relationships with staff
- Consider working with a whole service or area
- Work with existing site-based carer and consumer engagement processes when possible
- Consider common challenges faced by mental health services
- Consider strategies that facilitate cultural change
- Advocate for the inclusion of systems approach training for mental health clinicians at foundation level and beyond
- Consider common carer engagement issues
- Consider ways to build engagement with carers with ATSI and CaLD heritage

Future actions were identified to help mental health services build on the meaningful changes that they are currently implementing.

1. VALUE OF THE PRACTICAL GUIDE TO ENHANCE ENGAGEMENT WITH CARERS

The Practical Guide **was a useful tool to enhance Carer engagement with inpatient and community mental health services.**

Overall, findings showed that *the Practical Guide* was a useful tool to help Perth metropolitan inpatient and community mental health services enhance their engagement with carers.

The staff checklist demonstrated effectiveness as a tool by:

- raising staff awareness of the need to improve communication with carers, as well as specific strategies that assist this
- identifying specific areas for action
- measuring staff perceptions of specific aspects of carer engagement

2. PROJECT DESIGN

The strength-based, co-design approach ensures partnership of consumers, carers and staff, and relevance of initiatives

Strength based approach: this involved working with clinicians to identify and acknowledge current areas of practice that demonstrate engagement with family and friends in a caring role. This respectful approach helped build relationship with mental health service staff.

Co-design: Project officers worked with clinicians, carers and consumers in developing and implementing resources and initiatives. This modelled the Triangle of Care and ensured that initiatives were relevant to all stakeholders. Having project officers with clinical backgrounds and carer lived experience provided a peer approach with clinicians as well as a further way to help clinicians empathise with carers.

External facilitation helps to facilitate change

Staff in all mental health services have high workloads. Project officers were able to offer time and resources to work with the carer champion and their service through the stages of engagement, implementation and evaluation. This finding is consistent with challenges reported from the implementation of the Triangle of Care in the United Kingdom, where capacity and consistency of staff involvement impacted on the overall momentum of the project. The value of partnership with an external service to act as a 'critical friend' was also highlighted (Clarke-Mapp, 2013; Cummins, 2013). The assistance provided by HelpingMinds to make improvements in communication strategies with carers was reported on by carer champions in terms of benefits in participating in the project.

Staff were more likely to engage with carers when they had activities or resources to offer: such as a letter, pamphlet, carer pack, meetings and/or access to carer support services and groups. This was reported on by carer champions in a feedback survey at completion of the inpatient pilot.

Ensure sufficient length of time for engagement with services: The implementation of the partnership model between clinicians, consumers and carers requires engagement and commitment from staff at all levels, and it takes time to build relationships at multiple levels. Sufficient time is needed to provide opportunity for:

- More considered identification (including self-identification) of carer champions
- Multiple parties (often from different disciplines) to consider, review and approve resources and changes to procedures and documentation
- Work with existing site-based carer/consumer engagement networks/processes when possible. This build the skills and capacity of existing networks and leads to more sustained implementation of the Triangle of Care over time
- Post-checklists to be undertaken after new resources are implemented
- Greater opportunity to fit within relevant timing for the service. For example, this project fitted well with work being undertaken at the same time to address Standard 2 (Partnering with Consumers) of the National Safety and Quality Health Service Standards.

3. RESOURCES

Consider adaptations to staff checklist and timing of checklist completion
Maintain current adaptations:

- Change the checklist key for the headings 'red', 'orange' and 'green' so that staff rate their practice activities under each of the six partnership standards as:
    o Red - occurring sometimes
    o Orange - occurring most of the time
    o Green - always occurring and documented

    The change from 'underperforming' to 'this practice may be occurring sometimes' is more consistent with a strengths-based approach.

- Include cultural considerations under Standard 1 (see Appendix 1)

Consider further adaptations:
- Decrease the length of the staff checklist
- Undertake the post-checklist at least two months after resources are implemented rather than at a set time

Checklist length: Completing the staff checklist is valuable in raising staff awareness of specific strategies that assist engagement. However, the length of the checklist was identified by some staff as a barrier to completion. One option is to have carer champions and team leaders complete the full checklist, with other staff completing a shorter version. Another option is to spend more time with teams prior to initial checklist completion to

build support for checklist completion. This would be consistent with a cultural change project.

Checklist timing: The timeline of the current project meant that staff at three sites completed the post-checklist before resources and procedures had been implemented. At two further sites, checklists were undertaken directly after implementation of initiatives. The data would have been more meaningful if the post-checklists were completed after the newly developed resources had been embedded in the service. Extra time also gives the opportunity to implement intensive data collection strategies as required, such as attending several team meetings at each site to ask staff to complete checklists.

Staff completion of the e-learning modules needs management support. Uptake of the carer engagement e-learning modules was very low across sites. Strategies to support staff to complete the e-learning modules include:

- Complete the modules as part of staff training sessions – can include group learning
- Management to allocate time for staff to complete the modules
- Include the modules in induction for new staff

Work with at two carer champions at each site. Carer champions are staff who lead engagement with carers and act as a key contact for carer information. It can be helpful to have one carer champion who is a front-line clinician and one carer champion in a team leader/manager role. This provides the opportunity for initiatives to be peer-led and supported by someone in a decision-making role.

The Carer Champion Network can provide an ongoing role in linking carer champions from different sites and sectors, and in providing engagement with services over time. The network has the potential to further develop, motivate and sustain practice initiatives and drive change. Experience from the UK makes clear that cultural change takes time. Many services made ongoing changes towards implementation of the Triangle of Care over several years, allowing for multiple and staged initiatives (Cummins, 2013).

Possible formats for the Carer Champion Network include:
- Email list for resource sharing
- Web page on HelpingMinds website for resource sharing
- Utilise existing platforms across areas of the WA Department of Health
- Offer a full day carer champion symposium once a year

Carer support groups: Factors identified as contributing to a successful Carer support group include:

- The group helps to link carers with external support services

- carer support staff need to remain visible to clinicians by attending team meetings or visiting wards to continue to facilitate engagement and referrals

Not all carers are interested in attending groups. Thus having an external carer support worker/counsellor on site to make informal connections with carers is valuable in terms of providing pathways to accessing individual support and/or encouraging group participation.

Develop a Young Carer Toolkit to support clinicians to identify and support young carers. This resource could be modelled on the UK resource *Triangle of Care for Young Carers and Young Adult Carers: A Guide for Mental Health Professionals* (https://professionals.carers.org/sites/default/files/toc_ycyac-proof4.pdf).

4. RESPONDING TO SERVICE SPECIFIC NEEDS

Building and maintaining relationships with staff is critical
Building and sustaining relationships with staff at multiple levels enhanced staff involvement and their availability to engage with the project. Considerations for the future include:

- Take time to identify carer champions at the site level
- Work with existing site-based carer/consumer engagement networks/processes when possible. This builds the skills and capacity of existing networks and lead to more sustained implementation of a partnership model between clinicians, consumers and carers over time
- Engage key people to influence and support staff involvement with the project
- Involve mental health service reception staff as these staff have significant engagement with carers

Consider working with a whole service or area
Working with four services in each pilot gave a valuable overview of issues relevant across services. Going forward, it may be more useful to focus on a whole service or area. Advantages include:
- Helping the site or area to develop resources and processes that can be implemented across the area. Working with each site in an area would enhance engagement with the project across the area and help ensure that the resource or process was relevant to each site and/or could be tailored to each site
- Opportunity to gain knowledge of other initiatives within and external to the service that complement the project
- Greater opportunity to work with any existing carer and consumer engagement processes at the site or in the area. This builds capacity within these existing processes and increases sustainability

- Working across services within an area can help bridge the gaps between services e.g. between inpatient and community mental health services. For example, one community mental health service suggested that if a community service clinician attended the discharge meeting of a consumer in an inpatient facility, this could enhance the transition of both consumer and Carer to the community service

Work with existing site-based carer/consumer engagement processes when possible
This build the skills and capacity of existing networks and lead to more sustained implementation of the partnership model over time.

Policy needs to be supported by effective procedures

There were several examples during the project where a lack of effective procedures meant that policy was not consistently implemented:

- A service had a HelpingMinds counsellor on site, but most staff didn't know this and so didn't refer carers to the counsellor
- Another service had an excellent carer information booklet on their website, but wasn't distributing hard copies to carers
- An inpatient service had a prompt sheet to remind staff to distribute welcome letters, but this was not written into their procedures. This was consistent with lower gains in carer engagement than expected when staff completed final checklists. In contrast, the other two inpatient sites with more effective procedures showed that gains had maintained when staff completed final checklists.

Consider common challenges faced by mental health services
Challenges faced by mental health services relevant to their implementation of the partnership model include:
- Staff at all levels with high workloads can struggle to take on new initiatives and priorities
- Gaps between services e.g. between inpatient and community mental health services
- Cultural norms within Australian mental health services promote an individualised focus on the consumer rather than seeing the consumer within their social system – some staff identify that working with the carer is "not core business"

Consider strategies that challenge cultural norms of mental health practice and facilitate cultural change
Training in most mental health disciplines focuses more on work with an individual rather than considering a person within their social system. Working with social systems (or even considering the value of engagement with a family member or friend) involves a shift in mind-set for some clinical staff. "The standard routine for many professionals is to stay

close to what they consider safe and what they are familiar with. Choosing an alternative can be seen as neglect in the eyes of colleagues" (Schout et al., 2017, p.62).

Implementing the partnership model involves not only considering the consumer's social support system but *working in partnership* with the carer as well as the consumer. This can create a tension between discourses of working in a participatory, more democratic way versus the conventional professional discourse (Ney et al., 2013).

To make these shift, clinicians need:

- Clear knowledge about the value of working with a person's support system and not just the individual
- Clear guidance (from senior management, peers and via consistent policy and procedures) that this shift is supported
- Inclusion of training from a systems approach for mental health clinicians within foundation training and beyond
- Ensuring that all staff are clear about how to measure and report on carer contact about a consumer in their KPIs and ABF reporting statistics

5. COMMON CARER ENGAGEMENT ISSUES

Issues that were common to most mental health services engaged in the project included:

Standard 1: Carers and the essential role they play are identified
- Challenges in identification of carers in general, also carers with special circumstances e.g. young carers; when consumers are homeless and/or estranged from family
- How to identify and welcome carers to the service
- How to prioritise meetings with carers when there are so many other competing demands

Standard 2: Staff are carer aware
- Working with carers is 'not core business'
- Lack of training in carer engagement
- Low uptake of carer engagement e-learning modules
- Challenges engaging with consumers and carers with ATSI or CaLD heritage
- Lack of resources to support engagement with young carers

Standard 3: Policy and practice protocols regarding confidentiality and information sharing are in place
- Lack of clarity regarding legislation related to information sharing and consent

Standard 4: Defined staff positions are allocated for carers
- Need for defined staff positions focused on carer engagement.

Standard 5: A carer introduction to the service and staff is available
- Many clinicians not prioritising an early meeting with carers due to time constraints

Standard 6: A range of carer support services is available
- Carers needs not regularly considered

6. ENGAGING CARERS WITH ATSI AND CALD HERITAGE

Discussions with Aboriginal carers and consumers indicated that for many in the Aboriginal community, the most pressing issue comprises how to encourage consumer engagement with mental health services. Suggestions made by the carers and consumers to enhance Consumer engagement included:

- Provide Aboriginal outreach officers (preferably at least one male and one female) to visit people in their own homes or at other safe spaces
- Provide Aboriginal liaison officers (preferably at least one male and one female) at mental health services who can meet with Aboriginal consumers and carers on a drop-in basis
- Encourage consumers to bring along a support person when attending the mental health service
- Consider Aboriginal people's concepts of mental health and involve Aboriginal people who are healers when requested/appropriate.

CaLD carers and consumers identified that additional barriers faced by their community members included:

- Isolation, lack of family and community support
- Increased difficulty navigating mental health systems given language barriers
- Cultural differences in understanding mental health issues

As a start, interpreters can be used when talking with carers. Translated resources (including diagnosis specific information) from Mental Health in Multi Cultural Australia (www.mhima.org.au) and the Mental Health Commission (https://www.mhc.wa.gov.au/reports-and-resources/resources/resources-in-different-languages/) can also be provided.

7. FUTURE ACTIONS

Gains made during the project are encouraging steps towards best practice. There is still a significant gap between policy requiring carer engagement and practice. Culture change is required to embed meaningful engagement with family and friends in a caring role (Martin, 2017).

Experience from the UK makes clear that cultural change takes time. Many services made ongoing changes towards implementation of the Triangle of Care over several years, allowing for multiple initiatives (Cummins, 2013).

Common to all services is the opportunity for further engagement with carers through developing action plans to implement strategies such as:

Standard 1:
- Consider how to respond to special circumstances of the carer e.g. translate welcome letter in other languages, develop young carer resources
- Routinely involve carers in treatment, support and discharge planning
- Document involvement of carers in discharge process

Standard 2:
- Carers to deliver training on a regular basis as part of staff development
- Encourage staff to complete carer engagement e-learning modules
- Include carer engagement e-learning modules as part of induction

Standard 3:
- Add 'review consent to share information' to client three monthly reviews
- Offer staff training (and resources) in carer best practice for information sharing and confidentiality
- Ensure that policy is supported by effective procedures

Standard 4:
- Consider carer consultant and/or carer peer worker roles for the service
- Promote local carer champions via carer champion posters in waiting room and staff area

Standard 5:
- Develop carer information packs to be provided to new carers at first meeting
- Offer appointments to carers to hear their history with the consumer and any relevant information and concerns
- Seek carer feedback regarding the service as part of quality improvement activities

Standard 6:
- Carers needs not regularly considered

IMPLEMENTATION: IN-PATIENT SITES

INPATIENT SITE 1

At commencement of the project at inpatient site 1, a multidisciplinary working party was already established for a quality assurance project responding to patient satisfaction surveys. This group then became involved with this project as additional carer champions, consulting and participating in the project, with the lead carer champion, facilitating and acting as primary contact for the project officer. The lead carer champion, a clinical nurse specialist, advised on engagement with staff particularly in view of encouraging honesty in the completion of the checklist.

Strengths

Staff completing the checklists indicated that areas in which they were already engaging with carers included:

- Standard 1: Carers are involved in the discharge process
- Standard 2: Staff convey hope for recovery when working with carers
- Standard 3: Consumer consent to share information with the carer is sought; agreement is reached with the consumer about the level of information to be shared with the carer
- Standard 5: The carer is involved in discharge planning and is clear about what to do and who to contact in the organisation in a crisis
- Standard 6: A range of carer support services are in place locally

Areas for improvement

Areas for improvement identified in the checklists included:

- Standard 1: Carers are routinely identified; there is a documented procedure for welcoming carers
- Standard 2: Staff are carer aware and trained in carer engagement strategies
- Standard 4: A carer champion is identified within the service
- Standard 5: A carer introduction to the service and staff is available: an early appointment is offered to the carer to hear their story/history
- Standard 6: Ensure that all staff are aware of the HelpingMinds carer support service on-site

Initiatives

During the project, the following initiatives were undertaken:

- Standards 1 and 5: The identification of carers and introduction to service were identified as a primary focus. An introduction to service letter was developed as a

tool to provide information but also to improve identification and making contact with carers from the point of admission. The service statement of commitment to carers established the intent of the service in recognising carer rights outlined in the Carers Charter and establishing their commitment to seeking their views and involvement throughout assessment and the time of admission.

- Standard 2: The project e-learning modules were introduced to staff. The carer champion played a particularly active role encouraging completion of the modules in small groups during night shifts or quieter times on the ward.
- Standard 4: Staff positions allocated for carers started to be met via the carer champion role on the ward as well as the weekly presence of the HelpingMinds family support counsellor on site.
- Standard 6: The existing carer support group and individual counselling provided on-site by HelpingMinds was promoted to staff. This facilitated a greater presence on the ward of the HelpingMinds counsellor and smoother referral processes by building the partnership of frontline workers in both services.

Findings

Findings gave evidence of self-reported improvements in engaging with carers under each of the six standards (see figures below). The most significant gains were under standard 6 as staff were not previously aware of the HelpingMinds services available on site for carers and referral processes. Results continued to improve in the six months between post-intervention and the final checklist as more staff completed the e-learning modules and the introductory letter and statement of commitment became embedded in practice. It is important to note that the carer champion of inpatient services at site 1 continued to roll out the use of the introductory letter and statement of commitment beyond the post intervention measure to the remaining two wards in the service.

The only standard that did not continue to improve was standard 6 in terms of local carer support provided on-site by HelpingMinds. This suggests the need for HelpingMinds staff and managers at site 1 to continue to remind staff of their presence on-site and continue building frontline relationships between the two services.
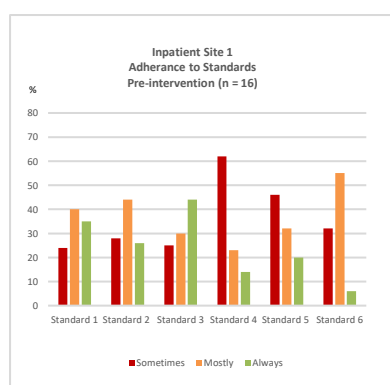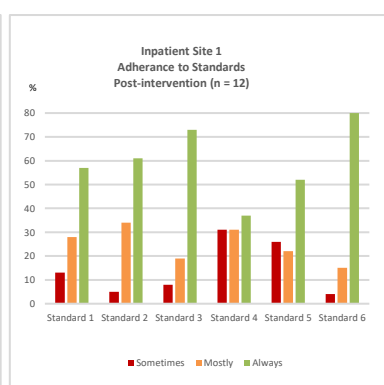

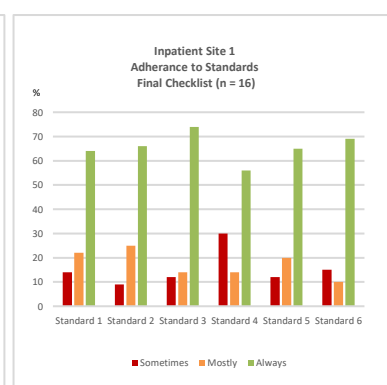**FIGURE 9: PRE-INTERVENTION**   **FIGURE 10: POST INTERVENTION**   **FIGURE 11: FINAL CHECKLIST**

Sessions with nursing staff from two wards were conducted at site 1 at the time of handover for introduction to the project, checklist completion and a second time in the middle phase of the project to present the e-learning modules, introductory letter, statement of commitment and referral processes for the HelpingMinds family support counsellor on-site. This was over two sessions each time to gather together a sample of staff (n=16). Post intervention and final checklists were facilitated by the carer champion on site.

Future actions

At the start of the second (community) pilot, a review was held with the carer champion of the inpatient unit and the carer champion for the community pilot at the community centre. Discussion covered gains made in the first pilot and areas still requiring improvement. This led to the decision for the introduction letter and service commitment statement to be implemented service wide across site 1, which included the assessment and treatment team, clinical treatment team, older adult community mental health team and all inpatient wards.

Engagement with carers could be further enhanced by developing an action plan to implement resources and strategies such as:

Standards 1 & 5:
- Consider how to respond to special circumstances of the carer
- 'Writing in' the provision of the introductory letter and statement of commitment to admission procedures. This is being considered at such a time that admission procedures are being reviewed. At present, the letter and statement of commitment are added to admission packs at reception. This proved successful in ensuring that provision of the letter and statement of commitment is not dependent on the discretion of the clinician but is part the pack that all admitting nurses use.

Standard 2:
- Mandatory completion of the e-learning modules as part of staff induction.

Standard 3:
- Add 'review consent to share information' to consumer review forms

Standard 4:
- Consider carer consultant and/or carer peer worker roles for the service
- Promote local carer champions

Standard 6:
- Regularly assess carers needs

INPATIENT SITE 2

Engagement with inpatient site 2 was initiated with the mental health clinical governance officer who facilitated a meeting for the project officer to present the project to nurse unit managers. One ward manager identified interest in participating in the project and she had already identified a registered nurse who had expressed an interest in a role as a carer champion on the ward.

Strengths

Staff completing the checklists indicated that areas in which they were already engaging with carers included:

- Standard 2: Staff are aware of policy that requires them to work with carers; staff convey hope when working with carers
- Standard 3: Carers are encouraged to share information and a policy is in place to support practice re: confidentiality
- Standard 4: All staff are responsible for identifying, involving and supporting carers

Areas for improvement

Areas for improvement identified in the checklists included:

- Standard 1: There is a documented procedure for welcoming carers
- Standard 2: Staff are carer aware and trained in carer engagement strategies
- Standard 3: Staff training is available and includes carer best practice for information sharing and confidentiality
- Standard 4: A network is in place to support carer champions
- Standard 5: Provide locally developed carer information packs to new carers at first meeting (This service had recently started to develop a consumer and carer welcome pack that is undergoing approval for use)
- Standard 6: Carer's needs and plans are regularly assessed (The carer champions had identified a need for a weekly carer support group and sought support to implement it as part of their introduction to service for carers. In facilitating this group, the carer champion planned to provide fact sheets appropriate to the identified need of carers attending the ward at that time).
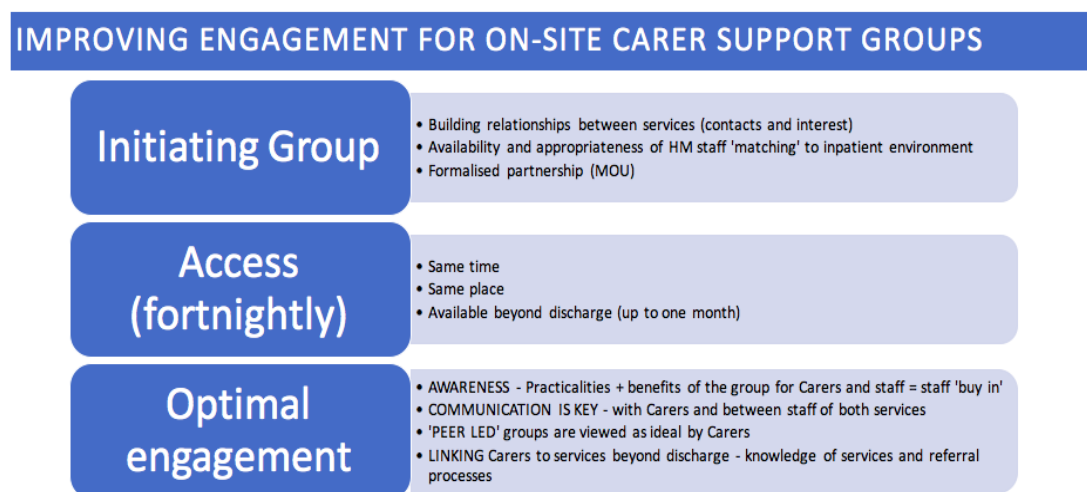
Initiatives

During the project, the following initiatives were undertaken:

- Standard 1: Identification of carers
- Standard 2: The project e-learning modules were introduced to all staff with completion requested by the nurse unit manager.

- Standard 4: Staff positions allocated for carers was met via the two staff in designated carer champion roles on the ward.
- Standard 6: A range of carer support services via the introduction of a carer support group on-site. With clinical (nursing) staff from site 2 to provide most of the sessions and monthly sessions co-facilitated by HelpingMinds staff. A partnership approach to the carer support group, between these staff members and the HelpingMinds facilitator, aimed for co-facilitation with a sharing of resources.

The development process included identification of an 'exemplar' carer support group run in an inpatient service. The carer support group had taken up to a year to implement effectively as part of a social work quality improvement project and much could be learnt from their experiences. They were identified as an 'exemplar' from a variety of sources including a carer participating in the project, HelpingMinds staff and self-reported improvements discussed by social work staff at that service. Through the process of gathering information to support the group a simple framework for best practice was developed as a reminder that the focus is not only what happens 'within' the group but how the promotion of a carer support group works within a service to raise staff carer awareness.
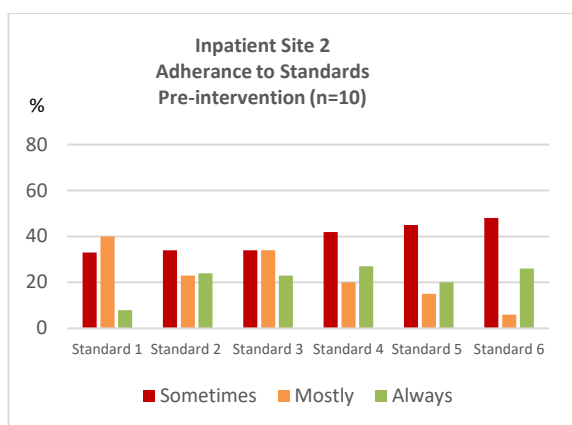
IMPROVING ENGAGEMENT FOR ON-SITE CARER SUPPORT GROUPS

Initiating Group
- Building relationships between services (contacts and interest)
- Availability and appropriateness of HM staff 'matching' to inpatient environment
- Formalised partnership (MOU)

Access (fortnightly)
- Same time
- Same place
- Available beyond discharge (up to one month)

Optimal engagement
- AWARENESS - Practicalities + benefits of the group for Carers and staff = staff 'buy in'
- COMMUNICATION IS KEY - with Carers and between staff of both services
- 'PEER LED' groups are viewed as ideal by Carers
- LINKING Carers to services beyond discharge - knowledge of services and referral processes
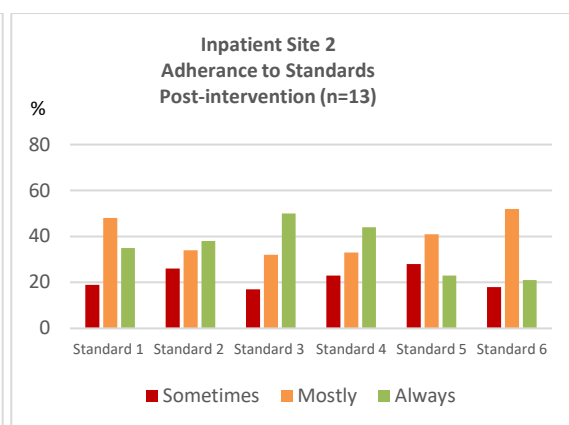
FIGURE 12: FRAMEWORK FOR ON-SITE SUPPORT GROUPS

Findings

Findings gave evidence of self-reported improvements in engaging with carers under each of the six standards (see figures below). The most significant gains were under Standard 1 in the identification of carers and their needs by staff and promotion of the group. Unfortunately, the carer support group was not successful. One of the barriers was that the group was only open to carers who were linked to a consumer who was an inpatient at that time. This was particularly limiting due to short admission times.

Inpatient Site 2
Adherence to Standards
Pre-intervention (n=10)

Inpatient Site 2
Adherence to Standards
Post-intervention (n=13)

FIGURE 13: PRE-INTERVENTION   FIGURE 14: POST INTERVENTION

Sessions with nursing staff were conducted at site 2 at the time of handover to introduce the project and complete the checklist and a second time in the middle phase of the project to present the e-learning modules and promote the group. A sample of staff (n=10) was gathered over 2 handover sessions. Post intervention checklists were facilitated by the carer champion on site.

Promotion of the group improved staff awareness regarding the range of HelpingMinds services that are available to carers and clarified referral processes. Standard 6 had the greatest drop in 'sometimes' ratings shifting to 'mostly', demonstrating staff awareness that the on-site carer support group aimed to provide and link carers with support.

Future actions

By the beginning of the community pilot with site 2 it was clear that the carer support group was unsuccessful. Going forward the aim was to engage HelpingMinds individual counselling for carers on-site. This would be open to all carers of any consumer accessing the service (Inpatient or Outpatient). In time it is expected that as demand increases a carer support group could once again be trialled.

INPATIENT SITE 3

Site 3 was nominated by their area health service to participate in the project. The two carer champions were clinical nurse specialists in a nurse unit management role.

Strengths

Staff completing the checklists indicated that areas in which they were already engaging with carers included:

- Standard 2: Staff are aware of policy that requires them to work with carers; staff convey hope when working with carers

- Standard 3: Agreement is reached with the consumer about the level of information to be shared with the carer; If the consumer requests no disclosure staff regularly revisit this decision with them

Areas for improvement

Areas for improvement identified in the checklists included:

- Standard 1: Carers are routinely identified when carrying out an assessment; there is a documented procedure for welcoming carers; strategies for medication management are explained to the carers
- Standard 2: Staff are carer aware and trained in carer engagement strategies; opportunities are offered to carers to participate in all aspects of assessment and the ongoing care, treatment and recovery of the consumer
- Standard 3: Staff training is available and includes carer best practice for information sharing and confidentiality
- Standard 4: A carer champion is identified within the service, or there are carer consultants employed; a network is in place to support carer champions
- Standard 5: Upon first contact, across all service settings provide the carer with an introductory letter; ensure that the service has meeting and greeting protocols in place to minimise carer distress and address any concerns they may have
- Standard 6: Carers needs not regularly considered

Initiatives

During the project, the following initiatives were undertaken:

- Standard 1 and 5: The identification of carers and introduction to service were identified as a primary focus. Inpatient site 3 already had a carers pack however it was identified that it required updating. A committee was already in place for making improvements to the pack. As a result, the project officer provided feedback and suggestions for the next committee meeting. During this process it was noted that the pack was generic for all wards. Given the need to make improvements in identifying and greeting carers, a welcome page and associated procedure was developed to provide carers with information specific to the ward and the treating team when the person they care for is admitted.
- Standard 2: The project e-learning modules were introduced to staff. The carer champion played a particularly active role encouraging completion of the modules.
- Standard 3: Policy and practice protocols regarding confidentiality and information sharing. Revisiting the consent of the consumer regarding information sharing was identified as an issue that was flagged in the associated prompt sheet for the welcome page.
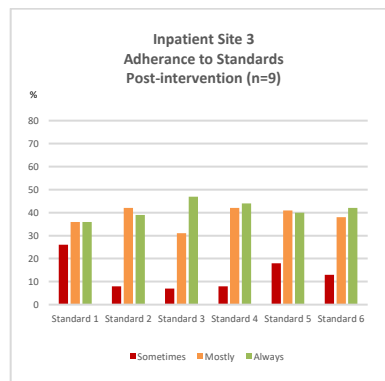
- Standard 6: During sessions in handover on the ward the HelpingMinds project officer informed staff of local HelpingMinds carer support services and referral processes. Importantly, it was in these sessions that carer involvement and support came to be recognised as the role of all staff.
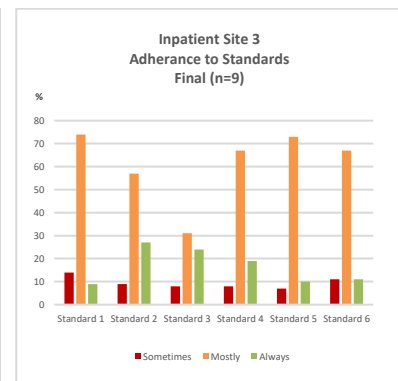
Findings

Findings gave evidence of self-reported improvements in engaging with carers under each of the six standards (see figures below).
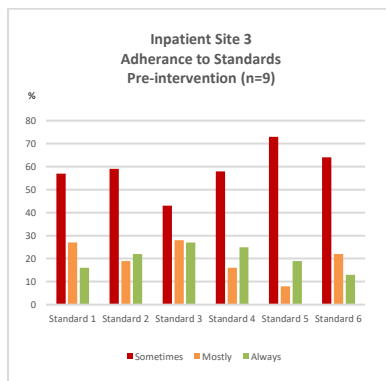
Figure 15: Pre-intervention   **Figure 16: Post intervention**   **Figure 17: Final checklist**

Sessions with nursing staff on the ward were conducted at the time of handover over 2 sessions to gather a sample of staff (n=9). The first sessions provided an introduction to the project and checklist completion and the second sessions in the middle phase of the project presented the e-learning modules, welcome page and prompt sheet and referral processes for the HelpingMinds family support counsellor on-site. At a third set of sessions staff completed the final checklist. The community pilot provided an opportunity to follow up with the carer champion and nursing staff at the ward. New resources developed with Community site 3 were shared with staff. This also provided the opportunity for staff to complete a final checklist. These findings showed that although there was still an improvement from the pre-checklist findings gains were not maintained. Findings from other sites where gains continued to be made provided some insight to why this was the case. At sites where there was continued improvement, resources had been either 'written in' to the admission procedure or practically put in place by having staff at reception place them in admission packs. This meant the provision of the resource to carers was not dependent on the discretion of the clinician but is part a pack that all admitting nurses use.

Future actions

Gains made during the project are encouraging steps towards best practice. Culture change is required to embed meaningful engagement with family and friends in a caring role (Martin, 2017). Experience from the UK makes clear that cultural change takes time (Cummins, 2013).

Inpatient site 3 is making improvements in their engagement with carers. Engagement with carers could be further enhanced by developing an action plan to implement resources and strategies such as:

Standards 1 & 5:
- Inclusion of the welcome page and associated procedure in the induction file for all new workers.
- Inclusion of the welcome page and associated procedure across all wards.
- A business plan for the welcome page to be translated into a variety of languages reflecting the demographic of families engaged with the service.

Standard 2:
- Mandatory completion of the e-learning modules as part of staff induction.

Standard 3:
- Add 'review consent to share information' to consumer review forms

Standard 4:
- Consider carer consultant and/or carer peer worker roles for the service
- Promote local carer champions

INPATIENT SITE 4

At inpatient site 4 each of the four wards at the mental health service engaged with the project. The Nursing Coordinator of the service was identified as the Carer Champion lead with the Nurse Unit Managers as Carer Champions on each of the wards.

Strengths

Staff completing the checklists indicated that areas in which they were already engaging with carers included:

- Standard 1: Carers are involved in the discharge process
- Standard 3: Consumer consent to share information with the carer is sought; agreement is reached with the consumer about the level of information to be shared with the carer; carers are encouraged to share information; staff are aware of a policy to support practice re: confidentiality
- Standard 5: The carer is involved in discharge planning and is clear about what to do and who to contact in the organisation in a crisis
- Standard 6: Carers have access to local carer advocacy services

Areas for improvement

Areas for improvement identified in the checklists included:

- Standard 1: Carers are regularly updated and involved re: care plans; there is a documented procedure for welcoming carers
- Standard 2: Staff are carer aware and trained in carer engagement strategies
- Standard 4: A carer champion is identified within the service; a network is in place to support carer champions, carer consultants and carer peers
- Standard 5: A carer introduction to the service and staff is available; provide locally developed carer information packs to new carers at first meeting make a member of staff responsible for developing, storing and issuing the packs (the checklist highlighted that this service already had a carer information pack however this was not being provided to carers at the point of admission); an early appointment is offered to the carer to hear their story/history

Initiatives

During the project, the following initiatives were undertaken:

- Standard 1 and 5: The identification of carers and introduction to service was a primary focus of the project. An admission procedure sheet was developed by the nurse unit managers and nursing coordinator incorporating identification of carers, information, involvement and orientation to service via the existing carers guide at this service. In addition, the department of social work approved the offer of a social work appointment for carers to hear their history or concerns and this was added to the procedure.
- Standard 2: The project e-learning modules were introduced to staff, with some completing prior to the allocated time for mandatory completion in January 2018.
- Standard 6: Staff were informed of the range of local carer support services and referral processes.
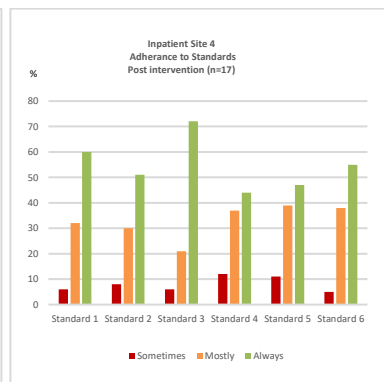
Findings

Findings provide evidence of self-reported improvements in engaging with carers under each of the six standards (see figures below). The strongest gains, from pre to post intervention, were under standard 6 in increased staff awareness of local carer support services. Standard 3 also demonstrated significant improvement with clarification of policy and practice protocols of information sharing.

Results continued to hold with some standards continuing to improve in the six months between post-intervention and the final checklist. This suggested the effectiveness of having mandatory completion of the e-learning modules by nursing staff over 3 days in January, 2018. Continued improvement under standard 5 suggests that the admission procedure is now embedded in practice including the provision of their carers guide. It is important to note that the carer champion at this service continues to make improvements with the
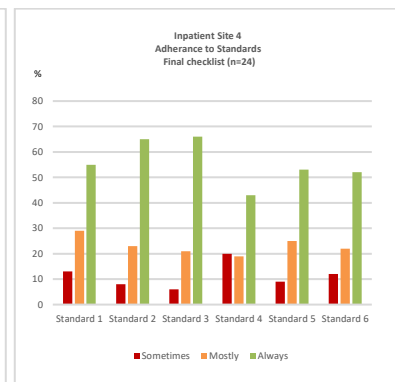
focus now on inclusions to recovery plans where staff need to note carer inclusion and reviews of consent to share information with the carer.
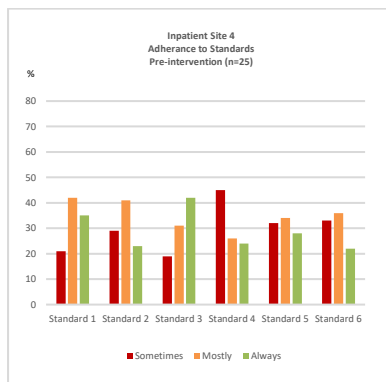
Figure 18: Pre-intervention   **Figure 19: Post intervention**   **Figure 20: Final checklist**

Future actions

Gains made during the project are encouraging steps towards best practice. Culture change is required to embed meaningful engagement with family and friends in a caring role (Martin, 2017). Experience from the UK makes clear that cultural change takes time (Cummins, 2013).

Inpatient site 4 continues to make meaningful changes in their engagement with carers. Engagement with carers could be further enhanced by developing an action plan to implement resources and strategies such as

Standards 1:
- Consider how to respond to special circumstances of the carer;

Standard 2:
- Now that nursing staff have completed the e-learning modules include them as mandatory for all staff induction at site 4.

Standard 3:
- Finalise the addition of 'review consent to share information' to consumer review forms and/or recovery plans, the inclusion of carers in the development of plans and that they are provided with a copy of the plan

Standard 4:
- Consider carer consultant and/or carer peer worker roles for the service
- Promote local carer champions

IMPLEMENTATION: COMMUNITY SITES

COMMUNITY SITE 1

Site 1 had previously engaged with the project with their inpatient service. Carers attending the inpatient service have access to on-site counselling on a weekly basis and a monthly carer support group provided by HelpingMinds. During the project the existing carer support was promoted, and an introductory letter and commitment to carers statement were developed.

Strengths

Staff completion of the checklists indicated areas in which they were already engaging with carers:

- Standard 1: Carers' views and knowledge are sought during assessment, treatment and care planning with consumers
- Standard 2: Staff are aware of policy that requires them to work with carers; information is provided to carers regarding services and strategies available if a crisis occurs or the consumer becomes unwell
- Standard 3: Consumer consent to share information with the carer is sought; agreement is reached with the consumer about the level of information to be shared with the carer; a policy is in place to support practice re: confidentiality

Areas for improvement

- Standard 1: Carers are routinely identified; there is a documented procedure for welcoming carers
- Standard 2: Staff are carer aware and trained in carer engagement strategies; training is delivered by carer trainers or carers as part of the training delivery team
- Standard 4: A network is in place to support carer champions and carer peer roles are in place
- Standard 5: The greatest area with need for improvement was across carer introduction to service.
- Standard 6: A request was made to provide carer support on-site at the community site

Initiatives

The carer champion at the community site developed an action plan with the project officer to enhance engagement with carers. Firstly, the project was included as an agenda item in business meetings. Staff were regularly encouraged to complete the e-learning modules and provided feedback on refining the introduction letter that was already in use in the inpatient service. The following initiatives were undertaken:

Standard 1 & 5:

- The identification of carers and introduction to service were identified as the primary focus. The existing introduction to service letter from the inpatient pilot was further refined as a tool to provide information but also to improve identification and contact with carers at admission.
- The service statement of commitment to carers established the intent of the service in recognising carer rights outlined in the Carers Charter and their commitment to involve carers throughout assessment and treatment. In order to embed the use of the letter and statement of commitment at admission this was added to admission packs at reception.

Standard 2:

- The project e-learning modules were introduced to staff. Carer champions at both the assessment and treatment team and the clinical treatment team encouraged staff to complete the modules.

Standard 4:

- Staff positions allocated for carers was met via the carer champion role. A carer champion profile is still being developed to be displayed on site. A HelpingMinds family support counsellor commenced at the community site.

Standard 6:

- The existing carer support group and individual counselling provided at the inpatient unit was expanded with the HelpingMinds family support counsellor providing individual counselling one half day per week at the community site.
- Referral processes were improved by promoting the carer support across the inpatient, assessment and treatment team, community treatment and older adult teams. The presence on-site of the same HelpingMinds worker at the inpatient and community sites has assisted in building the partnership of frontline workers across the service.

Findings

Findings from the initial checklist identified areas for improvement that were consistent with those identified with the inpatient service. Unfortunately, due to timing and the time constraints of deadlines with the project, post-intervention checklists were incomplete. However, very positive initiatives resulted from the project, including the expansion of carer support services, the development of the introduction letter and statement of commitment

rolled out service-wide, with the clinical and treatment team, assessment and treatment team and currently with the older adult community mental health team.

Community Mental Health Site 1
Adherance to Standards
Pre-intervention (n=13)
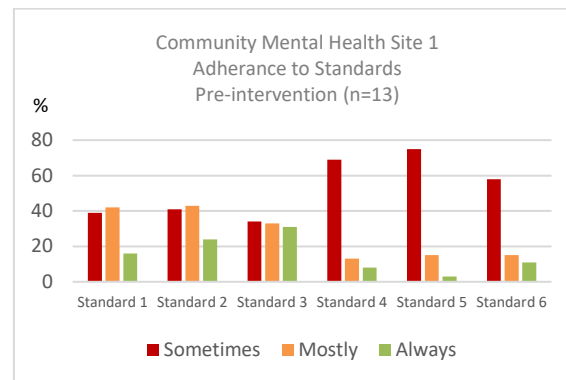
Figure 21: Pre-intervention

Future actions

Gains made during the project are encouraging steps towards best practice. Culture change is required to embed meaningful engagement with family and friends in a caring role (Martin, 2017). Experience from the UK makes clear that cultural change takes time (Cummins, 2013).

Site 1 is making meaningful changes in their engagement with carers. Engagement with carers could be further enhanced by developing an action plan to implement resources and strategies such as:

Standards 1 & 5:
- Writing in the provision of the introductory letter and statement of commitment to admission procedures in both inpatient and outpatient teams. This is being considered for when admission procedures are reviewed. At present, the letter and statement of commitment are added to admission packs at reception. This is proving successful in ensuring that it is not up to the discretion of the clinician but is part of the pack that all admitting nurses and/or care coordinators use.

Standard 2:
- Progression of mandatory completion of the e-learning modules as part of staff induction.

Standard 3:
- The need to revisit consumer consent on a regular basis (this is also in the process of being written in to three monthly review forms).

Standard 6:
- Regularly consider carer's needs

COMMUNITY SITE 2

The carer champions at community site 2 were identified as the team leaders of the assessment and treatment team (ATT) and the community treatment team (CTT). The project officer presented to both teams separately and the completed checklists collated to identify current strengths and areas for improvement.

Strengths

Staff completing the checklists indicated that areas in which they were already engaging with carers included:

- Standard 2: Staff are aware of policy that requires them to work with carers; staff convey hope for recovery when working with carers
- Standard 3: A policy is in place to support practice re: confidentiality
- Standard 4: Understanding that all staff are responsible for identifying, involving and supporting carers

Areas for improvement:

Staff indicated that areas for improvement included:

- Standard 1: Carers are regularly updated and involved re: care plans
- Standard 2: Staff are carer aware and trained in carer engagement strategies – training is delivered by carer trainers or carers as part of the training delivery team
- Standard 4: A carer champion is identified within the service, or there are carer consultants employed
- Standard 5: Introduction to service includes visibility of carer rights; locally developed carer information packs to new carers at first meeting
- Standard 6: A carer support service is in place locally; carers have access to local carer advocacy services and carer's needs and plans are regularly re-assessed

Initiatives:

The initiatives undertaken as part of the project (whilst located in outpatient services) are currently promoted and accessed by carers across the service (inpatient and outpatient).

Standard 2:

- The project e-learning modules were introduced to staff. Carer champions of the ATT and CTT teams encouraged staff to complete the modules. The availability of the e-learning modules was once again promoted with inpatient staff.

Standard 5:

- Introduction to service includes visibility of the Carers Charter and the service statement of commitment in working with carers (in poster form)
- Resources developed across sites from the project to be shared for inclusion or recommendations in improving the site's consumer and carers guide that is in development.

Standard 6:

- Carer support currently in place with a HelpingMinds family support counsellor co-located at the community mental health service one half day per week for individual counselling with the view of starting a carer support group as demand grows. This worker also provides referral for additional HelpingMinds services including: respite, carer advocacy and young carer support/activities.

Findings

At the start of the project, separate meetings with the two teams were held to introduce staff to the project and complete the checklists (n=16). At the end of the project the checklists were distributed by the carer champions.
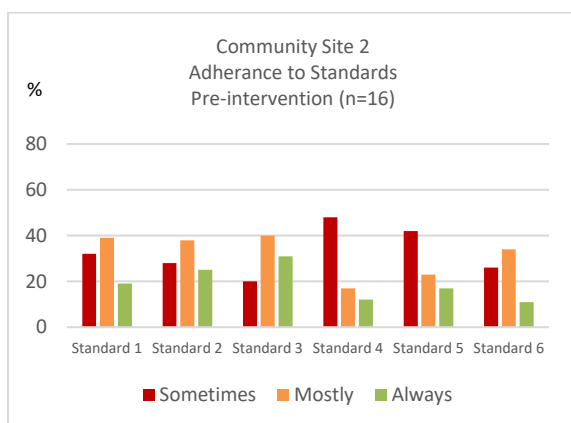

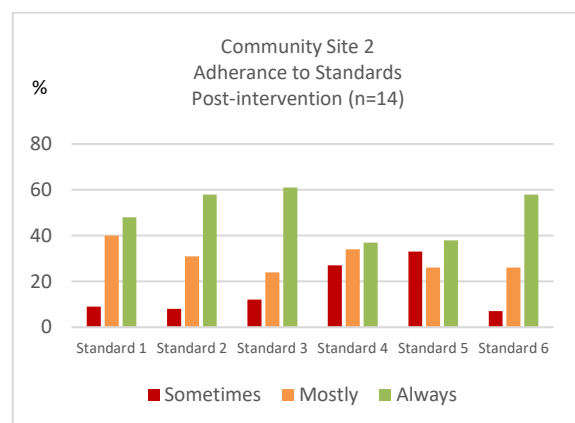**Figure 22: Pre-intervention**　　　　　　　　**Figure 23: Post intervention**

Improvements were noted across all standards. This indicated that the e-learning modules, in combination with discussions within teams and the project officer promoting carer support on-site, improved staff awareness of the importance of engaging with carers and families. The strongest improvements were under Standard 6 with carer support now in place on-site.

Future actions

Gains made during the project are encouraging steps towards best practice. Culture change is required to embed meaningful engagement with family and friends in a caring role (Martin, 2017). Experience from the UK makes clear that cultural change takes time (Cummins, 2013).

Site 2 is making improvements in their engagement with carers. Engagement with carers could be further enhanced by developing an action plan to implement resources and strategies such as:

Standard 1:

- Consider how to ensure carers are regularly updated and involved re: care plans

Standard 2:

- Include carer engagement e-learning modules as a mandatory part of induction (this is already under consideration by training and development staff at this service)

Standard 3:

- Consider routine use of Advance Health Directives

Standard 5:

- When carer information packs are complete consider procedures to ensure carers are identified and provided at the first meeting with the consumer

Standard 6:

- Regularly consider carers needs (this can be done in consultation with the HelpingMinds worker on-site.

COMMUNITY SITE 3

Carer champions identified numerous ways in which their area mental health service is already engaging with carers. These include a Consumer Advisory Council, regular satisfaction surveys of consumers and carers, carer peer worker and consultant positions, and a carers support group at community site 3.

Strengths

Staff completing the checklists indicated that areas in which they were already engaging with carers included:

- Standard 2: Staff are aware of policy that requires them to work with carers; staff convey hope for recovery when working with carers
- Standard 3: Consumer consent to share information with the carer is sought; a policy is in place to support practice re confidentiality
- Standard 4: Defined staff positions are allocated for carers – the area mental health service has a Carer Consultant
- Standard 5: A carer consultant has been engaged to update the carer information pack

- Standard 6: Carers have access to a range of resources including a carers support group

Areas for improvement

Staff indicated that areas for improvement included:

- Standard 1: Carers are routinely identified; special circumstances of carer recorded; there is a documented procedure for welcoming carers
- Standard 2: Staff are carer aware and trained in carer engagement strategies – training is delivered by carer trainers or carers as part of the training delivery team
- Standard 3: Policy and procedure regarding confidentiality and sharing of information – consent to share information is regularly revisited with the consumer; opportunities are provided to carers to discuss the care and treatment of the consumer; practice guidelines re information sharing are in place; carer contact is clearly identified in the consumer's file; staff training includes carer best practice for information sharing and confidentiality
- Standard 4: A carer champion is identified within the service
- Standard 5: A carer introduction to the service and staff is available; an early appointment is offered to the carer to hear their story/history; carer information packs provided to new carers at first meeting, cultural and language needs of carers addressed

Initiatives

A range of initiatives are being undertaken as part of the project. These initiatives will be used in adult community mental health services across this area:

- Standards 1 & 3: A carer engagement checklist is being developed. This procedure will ensure that carers are identified at first contact and that carer details are recorded. The carers information pack is being updated.
- Standard 3: Training was provided to clinicians on seeking consent and information sharing, with documents supporting best practice available to all staff. This will be developed as a Take 5 staff training tool
- Standard 5: Introduction to service letter and statement of commitment to be provided or sent to all carers at first contact. The statement of commitment is also being developed as a poster to be displayed in waiting rooms.
- Standard 6: Carers will be offered an initial appointment with a Carer Peer Worker at a nearby Adult Community Mental Health Service
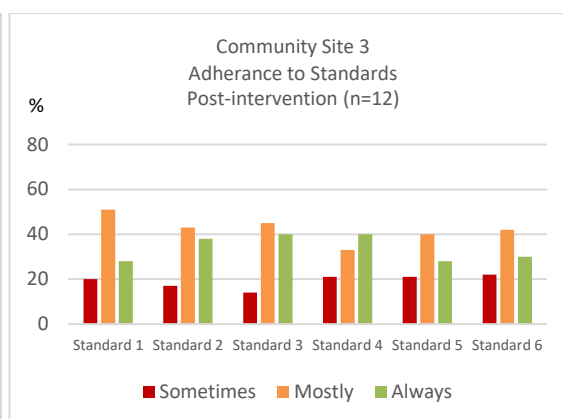
Findings

At the start of the project, clinicians attending a staff meeting were introduced to the project and completed checklists. A training session on consent and information sharing

was held with staff during the project. At the end of the project, staff attending three team meetings were updated on the project and completed checklists.

Project timings meant that staff completed final checklists while initiatives were still in the process of being implemented. However, findings indicated that staff still perceived an improvement in carer engagement across the standards during the project (see figures below).
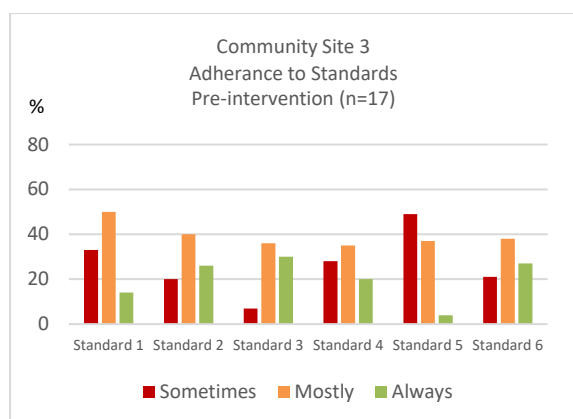
Figure 24: Pre-intervention   **Figure 25: Post-intervention**

The strongest improvements were in standards 1, 4 and 5. These are consistent with initiatives in standards 1 and 5 that are underway. Staff identified that they had greater responsibility for working with carers at the end of the project than they had at the start of the project (standard 4).

Future Actions

Gains made during the project are encouraging steps towards best practice. Culture change is required to embed meaningful engagement with family and friends in a caring role (Martin, 2017). Experience from the UK makes clear that cultural change takes time (Cummins, 2013).

Community site 3 is making meaningful changes in their engagement with carers. Engagement with carers could be further enhanced by developing an action plan to implement resources and strategies such as:

Standard 1:
- Consider how to respond to special circumstances of the trainer e.g. via translating introduction to service letter in other languages, develop young carer resources
- routinely involve carers in treatment, care and discharge planning

Standard 2:
- Carer consultant to deliver training on a regular basis as part of staff development
- Encourage staff to complete carer engagement e-learning modules
- Include carer engagement e-learning modules as part of induction

Standard 3:
- Add 'review consent to share information' to client three monthly reviews
- Ensure that policy is supported by effective procedures

Standard 4:
- Promote local carer champions via carer champion posters in waiting room and staff area

Standard 5:
- Offer early appointments to carers to hear their history with the consumer and any relevant information and concerns

Standard 6:
- Regularly consider carer's needs

COMMUNITY SITE 4

Community site 4 already had a range of strategies for carer engagement.

Through involvement with this project, significant initiatives to enhance engagement with carers are being proposed across this area's community (adult and older adult) and inpatient services.

Strengths

Staff completing the checklists indicated that areas in which they were already engaging with carers included:

- Standard 1: Carers are routinely identified; consumer consent regarding information sharing is routinely obtained and recorded
- Standard 2: Staff are aware of policy that requires them to work with carers; staff work in a way that supports relationships within families and this is documented
- Standard 3: Consumer consent to share information with the carer is sought; carers are encouraged to share information regarding the consumer to inform treatment and support
- Standard 6: Carers have access to a range of resources including a carers support group

Areas for improvement

Areas for improvement identified in the checklists included:

- Standard 1: The procedure for welcoming carers is documented

- Standard 2: Staff are carer aware and trained in carer engagement strategies – training is delivered by carer trainers or carers as part of the training delivery team
- Standard 3: Policy and procedure regarding confidentiality and sharing of information – consent to share information is regularly revisited with the consumer; carer engagement is clearly identified in the consumer's file; staff training includes carer best practice for information sharing and confidentiality
- Standard 4: A carer champion is identified within the service; carer peer roles are in place
- Standard 5: Carer information packs are provided to new carers at first meeting

Initiatives

Carer champions developed an action plan to enhance engagement with carers. This plan included significant commitments by the service to offer early appointments to new carers and involve carers in the development of care plans. Initiatives included:

Standards 1 & 3:
- A carer engagement checklist and procedure for use at admission have been developed. The checklist includes identifying the special circumstances of the carer, offering an early appointment with the carer and involving the carer in developing of the care plan. The approval process for implementing the new form and procedures is underway

Standard 5:
- Welcome letter to be provided or sent to all carers at first contact
- A carer information pack is being developed. The working group for this will include membership of Mental Health Consumer and Carer Guidance Group
- Carer and family support is being included as part of an area-wide Aboriginal strategic planning

Standard 6:
- Carers will be offered an initial appointment with the Care Coordinator
- Carers are also referred to the local HelpingMinds carer support group and to local carer counselling services.

Findings

At the start of the project, clinicians attending a staff meeting were introduced to the project and asked to complete checklists. Checklists were also distributed to other staff by carer champions. At the end of the project, checklists were distributed by the carer champion and completed by a sample of staff.

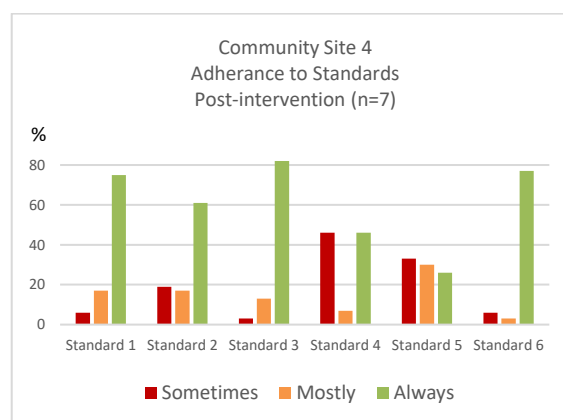Project timings meant that staff completed final checklists before initiatives were implemented. However, findings indicated that staff still perceived an improvement in carer engagement across the standards during the project (see figures below).
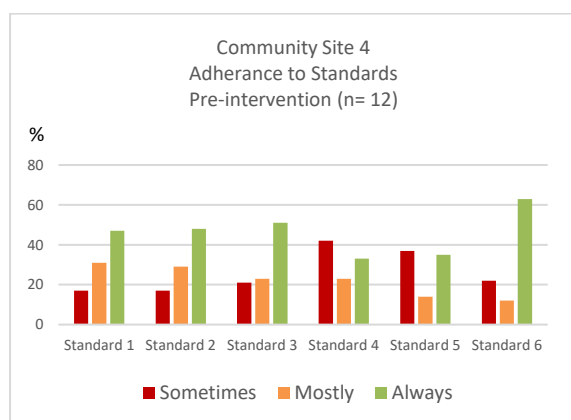
Figure 26: Pre-intervention   **Figure 27: Post-intervention**

The strongest improvements were in standards 1 and 3, consistent with initiatives being undertaken in these areas. Improvements to standard 5 would be expected once the welcome letter and the carer information pack are developed and distributed.

Future Actions

Gains made during the project are significant steps towards best practice. Culture change is required to embed meaningful engagement with family and friends in a caring role (Martin, 2017).   Experience from the UK makes clear that cultural change takes time (Cummins, 2013).

Community site 4 is making meaningful improvements in engaging with carers. Engagement with carers could be further enhanced by developing an action plan to implement resources and strategies such as:

Standard 1:
-   Consider how to respond to special circumstances of the carer e.g. translate welcome letter in other languages, develop young Carer resources
-   Document involvement of carers in discharge process

Standard 2:
-   Carer trainers or carers deliver training on a regular basis as part of staff development
-   Encourage staff to complete carer engagement e-learning modules
-   Include carer engagement e-learning modules as part of induction

Standard 3:

- Add 'review consent to share information' to client three monthly reviews
- Offer staff training (and resources) in carer best practice for information sharing and confidentiality

Standard 4:
- Consider carer consultant and/or carer peer worker roles for the service
- Promote local carer champions via carer champion posters in waiting room and staff area

Standard 5:
- Develop carer information packs to be provided to new carers at first meeting
- Seek carer feedback regarding the service as part of quality improvement activities

Standard 6:
- Regularly consider carer's needs

COMBINED FINDINGS FROM ALL PILOT SITES

There was significant commonality across all inpatient and community sites in terms of identified areas for improvement and resources implemented.

Strengths in carer engagement

Existing strengths in carer engagement commonly identified by staff across sites:

- Standard 2: Staff are aware of policy that requires them to work with carers; staff convey hope when working with carers
- Standard 3: Consumer consent to share information with the carer is sought; agreement is reached with the consumer about the level of information to be shared with the carer
- Standard 6: A range of carer support services are available

Areas for improvement

Areas for improvement common to most sites included:

- Standard 1: Carers are routinely identified; special circumstances of carer recorded; there is a documented procedure for welcoming carers
- Standard 2: Staff are carer aware and trained in carer engagement strategies – training is delivered by carer trainers or carers as part of the training delivery team
- Standard 3: Policy and procedure regarding confidentiality and sharing of information – consent to share information is regularly revisited with the consumer; opportunities are provided to carers to discuss the care and treatment of the consumer; practice guidelines re information sharing are in place; carer contact is clearly identified in the consumer's file; staff training includes carer best practice for information sharing and confidentiality
- Standard 4: A carer champion is identified within the service; carer peer/consultant roles are in place
- Standard 5: A carer introduction to the service and staff is available; an early appointment is offered to the carer to hear their story/history; carer information packs provided to new carers at first meeting, cultural and language needs of carers addressed; feedback is sought from carers as part of quality improvement activities

Project Outputs

Several key resources were already available for use during this project, including:
- *A Practical Guide for Working with Carers of People with Mental Illness* (2016)
- Staff checklists – slightly adapted from *the Practical Guide* (see Appendix 1)
- Carer engagement e-learning modules
- Carer support groups, led by HelpingMinds, mental health services, or both in partnership
- Carer peer workers & counsellors

A range of resources and initiatives were developed during this project, including:
Written materials:
- Introduction to services letters (community and inpatient)
- Service statement of commitment to carers – fact sheet and poster
- Carer engagement checklist – admission (community)
- Carer welcome procedure (inpatient)
- Who is a carer/next of kin fact sheet
- Starting conversations with consumers about consent – clinician guide
- Information sharing – clinician guide
- Consumer and carer list of useful questions
- Framework for carer support groups
- Flyer for carer on-site support

Carer support services:
- The provision of carer support groups, counselling and/or carer peer support offered on-site at several mental health services

Training:
- Confidentiality training offered by the Office of the Chief Psychiatrist in response to feedback from the project

Checklist Findings

Combined inpatient service findings and combined community service findings are provided, as well as a comparison between the two settings. Overall findings are then provided. This section focusses on pre and post findings, and does not include the final checklists completed by some inpatient sites.

Inpatient findings

Staff completing checklists at the start of the project identified room for improvement in all six standards. At the end of the project, staff identified higher levels of carer engagement in each standard (see figures below).

Combined Inpatient Mental Health Services: Pre and Post Intervention
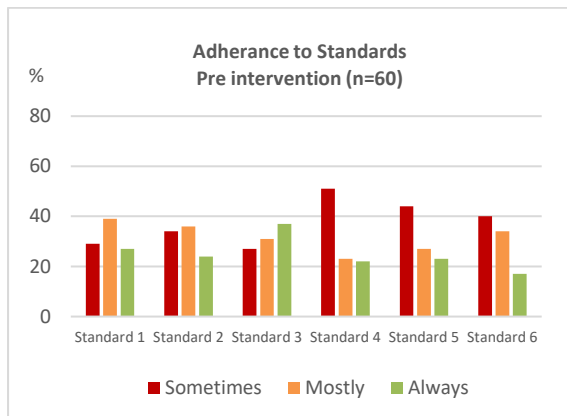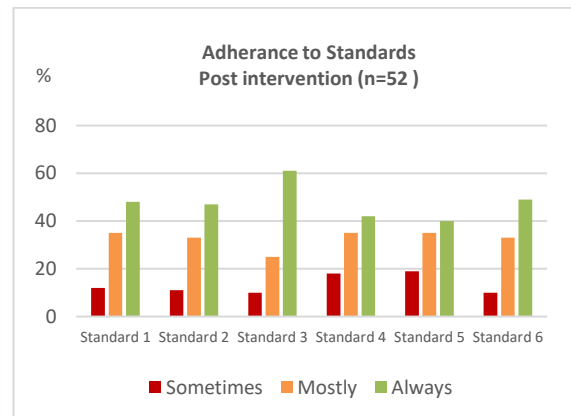

Figure 28: Combined Inpatient Pre-intervention   Figure 29: Combined Inpatient Post intervention

The greatest gains were in standards 4 (staff positions allocated for carers), 5 (carer introduction to the service is available) and 6 (carer support services are available). This is consistent with initiatives promoting carer champions, introducing welcome letters and statements of commitment, bringing support services on-site and reminding all services of existing carer support services in their regions.

The least improvement was reported under standard 1. This highlights the complexity in the identification of Carers, especially special circumstances such as young carers, carers estranged from family, communication issues and cultural considerations.

STANDARD 1: CARERS AND THE ESSENTIAL ROLE THEY PLAY ARE IDENTIFIED AT FIRST CONTACT, OR AS SOON AS POSSIBLE THEREAFTER

Findings improved across all sites under standard 1. However this was the standard with the least improvement overall. This highlights the complexity in the identification of carers, especially the need for improvements in identifying special circumstances, such as young carers, any communication issues and/or cultural considerations. It is particularly important to continue improvements under this standard as this is where groups of carers with complex needs potentially 'fall through the cracks' and are not identified. Discussions with staff highlighted challenges when consumers are estranged from family and friends, particularly those who are homelessness. When carers are identified there is potential for re-connecting the consumer with family and friends.

STANDARD 2: STAFF ARE CARER AWARE AND TRAINED IN ENGAGEMENT STRATEGIES

The need for training in carer engagement strategies was highlighted in the initial staff checklists. Unfortunately, due to time constraints and competing priorities, not all staff completed the carer engagement e-learning modules. Some sites have made the e-learning mandatory for all staff to complete over a couple of designated days and/or part of induction processes for new staff.

STANDARD 3: POLICY AND PRACTICE PROTOCOLS REGARDING CONFIDENTIALITY AND SHARING INFORMATION ARE IN PLACE

Standard 3 also evidenced strong improvements in ratings of 'always'. Discussion with nursing staff identified concerns regarding consent and information sharing that can become a barrier to engaging with carers. The use of procedures and prompts for practice, such as those developed at site 3 and site 4, worked to promote and increase compliance in documentation regarding consumer consent. Importantly, these procedures ensure that issues regarding consent are not only recorded but revisited.

STANDARD 4: DEFINED STAFF POSITIONS ARE ALLOCATED FOR CARERS IN ALL SERVICE SETTINGS

All sites demonstrated a need for defined staff positions focused on carers. Through the use of the resources/activities developed, a greater awareness developed in the role and responsibility of *all staff* in identifying, involving and supporting carers.

STANDARD 5: A CARER INTRODUCTION TO THE SERVICE AND STAFF IS AVAILABLE, WITH A RELEVANT RANGE OF INFORMATION ACROSS THE CARE SETTINGS

A carer introduction to service was identified as a priority area across all four sites. A range of different approaches (introduction letter, statements on their commitment to Carers and their Carer rights, changes to admission procedures and Carer support groups) were used to address this standard.
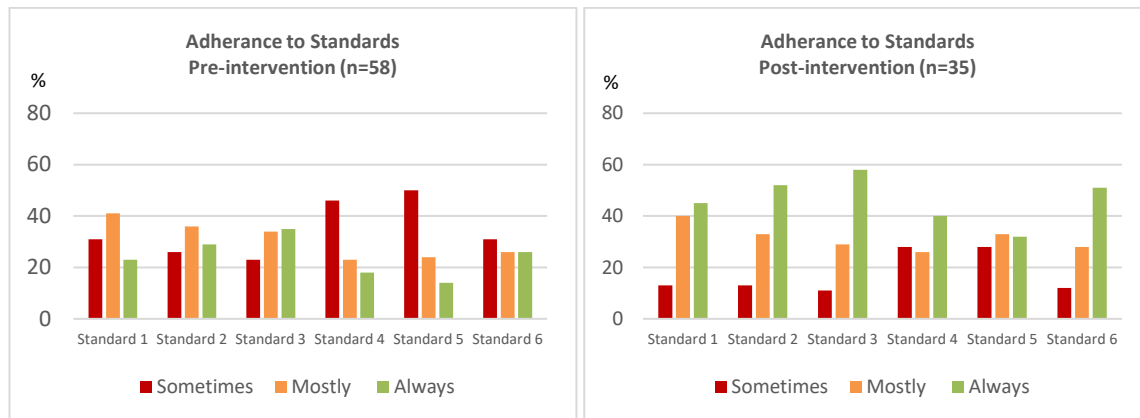
STANDARD 6: A RANGE OF CARER SUPPORT SERVICES IS AVAILABLE

The area of greatest improvement was standard 6, with the range of local carer support services available. For this standard, ratings of 'always' increased by 32%.

Community Findings

Staff completing checklists at the start of the project identified room for improvement across all six standards. At the end of the project, staff identified higher levels of carer engagement in each standard (see figures below).

Combined Community Mental Health Services: Pre and Post Intervention

Figure 30: Combined Community Pre-intervention   Figure 31: Combined Community Post intervention

The greatest gain was in standard 6 (carer support services are available). This is consistent with initiatives bringing support services on-site and reminding all services of existing carer support services in their regions.

Comparing inpatient and community findings

Similar areas for improvement were identified in inpatient and community services. Key issues in both settings included identification and welcome of carers, carer support, and issues related to consent and information sharing. As a result, similar resources and initiatives were implemented in inpatient and community services.

Staff perceptions of carer engagement as measured by the checklists, were consistent with this similarity of issues across inpatient and community settings. That is, very similar patterns were evident when comparing the checklist findings of inpatient and community health services.

Overall findings

As would be expected, the overall combined findings across all services at the start of the project identified room for improvement across all six partnership standards. At the end of the project, staff indicated that they perceived higher levels of carer engagement across the each of the standards at the end of the project (see figures below).

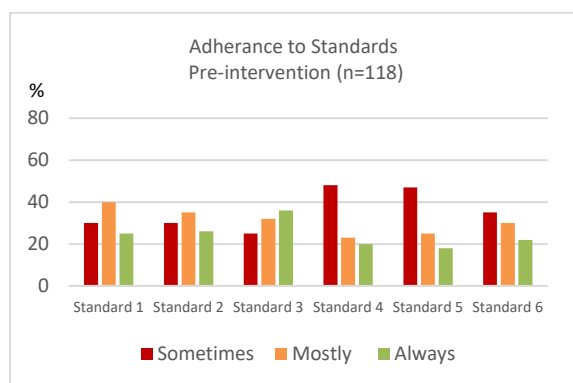**Combined Inpatient and Community Mental Health Services: Pre and Post Intervention**

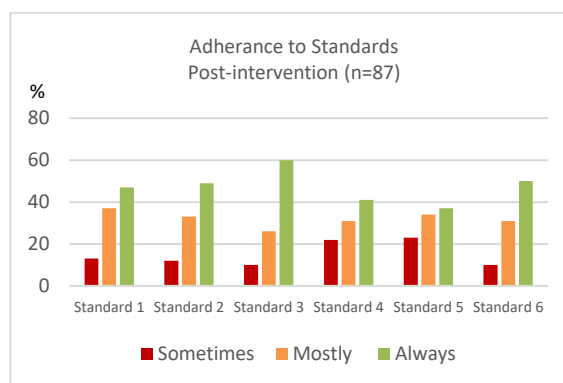**Figure 32: Combined Sites Pre-intervention**   **Figure 33: Combined Sites Post intervention**

The greatest gains were in standards 4 (staff positions allocated for carers), 5 (carer introduction to the service is available) and 6 (carer support services are available). This is consistent with initiatives promoting carer champions, introducing welcome letters and statements of commitment, bringing support services on-site and reminding all services of existing carer support services in their regions.

STANDARD 1: CARERS AND THE ESSENTIAL ROLE THEY PLAY ARE IDENTIFIED AT FIRST CONTACT
Findings improved across all sites under standard 1. However, this standard showed lower gains than other standards. This highlights the complexity in the identification of carers, in particular the need for improvements in identifying special circumstances, such as young carers, any communication issues and/or cultural considerations. It is particularly important to continue improvements under this standard as this is where groups of carers with complex needs potentially 'fall through the cracks' and are not identified. Discussions with staff highlighted challenges when consumers are estranged from family and friends, particularly those who are homelessness. When carers are identified there is potential for re-connecting the consumer with family and friends.

STANDARD 2: STAFF ARE CARER AWARE AND TRAINED IN ENGAGEMENT STRATEGIES

The need for training in carer engagement strategies was highlighted in staff checklists at the start of the project. Unfortunately due to time constraints and competing priorities, low numbers of staff completed the carer engagement e-learning modules.

STANDARD 3: POLICY AND PRACTICE PROTOCOLS REGARDING CONFIDENTIALITY AND SHARING INFORMATION ARE IN PLACE

Standard 3 showed lower gains than other standards. Discussion with staff at most sites identified concerns regarding consent and information sharing that can become a barrier to engaging with carers. Training and clinician guides on these issues were well received at one service and could be more useful across services.

STANDARD 4: DEFINED STAFF POSITIONS ARE ALLOCATED FOR CARERS IN ALL SERVICE SETTINGS

All sites demonstrated a need for defined staff positions focused on carers. Initiatives implemented through the project developed a greater awareness developed in the role and responsibility of *all staff* in identifying, involving and supporting carers.

STANDARD 5: A CARER INTRODUCTION TO THE SERVICE AND STAFF IS AVAILABLE, WITH A RELEVANT RANGE OF INFORMATION ACROSS THE CARE SETTINGS

A carer introduction to service was identified as a priority area across all sites. A range of different approaches (introduction letter, statements on their commitment to Carers and their Carer rights, changes to admission procedures and Carer support groups) were used to address this standard.

STANDARD 6: A RANGE OF CARER SUPPORT SERVICES IS AVAILABLE

Improvement in standard 6 was consistent with initiatives bringing support services on-site and reminding all services of existing carer support services in their regions.

Findings regarding the methodology

The pilot was conducted within budgetary and time constraints which created an artificially short time frame for identifying, implementing and assessing the effectiveness of solutions. In a real-world situation, the time frame for engaging with staff at sites would ideally be linked to the nature of the initiatives undertaken, with staff and management determining the level of ongoing engagement required.

This was evident when returning to the inpatient sites (which commenced with the project in July 2017) and repeating the checklist for a third time, more findings emerged. In particular, it became apparent that initiatives that were embedded in procedures and had become part of every-day practice were better known by staff, whereas those actions that remained effectively discretionary were less likely to be known by staff.

To strengthen the findings of this project, we sought external corroborating data that might indicate a shift in carer experiences of service. One of the inpatient sites compared Press Ganey responses from consumers at the start and after the completion of the project. Findings showed an increase of eight per cent in satisfaction within the "visitors and family" category of service delivery.

As a recommendation, and consistent with the system wide reforms recommended in *Better Choices. Better Lives (WA Mental Health Commission 2016, p. 143)*, it would be valuable to

monitor the extent to which carers are able to participate in the co-design of services, and also to include feedback from carers in future experience surveys across the health services[2].

MOVING FORWARD

HelpingMinds is committed to continuing this valuable project into the future. Funding would enable working with more staff to ensure all mental health services improve their engagement with carers.

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[2] For example, a short form of the Carer Experience Survey is currently being considered by the **Australian Mental Health Outcomes and Classification Network**

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APPENDIX 1: STAFF CHECKLIST (AMENDED)

Partnership Standard 1:

Carers and the essential role they play are identified at first contact, or as soon as possible thereafter

	Activities	R	O	G	Action Plan
1.1	Carers are routinely identified when carrying out an assessment				
1.2	Special circumstances of the carers are recorded, for example: • parent of young family • single parent • caring for parents • young carer • carer with mental illness • friend • partner • relative • any cultural considerations and/or communication issues				
1.3	Carers views and knowledge are sought throughout the assessment and ongoing support process				
1.4	Consent of consumer is routinely obtained and recorded re: carers involvement				
1.5	Carers are regularly updated and involved re: care plans				
1.6	Strategies for medication management are explained to the carers				
1.7	Carers have access to advice re: advocacy, rights, information and support				
1.8	There is a documented procedure for welcoming carers				
1.9	Carers are involved in the discharge process				

Red indicates this practice may be occurring sometimes but is generally not consistent nor documented.
Orange indicates this practice is occurring most of the time but documentation could be further developed.
Green indicates this practice is always carried out and consistently documented.

PARTNERSHIP STANDARD 2:

Staff are carer aware and trained in carer engagement strategies

	Activities	R	O	G	Action Plan
2.1	Your organisation has a policy that requires you to work with carers				
2.2	All staff have received carer awareness training				

2.3	The training includes:
	• awareness of carer needs.
	• carer expectations re:
	  o assessment, care and support
	  o dealing with carer queries and concerns
	  o advising on sources of help
	  o advising on treatments, strategies and medication management
	  o how to involve and engage with carers and consumers				

2.4	Training is delivered by carer trainers or carers as part of the training delivery team				
2.5	Opportunities are offered to carers to participate in all aspects of assessment and the ongoing care, treatment and recovery of the consumer				
2.6	The level of support carers are able, or need, to provide is taken into account in the ongoing planning for the consumer				
2.7	Information is provided to carers regarding services and strategies available if a crisis occurs or the consumer becomes unwell				
2.8	You work in a way that supports relationships within families, and this is documented				
2.9	Carers are provided with opportunities to enhance their abilities in the caring role				
2.10	You convey hope for recovery when working with carers				

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PARTNERSHIP STANDARD 3:

Policy and practice protocols regarding confidentiality and sharing of information are in place.

	Activities	R	O	G	Action Plan
3.1	Consumer consent to share information with the carer is sought				
3.2	Agreement is reached with consumer about the level of information to be shared with the carer				
3.3	If the consumer requests no disclosure, staff regularly revisit this decision with them				
3.4	Opportunities are provided to carers to discuss the care, treatment, recovery and support of the consumer (even if, for reasons of confidentiality, you cannot provide specific personal information)				
3.5	Carers are encouraged to share information re: consumer to inform assessment, treatment and support				
3.6	Carer notes and letters are kept in a separate section of the consumers' case notes/on IT systems				
3.7	Wellness Plans/Advance Directives are routinely used				
3.8	A Recovery Plan is in place				
3.9	Practice guidelines re: information sharing with carers are in place				
3.10	A policy is in place to support practice re: confidentiality				
3.11	Staff training is available and includes carer best practice for information sharing and confidentiality				

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Green indicates this practice is always carried out and consistently documented.

PARTNERSHIP STANDARD 4:

Defined staff positions are allocated for carers in all service settings

	Activities	R	O	G	Action Plan
4.1	A carer champion is identified within the service, or there are carer consultants employed				
4.2	All staff are responsible for identifying, involving and supporting carers				
4.3	A network is in place to support carer champions, carer consultants and carer peers.				
4.4	Carer peer roles are in place				

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PARTNERSHIP STANDARD 5:

A carer introduction to the service and staff is available, with a relevant range of information across the care settings.

	Activities	R	O	G	Action Plan
5.1	Upon first contact, across all service settings, provide the carer with: • an introductory letter that explains the service and points of contact (for example, CMO staff names and contact numbers) • carer rights and responsibilities information • the partnership policy of the service • information regarding carer support services (for example, local groups, carer champions, carer consultants, carer peer workers) • a number to call for after-hours service				
5.2	Offer an early appointment to the carer to hear their story/history and to address their concerns				
5.3	Ensure that the service has meeting and greeting protocols in place to minimise carer distress and address any concerns they may have				
5.4	Discuss with the carer whether they wish to bring a support person with them to meetings				
5.5	Provide locally developed carer information packs to new carers at first meeting				
5.6	Ensure that the cultural and language needs of carers have been addressed during the preparation of this pack				
5.7	Ensure that the format of the information pack is flexible and regularly updated				
5.8	Make a member of staff responsible for developing, storing and issuing the packs				
5.9	Ensure that the carer is involved in discharge planning and is clear about what to do and who to contact in the organisation in a crisis				
5.10	Ensure that the carer is asked for feedback regarding the service provided as part of quality improvement activities				

PARTNERSHIP STANDARD 6:

A range of carer support services is available.

	Activities	R	O	G	Action Plan
6.1	A carer support service is in place locally				
6.2	Carers have access to local carer advocacy services				
6.3	Carers have access to a range of support services if required				
6.4	Carers' needs and plans are regularly re-assessed				
6.5	More specialised services such as family therapy are offered to carers and family if required				

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IDENTIFYING CARERS AND NEXT-OF-KIN

Who is a Carer?

When we ask who your support person or Carer is, we are asking about:

- A person who is important in your life **and/or**
- A person who gives you support

This support person or Carer may be a:

- Family member
- Partner
- Friend or neighbour

You may not see this person as a Carer. Your support person may not see themselves as a Carer.

We ask you to include a support person or Carer in your work with us so that they can better understand what's happening for you. This can help them support you in ways that you need.

Who are my Next of Kin?

We ask about your next of kin so that we know who to contact first in case of an emergency.

Your next of kin is generally your:

- Husband / wife / partner **or**
- Parents **or**
- An adult child **or**
- An adult brother or sister

SERVICE HEADER

CARER ENGAGEMENT CHECKLIST – ADMISSION
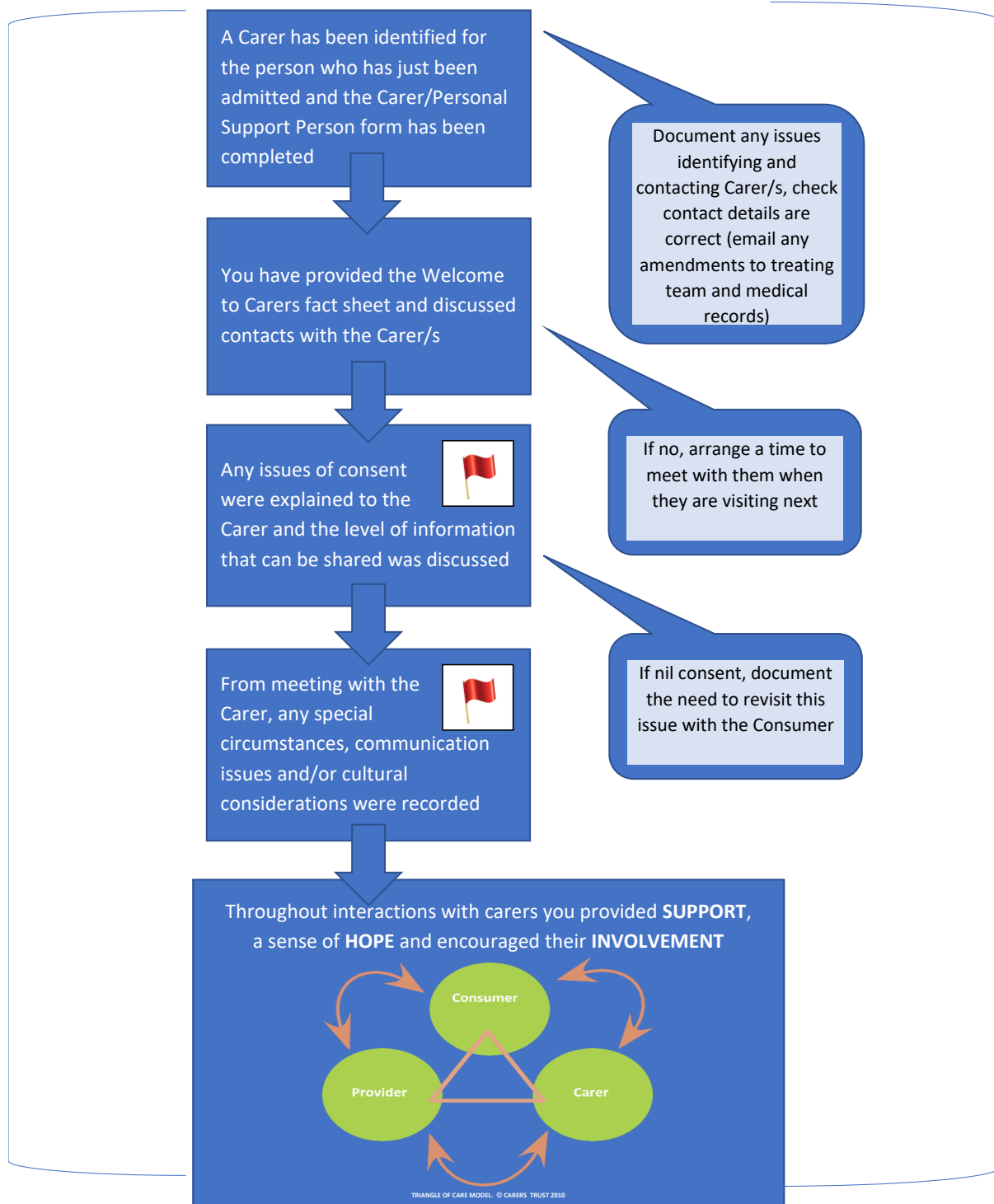
Has the Consumer been asked who provides them with support?			
Consent Provided by Consumer to Share Information			
Consent documented?	**Yes**	**No**	**Date**
If nil consent, explain to Carer and share general information.	**Yes**	**No**	**Date**
Carer Details:			
A Carer has been identified for the person who has just been admitted?	**Yes**	**No**	**Date**
Name:			
Address:			
Telephone:	Email:		
Welcome to Service			
Introduction to service letter provided?	**Yes**	**No**	**Date**
If no, time scheduled to meet with carer or mail out	**Yes**	**No**	**Date**

Special Circumstances of Carer			
	Parent of young family		Young carer
	Single parent		Caring for parents
	Carer who is also a consumer		Partner
	Relative		Friend

Communication issues	
Detail:	**N/A**

Cultural Considerations	
Detail:	**N/A**

Carer's Appointment Made with Care Coordinator				
Has a Carer's appointment been made with Care Coordinator (with Consumer consent/participation)	**Yes**	**No**	**N/A**	**Date**

Carer Involvement in Care Plan			
Has the Carer been involved in developing the Care Plan	**Yes**	**No**	**Date**

Carers Welcome Procedure (responsibility of the admitting nurse)

A Carer has been identified for the person who has just been admitted and the Carer/Personal Support Person form has been completed

Document any issues identifying and contacting Carer/s, check contact details are correct (email any amendments to treating team and medical records)

You have provided the Welcome to Carers fact sheet and discussed contacts with the Carer/s

If no, arrange a time to meet with them when they are visiting next

Any issues of consent were explained to the Carer and the level of information that can be shared was discussed

If nil consent, document the need to revisit this issue with the Consumer

From meeting with the Carer, any special circumstances, communication issues and/or cultural considerations were recorded

Throughout interactions with carers you provided **SUPPORT**, a sense of **HOPE** and encouraged their **INVOLVEMENT**

Consumer

Provider

Carer

TRIANGLE OF CARE MODEL. © CARERS TRUST 2010

Remember: *"Carers are as essential to your work as your work is to them and the person they support"*
(Carer).

WELCOME LETTERS (COMMUNITY AND INPATIENT)

Dear _____ ,

The **X Community Mental Health Service** provides services for adults experiencing mental health issues. _____ recently attended an appointment with us. We understand that you give them care and support.

We recognise the role of family and friends in the recovery of people with mental health issues, and we are committed to working with family and friends in caring roles.

Your contact person with our service is _____ (Care Coordinator) on **(08)** .

If you have an urgent concern after hours, call the Mental Health Emergency Response Line on **1300 555 788** (local call).

We will work with your family member/friend to develop a recovery plan. We will encourage them to share information with you and, with their permission, you are welcome to accompany them to appointments.

The treating team is led by _____, a Consultant Psychiatrist. A member of the treating team will contact you to arrange a family meeting or you can contact us to ask for a family meeting.

Please call us on **xxxx** to make an appointment with the Care Coordinator share your history with your family member/friend or to talk about information or concerns. This will help us work together to support his/her recovery.

Family and friends in a caring role need support too. We work with HelpingMinds, a non-government organisation that provides carer services such as counselling, carer support groups, peer support, advocacy and respite. You can contact HelpingMinds on **(08) 9427 7100** or **1800 811 747**.

I have attached a copy of the WA Carers Charter. This tells you about your rights and our commitment to working with you. Please contact us with any questions.

Yours sincerely

Welcome to Carers

The **……………..** provides inpatient mental health services for adults with mental health issues requiring assessment, treatment and care.

_____ was admitted on __/__/____.

We understand that individual recovery journeys have better outcomes when Carers are recognised, included and supported. We'd like to provide you with some general information regarding their admission and how we can work together.

Visiting times are …..am to ……pm, …..pm to …..pm and …..pm to …..pm (weekdays) and …..am to …..pm, ……pm to ……pm and ……pm to …..pm (weekends and public holidays). You can phone and ask to speak to _____ during their admission to …………. on (08) ………… or (08) …………..

Carer contacts:

If you have concerns or questions you can contact the ward on (08) ……. or (08) ……….

Your **Allocated Nurse**: _____will be your key contact on the ward. If the allocated nurse is not available, you can speak to the **Shift Co-ordinator**.

Treating Consultant Psychiatrist: _____

Psychiatric Registrar: _____

Social Worker: _____

Please contact the Social Worker or Psychiatric Registrar to arrange a family meeting. You can contact them during work hours through the hospital switchboard on (08) ……...

We will be encouraging _____ to share information with you and, with their permission, you are welcome to be involved in treatment and care planning.

We also encourage you to make an appointment with the Social Worker if you would like to share your story, if you have information to share and/or concerns to raise. Your Social Worker can provide you with support and information about Carer services for education, counselling, respite and advocacy.

Please feel free to contact the treating team with any questions on the ward telephone number.

Are you a family member or friend in a caring role?

Our Commitment to Carers

We are committed to better recognise, involve and support family and friends in a caring role. We will continue to train all staff to improve how we work with family and friends in a caring role.

Western Australian Carers Charter (Carers Recognition Act 2004)

1. Carers must be treated with respect and dignity.
2. The role of carers must be recognised by including carers in the assessment, planning, delivery and review of services that impact on them and the role of carers.
3. The views and needs of carers must be taken into account along with the views, needs and best interests of people receiving care when decisions are made that impact on carers and the role of carers.
4. Complaints made by carers in relation to services that impact on them and the role of carers must be given due attention and consideration.

In working in partnership with us we hope that you will:

- Share information about your caring role
- Be involved in the recovery plan and discharge planning (with the consent) of the person you support and care for (discuss your availability with us).
- Tell us about your needs to sustain your caring role.
- Share information with us about your cultural background.
- Tell us if you have any concerns.

Are you a family member or friend in a caring role?

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We will continue to train all staff to improve how we work with family and friends in a caring role.

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4. Complaints made by carers in relation to services that impact on them and the role of carers must be given due attention and consideration.

In working in partnership with us we hope that you will:

- Share information about your caring role
- Be involved in the recovery plan and discharge planning with the consent of the person you support and care for (discuss your availability with us).
- Tell us about your needs to sustain your caring role.
- Share information with us about your cultural background.
- Tell us if you have any concerns.

Did you know…
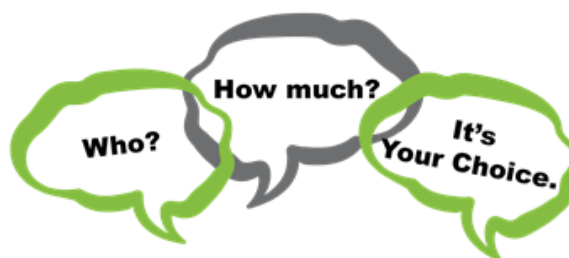
We can talk about **how much** of your information you would like us to share.

For example, you might want a family member, carer or other support person to know about:

- **Medications**, so if needed the support person can help you remember to fill scripts, work out what needs to be taken and when.

- **The wellness plan,** so if needed the support person can help you get to appointments or do activities.

- **Possible side-effects,** so that the support person can notice if you are becoming unwell.

Your rights…

Let us know **who's important to you** – who you'd like us to share information with.

Talk with us about **what information** you'd like us to share.

INFORMATION SHARING WITH CARERS – CLINICIAN GUIDE

Carers are key partners in the recovery of people with mental health issues (Mental Health Act, Principle 14).

If a consumer does not consent to information sharing with a carer, some information can still be shared with the carer, unless the Psychiatrist decides that is not in the consumer's best interests.

General information can be shared without permission, while **personal information** cannot be shared without permission. Whether information is general or personal may be specific to each person.

General information – information that builds on the carer's existing knowledge (e.g. carer might know the condition that the person is being treated for)

Personal information – not already known to the carer/support person. This information is specific to the consumer and may be considered sensitive (e.g. living arrangements, sexual orientation, drug use, political/cultural beliefs).

Give information to family members or friends in a caring role about:

- ☐ mental health diagnosis & how to respond to behaviour that may occur*
- ☐ proposed treatment and care, and other available options*
- ☐ medication – benefits, possible side effects*
- ☐ consumer rights & any confidentiality restrictions requested by consumer
- ☐ community and in-patient services available to meet the person's needs
- ☐ how to access help, including out-of-hours services
- ☐ carer support services & how to access
- ☐ Provide a copy of the MHC brochure *Information for Personal Support Persons*

* if diagnosis/medication known to carer but no consumer consent to share – give general information

Involve family members or friends in a caring role:

- ☐ ask them to share any relevant history of the consumer, information & concerns. (carers can provide this even if consumer does not consent to share information). Keep this confidential if requested
- ☐ involve carers in matters relating to the consumer's treatment and care, and in the preparation and review of any treatment, support and discharge plan

CHECKLIST OF USEFUL QUESTIONS FOR CONSUMERS

Checklist of useful questions for consumers

About the mental health issue

- ☐ Has a diagnosis been made?
- ☐ What symptoms suggest this diagnosis?
- ☐ Where can I get more information about this mental health issue/illness?
- ☐ What about any diet, disability or physical issues that they have? What can be done and who can help with these?
- ☐ Can you arrange an interpreter or help with communication issues?
- ☐ Has our culture, religion and background been considered?

Medication

- ☐ What medication has been prescribed, and what is it for? How often should this be taken?
- ☐ What are the possible short and long-term side effects of this medication?
- ☐ Are there alternatives to this medication?
- ☐ What happens if I stop taking the medication?
- ☐ Can you provide me with written information about this medication?
- ☐ How often will my medication be reviewed?

About care and treatment

- ☐ Who can I talk to if I don't agree with the treatment suggested?
- ☐ Can we develop a wellness plan?
- ☐ Can we include my family/support person/carer in the planning?
- ☐ How long do I need to stay? (if inpatient)
- ☐ Can my family/support person/carer be told if I leave?
- ☐ What support and services can be arranged for me after discharge?
- ☐ Are there local services that my family/support person/carer can access?

Sharing information

I want to discuss what information I would like shared/not shared with my family/support person/carer. Can you make a note on my file that the boxes ticked are what I want shared with my family/support person/carer?

- What my diagnosis is and information about my mental health issue
- How they can best support me now and in the future
- Who my treating team are so that they can be contacted by my family/support person/carer with any urgent concerns
- Available treatment and medication options
- My wellness and discharge plans

I'd like my consent to stay in place for times when I am unwell
I'd like to revisit this list regularly (as it may change)

Consumer Signature: Date:

CHECKLIST OF USEFUL QUESTIONS FOR CARERS

Checklist of useful questions for carers

About the mental health issue

- ☐ Has a diagnosis been made?
- ☐ What symptoms suggest this diagnosis?
- ☐ Where can I get more information about this mental health issue/illness?
- ☐ What about any diet, disability or physical issues that they have? What can be done and who can help with these?
- ☐ Has our culture, religion and background been considered?

Medication

- ☐ What medication has been prescribed, and what is it for? How often should this be taken?
- ☐ What are the possible short and long-term side effects of this medication?
- ☐ Are there alternatives to this medication?
- ☐ What happens if they stop taking their medication?
- ☐ Can you provide me with written information about this medication?
- ☐ How often will their medication be reviewed?

About care and treatment

- ☐ Who can I talk to if they don't agree with treatment suggested?
- ☐ Can we develop a wellness plan together?
- ☐ What can I do to help?
- ☐ How long do they need to stay? (if inpatient)
- ☐ How often can I see them and what times?
- ☐ If they leave will I be told?
- ☐ What support and services can be arranged for them after discharge?

Sharing information

- ☐ Share your observations about symptoms and triggers
- ☐ Can you provide advice on managing behaviours both now and after discharge?
- ☐ Can I provide information that I would like to keep confidential?
- ☐ Can I meet with you on my own?
- ☐ Have staff asked about how much information they are happy to share with me?
- ☐ If they don't want to share information with me, what general information can be shared?
- ☐ Will this issue be revisited with them? (as it may change)
- ☐ Will I be informed about meetings to discuss their care and treatment?

Support for me

- ☐ Is there a local Carer support group, counselling or other services I can attend?
- ☐ Can I attend this after the person I care for has been discharged from this service?
- ☐ Can you provide me with information about services to help me in my caring role?