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Working with Families and Carers

Policy Number 1.434

Policy Function Continuum of Care

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Summary This policy provides direction to Justice Health and Forensic Mental Health Network clinicians in their work with families and carers of patients with a mental illness across adolescent and adult correctional facilities, Long Bay Hospital and the Forensic Hospital. This policy aims to establish key principles and standards for engaging and supporting families and carers in the significant role they play in mental health recovery.

Responsible Officer Executive Director Clinical Operations

Applicable Sites

☐ Administration Centres
☒ Community Sites (e.g. Court Liaison Service, Community Integration Team, etc.)
☒ Health Centres (Adult Correctional Centres or Police Cells)
☒ Health Centres (Youth Justice Centres)
☒ Long Bay Hospital
☒ Forensic Hospital

Previous Issue(s) Policy 1.436 (Dec 2017); Policy 1.435 (July 2018)

Change Summary

- Amalgamation of above two policies
- Inclusion of Adolescent Health
- Enhanced Aboriginal health lens
- Addition of NDIS and COPMI considerations

HPRM Reference POLJH/1434

Authorised by Chief Executive, Justice Health and Forensic Mental Health Network

1. Preface

For health professionals working with people with a mental illness, supporting and including their families and carers in treatment and related decisions are pivotal to achieving strong outcomes in mental health care. Social support and particularly the emotional support from a close relationship is an important protective factor for mental health problems (Robinson, Rodgers and Butterworth, 2008). Research shows that supporting carers benefits consumers, including enhancing the effectiveness of service delivery, decreasing hospital admissions and reducing relapse rates, as well as the distress levels of families (French, Smith, Shiers, Reed and Rayne, 2010).

Outcomes of a carer consultation by Mental Health Carers NSW evidenced that supportive professionals have an enormous impact on carers' ability to care effectively and sustain appropriate treatment for persons with a mental illness (ARAFMI, 2007). Australian studies have highlighted the importance of supporting these carers who have been shown to have higher rates of mental health problems than the general population (Edwards et al, 2008) and relatively low collective wellbeing (Cummins et al, 2007).

Families and carers of patients of Justice Health and Forensic Mental Health Network's (the Network) mental health services face additional complexities and stressors in their interface with the criminal justice and forensic mental health systems, where they themselves may be victims of crimes perpetrated by the person they are caring for.

This policy has been designed to provide direction to clinicians of the Network on working with these families and carers in a way that is aligned to legal frameworks, principles and standards.

1.1 Scope

The scope of this policy includes families and carers of patients across the Network in the following domains:

- Adolescent Health, including the Adolescent Health Custodial team operating in NSW Youth Justice Centres (YJC), Adolescent Court and Community Team (ACCT), Community Integration Team (CIT), where the patient is receiving mental health related treatment.
- NSW Adult Correctional Centres, where the patient is under the care of Custodial Mental Health (CMH). CMH service scope is referred to in section 1 of policy 1.443 – *Custodial Mental Health Referral and Case Management Policy*.
- Long Bay Hospital, as a declared mental health facility where patients are subject to statutory obligations set out in mental health legislation,
- The Forensic Hospital, inclusive of adolescent and adult patients, regardless of their legal status which may be Civil, Forensic or Correctional.

2. Policy Content

2.1. Mandatory Requirements

Network staff must ensure they are practicing within the overarching legal framework of this policy, which is determined by the NSW legislation and National standards outlined below:

- The NSW *Mental Health Act 2007* (MH Act), particularly *Chapter 4 Care and Treatment*, which recognises the role of carers and their interests as they relate to designated carers

nomination and principal care provider and information provision relating to admission, transfer, medication, events effecting care and notification of upcoming Mental Health Review Tribunals (MHRT).

- The NSW *Mental Health (Forensic Provisions) Act 1990* (MHFP Act).
- The NSW *Carers (Recognition) Act 2010* (CR Act) which recognises carers in NSW by law and establishes obligations for public sector agencies in ensuring that staff have an awareness and understanding of the NSW Carers Charter. Public sector agencies must consult with carers or bodies representing carers when developing policies that impact upon them.
- The *Children and Young Persons (Care and Protection) Act 1998* (CYP Act).

Also of relevance:

- The *NSW Family and Carer Mental Health Program Framework* of which the purpose is to improve the wellbeing of families and carers of people with mental health conditions and the people they support.
- *National Safety and Quality Health Service Standards* (Standard 2) which sets out that families and carers and the people they support have the right to contribute to the improvement of mental health services
- *National Standards for Mental Health Services 2010* (Standard 3 and Standard 7) which promotes consumer and carer participation in all aspects of care and treatment and the design and delivery of services.
- The NSW Health Recognition and Support for Carers key Directions 2018-2020 is designed to provide guidance on responding to the needs of carers across the NSW public health system.

2.2. Implementation - Roles & Responsibilities

2.1.1 Custodial Mental Health (CMH)

Note 1: Not all patients within the Mental Health Screening Units (MHSU) - CMH are covered by mental health legislation. The Network only has mandatory obligations under such legislation for the following patients in this setting:

- Patients on Forensic Community Treatment Orders; and
- Patients who have been placed on a s.55 Order and are awaiting transfer to the LBH Mental Health Unit.
- Patients on Forensic Orders.

However it is good practice that patients who are receiving mental health care in the Network be allowed to nominate a designated carer/s to act on their behalf (s. 72 of the MH Act) and entered into i.PM or using a Consent to Liaise form (JUS020.035). The below roles and responsibilities are in relation to mandatory requirements set out in section 2.1. Additional roles and responsibilities are further outlined in section 3 of this policy.

The consultant psychiatrist is responsible for:

- Ensuring the nomination of a designated carer(s) and principal care provider (as per s.72 and s.72A of the MH Act) and entered into the patient's health record and/or designated to another appropriate party for processing;
- (For patients covered by mental health legislation) ensuring the patient's designated carer and principal care provider (if identified) are informed of the admission within 24 hours where possible (as per s.75 of the MH Act);
- Assessing the patient's capacity to make decisions regarding the disclosure of information to his or her carer/s;
- Ensure that where there is no designated carer nomination in force and where the patient has declined to nominate or exclude a designated carer that reasonable steps are taken to identify a person who might act in the capacity of principle care provider in accordance with s. 71 of the MH Act.
- (For patients covered by mental health legislation) ensuring designated carer/s and principal care provider are notified of upcoming Mental Health Review Tribunals in accordance with s.78(1)(h) of the MH Act.

Note 2: These responsibilities may be delegated to the psychiatry registrar working under the supervision of the consultant psychiatrist, nursing staff or other member of the MDT, but remain the responsibility of the consultant.

The Family and Carer Consultant is responsible for:

- Ensuring that the Network staff have an understanding of the NSW Carers Charter;
- Receiving and actioning referrals for family and carer support, as appropriate;
- Providing consultancy, support and resources to clinicians;
- Ensuring communication of information received from families and carers to the treating MDT;
- Maintaining the Network Family and Carer email address (JHFMHN-FamilyAndCarer@health.nsw.gov.au), so as to send and receive family and carer correspondence;
- Ensuring family and carer co-production in service design, delivery and evaluation;
- Informing families and carers of and providing them access to the Carer Experience Survey (CES);
- Maintaining working relationships with Community Managed Organisation (CMO) partners, the peak carer bodies and Local Health Districts (LHDs) that increase family and carer support accessibility;

2.1.2 Long Bay Hospital Mental Health Unit (LBH MHU)

In addition to the roles and responsibilities listed in section 2.2.1:

- The consultant psychiatrist is responsible for functioning as the direct, initial point of contact and liaison for family and carers.
- The primary/ secondary nurse or delegate is responsible for ensuring that the patient and his/her family and/or designated carer(s) and principal care provider are involved in transfer planning as far as possible in the correctional context; and

- The primary/ secondary nurse or delegate is responsible for ensuring that the patient and, with the patient's consent, his or her designated carer(s) and principal care provider and/or family (including children where relevant), are verbally informed of the transfer of care plan as appropriate within security constraints.

2.1.3 Long Bay Aged Care Rehabilitation Unit (ACRU)

In addition to the functions listed above for the Consultant Psychiatrist or delegate and Ward Clerk:

Clinical Nurse Consultant (CNC), Specialist Mental Health Service for Older People (SMHSOP) is responsible for:

- Functioning as the direct initial point of contact and liaison for family and carers;
- Fulfilling the key role in developing the relationship between the ACRU and the families and carers of its patients;
- Ensuring that the patient and his/her family and/or designated carer(s) and principal care provider are involved in transfer planning as far as possible in the correctional context; and
- Ensuring that the patient and, with the patient's consent, his or her designated carer(s) and principal care provider and/or family (including children where relevant), are verbally informed of the transfer of care plan, as appropriate within security constraints.

2.1.4 Long Bay Hospital Medical Subacute Unit (MSU)

The MDT are responsible for:

Arranging End of Life Care for patients nearing the end of their life in accordance with policy 1.174 - *End of Life Care, Resuscitation Plans and Advanced Care Directives.* This should include the development of a care plan that is inclusive of the patient's family and carer. A care plan may:

- Provide information as to how pain and other symptoms might be managed;
- Show how emotional, cultural and spiritual support could be provided;
- Help family and carers make decisions about care options;
- Provide information relating, or referral, to bereavement services.

2.1.5 The Forensic Hospital

The Forensic Hospital offers a wider multidisciplinary staff compliment than CMH and LBH. Subsequently, contact with families and carers may be made by a more diverse staff body:

The consultant psychiatrist is responsible for:

- Roles outlined in section 2.2.1, or
- Delegating these roles to another appropriate member of the multidisciplinary team (MDT) such as the psychiatric registrar, social worker (SW) or nurse (such as the patient's Care Coordinator).

The social worker (SW) is responsible for:

- In consultation with the MDT, making initial contact, developing the relationship and sustaining regular contact with families and carers as outlined in sections 3.4 and 3.9;
- Completing a comprehensive psychosocial assessment, involving the patient, family, carers and significant others, where possible, including a detailed genogram. This may include the

Mental Health Family Focused Assessment (COPMI) where appropriate, as per GL2014_002 Mental Health Clinical Documentation Guidelines;

- Organising meetings and opportunities for inclusion with family and carers, as detailed in section 3.4 and 3.9; and
- Supporting their allocated ward in navigating contact with families and carers where challenges arise.

The Family and Carer Consultant is responsible for:

- All responsibilities outlined in 2.2.1; and
- Liaising with MDT's around contact with families and carers;
- Developing the capacity of mental health clinicians via the facilitation of In-Services in relation to professional and sensitive engagement with carers and families;
- Maintaining up to date and accessible and co-designed resources for families and carers;
- Ensuring appropriate transport is available for visitors requiring transfer from the FH entrance to the wards (e.g. wheelchair or vehicle access).

The Care Coordinator (CC) is responsible for:

- In consultation with the MDT, making initial contact, as soon as possible post admission to provide information outlined in section 3.5.
- Ensuring the designated carer(s) and principle care provider is:
  (a) entered into the patient's Treatment and Management Plan (TPRIM) as soon as nominated, and
  (b) uploading form SMR025.170 *Nomination of Designated Carer(s)* to *4. Legal Correspondence* in JHeHS;
- Ensuring the carer(s) is/are identified at Patient Registration (i.PM);
- Functioning as a point of contact and liaison for family and carers;
- Ensuring that the patient and his/her family and/or designated carer(s)/principal care provider are involved in ongoing treatment and transfer planning and are kept informed of the patient's expected transfer of care dates and times (as appropriate); and
- Ensuring that a copy of the transfer of care plan is given to the patient and, with the patient's consent, his or her designated carer(s)/principal care provider and/or family (including children where appropriate).

The Ward Clerk is responsible for:

- Providing the PAS Inpatient/Appointment Coordinator and Data Management Coordinator the details of the Designated Carer(s) and Principal Care Providers as per the PAS business process.
- Carrying out administrative tasks related to the visits booking process, as prescribed by *Forensic Hospital Visits Policy*; and
- Liaising with the relevant clinicians in relation to impending visits by carers or family members in relation to approval of the visit by the MDT.

The PAS Inpatient/Appointment Coordinator:

- Initial registration of the designated carer/principal care provider details in PAS.

Data Management Coordinator FH is responsible for:

- Ensuring that family and carer contact details are entered into the Patient Information Reporting Centre (PIRC2) database, including name, address, phone number, email address and relationship to the patient.

3. Procedure Content

3.1. Recovery-focused practice with Families and Carers

In working with individuals, their families and support networks, mental health practitioners support people to become decision-makers in their own care, implementing the principles of recovery-oriented mental health practice *National practice standards for the mental health workforce 2013* (Standard 2) by:

- Working with families and carers as partners in care and providing opportunities for the co-production of resources, events etc;
- Applying the principles of self-determination;
- Expressing hope and optimism, applying a strengths-based approach and valuing the person's and family/carers' knowledge and perspectives;
- Demonstrating respect for family members' and carers' roles, acknowledging diverse family capacities, experiences, value systems and beliefs;
- Identifying the impact of the person's mental health needs on their family and carers, including partners, significant others, children, parents and siblings, and supporting referrals and interventions to help meet these needs;
- Identifying the needs of family members and carers in circumstances where the person has chosen to exclude their involvement in his/her treatment and care and supporting interventions to meet these needs;
- Assisting families and carers to contact appropriate community or peer advocates and consultants;
- Encouraging feedback on service delivery, policy and planning; and
- Providing information in a format that is accessible to educate family members and carers regarding mental health issues and conditions, physical and comorbid health conditions, mental health services, other support services and self-help organisations.

3.2. Aboriginal and Torres Strait Islander Families and Carers

It is essential to explicitly and separately acknowledge the critical role kinship and family structures hold for the Aboriginal community and the inextricable links these family and kinship systems have to social and emotional wellbeing and recovery.

According to the *2015 Network Patient Health Survey – Aboriginal People's Health Report*, a higher proportion of Aboriginal participants, especially Aboriginal women, reported receiving a mental health diagnosis while in custody than their non-Aboriginal counterparts. With 3,444 Aboriginal adults in full time custody as of June 2019 (CSNSW Offender Population Report, June

2019), it is reasonable to assume that a significant proportion of those individuals are experiencing mental health related issues. The volume of families and carers within those supporting kinship Networks then, is significant.

Mental Health Carers Australia is the only national advocacy group solely concerned with the well-being and promotion of mental health carer needs. Mental Health Carers NSW is the peak body for the systemic advocacy and empowering of mental health carers in NSW. Carers Australia, the national peak body representing Australia's unpaid carers, is committed to reconciliation as detailed in the *Carers NSW Reconciliation Action Plan 2016 – 2018* (RAP). The *National practice standards for the mental health workforce 2013* (Standard 4) mandates that mental health practitioners:

- develop an understanding of Aboriginal and Torres Strait Islander history, and particularly the impact of colonisation on present day grief, loss and trauma and its complexity;
- communicate in a culturally sensitive and respectful way, being aware of potential mistrust of government and other service providers as a result of past history;
- use culturally sensitive language and preferred terminology;
- implement culturally specific practices as described in relevant national, state and local guidelines, policies and frameworks that pertain to working with Aboriginal and Torres Strait Islander peoples;
- respectfully collect and record information identifying Aboriginal and Torres Strait Islander status;
- work in collaboration with Aboriginal and Torres Strait Islander cultural advisors where appropriate and engage meaningfully to develop culturally appropriate care.

PD2012_16 *NSW Aboriginal Health Plan 2013-2023* recognises the importance of strengthening partnerships with Aboriginal communities in its six mandatory requirements which apply to the Network.

Network staff must take steps to ensure the above standards underpin their work with Aboriginal patients and their families and carers such as:

- Engaging Aboriginal-identified staff in all aspects of patient care;
- Engaging families and carers in all aspects of care;
- Considering social and emotional wellbeing lens in clinical formulations;
- Taking a strengths-based approach as opposed to a deficits based approach when treatment planning;
- Referring to GL2019_008 *Communicating Positively: A Guide to Appropriate Aboriginal Terminology* which may be helpful in supporting a culturally safe health system;
- Referring to PD2019_025 *Aboriginal Cultural Activities Policy* to support recognition of values, strengths and differences to be recognised, respected and celebrated.

3.3. Admission and Initial Contact – Adolescent Health

Admission of young people into Youth Justice NSW Centres is conducted in accordance with Network Policies; 1.036 *Health Assessments (Adolescents),* 1.080 *Clinical Services Provided by*

Justice Health & Forensic Mental Health Network, 1.085 *Consent to Medical Treatment - Patient Information,* 1.075 *Clinical Handover,* 1.230 *Health Care Interpreter Services – Culturally and Linguistically Diverse Patients and d/Deaf Patients,* GL2014_002 *Mental Health Clinical Documentation Guidelines,* 5.105 *Child Protection,* 1.335 *Referrals of Young People to the Community Integration Team.*

On admission into the adolescent custodial setting an initial Bio – Psycho – Social health assessment is completed for all young people within the first 48 hours. Following this a more comprehensive Bio – Psycho – Social assessment is completed within a time frame of ten days. Youth Justice NSW will inform the Network or parent or carer details which is confirmed at time of assessment with the young person.

For young people under the Care of the Minister, Family and Community Services (FaCS) are contacted for any commencement or changes to the young person's treatment in custody and on release from custody.

With any young person who reports a health condition at assessment which may or may not require treatment or be life threatening, the parent and/or carer is contacted by the Network clinic staff to verify and seek further clarification in regards to treatment received and the required ongoing treatment in custody for the young person.

With the young person's consent, or in accordance with Chapter 16A provisions of the *Children and Young Persons (Care and Protection) Act 1998,* The Care Act allows agencies working with children and families to exchange information that promotes a child or young person's safety, welfare and/or wellbeing, whether or not the child or young person has been reported to the Child Protection Helpline. Staff may provide, request and receive information under Chapter 16A and Section 248.

The clinic staff at the Youth Justice NSW centre may also contact the young person's treating team in the community for further information. This may include General Practitioners (GP's), Community Mental Health Service, Paediatricians, Local Health District(s) or Aboriginal Medical Service.

The parent and/or carer can contact health staff to share information and seek information regarding the health status of young people in the Network's care. Information is provided within the confines of confidentiality and Youth Justice NSW security policy.

Interpreters are utilised when parents and/or carers are from Culturally and Linguistically Diverse (CALD) backgrounds. Cultural consideration is provided for young people and their parent and/or carer where there are significant family circumstances such as sorry business.

3.4. Admission and Initial Contact – CMH and LBH

Admission procedures are carried out in accordance with Network policies 1.443 *Custodial Mental Health Referral and Case Management Policy*, 1.037 *Long Bay Hospital Admission Policy, (Referral, Admission and Assessment)*, 1.225 *Health Assessments in Male and Female Adult Correctional Centres and Police Cells*, 1.300 *Remote Off-Site and After Hours Clinical Services Policy* and 1.230 *Health Care Interpreter Services – Culturally and Linguistically Diverse Patients and d/Deaf Patients*. Also of relevance is NSW Health *Mental Health Clinical Documentation Guidelines* GL2014_002.

Roles and responsibilities that relate to working with families and carers upon a patient's admission to these settings are outlined in section 2.2.1, 2.2.2 and 2.2.3 and further in section 3.6.

Following the consultant psychiatrist undertaking the roles and responsibilities outlined in section 2.2.1:

Nursing Unit Manager (NUM) is responsible for:

- Ensuring that a copy of the initial carer registration is entered into the patient's health record including uploaded to Justice Health Electronic Health System (JHeHS);
- Advocating for the respectful engagement and inclusion of families and carers in the unit's daily operations.

The Ward Clerk may be responsible, where relevant, for:

- Registering the details of the designated carer(s) and principal care provider in Patient Administration System (PAS); and
- Forwarding the initial carer registration to the PAS Inpatient Clerk.

To establish initial contact with the relevant carer, the following functions should be carried out:

1. The Consultant Psychiatrist or delegate must contact the designated carer(s) and principal care provider as soon as possible following the patient's admission, and preferably within 24 hours. The following information should be provided:

- The name of the unit, its telephone numbers and function,
- The names of the patient's primary and secondary nurses and telephone contact numbers, and
- The names of the registrar, psychiatrist, NUM for the patient's unit and any other relevant contacts (e.g. CNC SMHSOP – ACRU, Family and Carer Consultant).

4. The address, telephone number and any other contact details that the carer wishes to provide must be documented in the patient's health record. The carer should also be offered the opportunity to ask questions or raise any urgent concerns and these must also be recorded in the health record.

Note 3: The Network must take all reasonably practicable steps to ensure that contact details are withheld from a patient for any person who has request nil contact or where there is an Apprehended Violence Order (AVO) with non-contact conditions (where this is known by the Network).

3.5. Admission and Initial Contact – Forensic Hospital

Patients are admitted in accordance with Network policies and procedures 1.336 *Referral (Adults and Adolescents) Forensic Hospital*, 1.337 *Admission (Adults and Adolescents) Forensic Hospital* and 1.338 *Transfer of Care (Adults and Adolescents) Forensic Hospital*.

Roles and responsibilities that relate to working with families and carers upon a patient's admission to The Forensic Hospital are also outlined in section 2.2.5.
As per s.3.12(1) of 1.337 *Admission (Adults and Adolescents) Forensic Hospital,* the social worker (SW) or care coordinator (CC) must contact the designated carer/principal care provider as soon as possible following the patient's admission, preferably within 24 hours. The following information should be provided at this time:

- the name and location of the Forensic Hospital, including the name and phone number of the unit the patient has been admitted to;

- the name and contact number of the delegated staff member calling; and
- the names of the registrar, psychiatrist and SW for the patient's unit;
- the delegated staff member must document the address, telephone number and any other contact details that the carer wishes to provide in the patient's health record;
- the carer should also be offered the opportunity to ask questions or raise any urgent concerns and these must also be recorded in the health record and discussed with the MDT at the next opportunity;
- the delegated staff member must provide the ward clerk this information who will then provide it to the PAS Inpatient Clerk for registration.
- A family welcome meeting should be offered and organised within the first four weeks of the patient's admission; this meeting should also function to determine the level of education and support required by the family and carers. The Family and Carer Consultant must document this initial contact in a Carer Checklist, which will be updated at every episode of carer involvement and filed in the patient's health record.
- Where a patient identifies as Aboriginal, staff should ensure the Aboriginal Mental Health Worker and/or Peer Worker is notified of their admission and included in family welcome meetings and other times at the patient's request and/or where indicated.

3.6. Nomination of Designated Carer and Principal Care Provider

Staff must refer to the following sections of the MH Act and *Mental Health Regulation 2013* to direct practice in relation to the nomination of Designated Carer(s):

- s. 71 of the MH Act - definition of Designated Carer(s).
- s. 72 of the MH Act - nomination requirements.
- Clause 42 of the *Mental Health Regulation 2013* - the period for which a nomination of a designated carer remains in force is 12 months. At this time, the nomination must be reviewed.
- The psychiatrist/psychiatry registrar must ensure that, in accord with s71 of the MH Act, where there is no nomination in force and where the patient has declined to nominate or exclude a designated carer, that reasonable steps are taken to identify a person who might act in the capacity of the designated carer and principal care provider for the purposes of the Act.

Staff must refer to the following sections of the MH Act to direct practice in relation to the nomination of Principal Care Provider(s):

- s.72(a) of the MH Act - nomination of a Principal Care Provider.

3.7. Ongoing Contact – Adolescent Health

While a young person is in custody regular contact is made with families and/or carers of young people to seek consent for minors or to communicate health issues and treatment received in the community and ongoing treatment requirements in the community on release. This exchange of dialogue may be conducted via the following forums:

- Pre-release case conferences are conducted at least one month prior to the young person's release for young people on control orders. The young person's parent or carer is invited to this forum which is facilitated by the YJNSW case worker and is essentially an interagency collaboration involved in the young person's support and care in developing a case plan for the young persons' release to the community. The network representative at this case conference will provide relevant health information for continuity of care for the young person's release from custody. The young person's parent or carer will be contacted when planning post release medical appointments and where possible the clinic staff will provide a verbal handover to the parent or carer if engaged with the young person at the release from custody stage.
- A health discharge summary is provided to the young person and the young person's parent or carer on release from custody. Parents or carers are able to contact the Network clinic staff immediately following the young person's release with any health related questions regarding the discharge summary and the required ongoing health care in the community.
- If the young person has any identified mental health and/or drug and alcohol concerns on admission into custody a referral to the Community Integration team (CIT) will be initiated early in the custodial stay. CIT Clinician's provide education and support to parents and carers where the young person resides or are engaged. Parents and carers will have access to psychoeducation and connection to family related services if required, brief interventions for example supportive counselling. CIT will act as a point of contact for parents and/or carers for issues as they arise.
- Ongoing collaborative case conferences are routinely held in the community once the young person has been released in order to monitor and evaluate the young person's ongoing care in the community. These case conferences are usually lead by the YJNSW or FaCS case worker. The young person's parent or carer is invited to these case conferences, CIT also attends as required and the Network Aboriginal Mental Health Clinical Leader (AMHCL) for young people from an Aboriginal background requiring specialised cultural support.

3.8. Ongoing Contact – CMH and LBH

Opportunities will occur for all staff to develop an ongoing relationship with the patient's family and carers, as the family interacts with staff in the normal course of events. However, specific roles are allocated to ensure consistency, accountability and reliability.

In the challenging situation with which these families must contend, their level of involvement must always be guided by their wishes, with great sensitivity. The relevant clinician/delegate should ascertain from the designated carer(s) and principal care provider whether there are other family members, friends or significant others who wish to be included in the patient's care, and their contact details must be filed in the health record, if both the patient and the family/friend/significant other consent.

The relevant clinician/delegate should:

- Inform the carers that clinical concerns may be addressed by the psychiatrist, registrar or MDT and that s/he must be invited to attend MHRT hearings;

- Inform families and carers of visit processes. Should they wish to visit, they should be referred to the Corrective Services NSW (CSNSW) Welfare Officer (WO) or Services and Programs Officer (SAPO).
- Maintain ongoing communication with the WO or SAPO to ensure holistic care and discharge planning that is inclusive of families and carers, where the WO or SAPO is involved with the family/carer.
- Refer to the Family and Carer Consultant if the support needs of families and carers exceed the resource capacity of the clinicians, ensuring open lines of communication and consultation.

In addition, MHU clinicians may also convene a health professionals meeting between the MDT, relevant CSNSW staff and family/carers to establish the patient's background, to connect with family/carers and to formulate care planning. The decision to hold such meetings is based on clinical need and may be particularly beneficial where the patient is cognitively impaired or psychotic. The patient does not attend but is usually informed of the meeting, unless lacking the capacity to comprehend the purpose of the proceedings. In the ACRU, the Network clinicians may meet with the patient and family/carers in the Visits Area or meeting room to discuss care planning and to connect with the family/carers, and may occasionally accompany them to inspect and assess nursing homes.

3.9. Ongoing Contact – Forensic Hospital

Opportunities will occur for all staff to develop an ongoing relationship with the patient's family and carers, as the family interacts with staff in the normal course of events. However, specific roles are allocated to ensure consistency, accountability and reliability.

The MDT is responsible for:

- Ensuring the patient has approval for telephone access to and/or audio visual contact with family members, friends and significant others in accordance with the *Forensic Hospital Telephone Calls and Audio Visual Contact Policy*.
- Ensuring the patient has the opportunity to receive visits by family members, friends and significant others in accordance with the *Forensic Hospital Visits Policy*.
- Where there is a family/ carer visit booked for an Aboriginal patient, the team should involve the Aboriginal Mental Health Worker and/or Peer Worker to promote appropriate visit conditions and welcome to the Forensic Hospital.

The SW, in consultation with the MDT, is responsible for:

- Undertaking an assessment of family and carer needs. In the challenging situation with which these families must contend, the level of involvement must of course always be guided by the wishes of the family and managed with great sensitivity.
- Ascertaining whether there are other family members, friends or significant others who wish to be included in the patient's care; their contact details must be filed in the health record, if both the patient and the family/friend consent.
- Offering and arranging family/carer meetings with the MDT at a frequency decided upon by both parties, to ensure that any clinical concerns will are collaboratively addressed.

- Advising the carer that they will be notified of in-depth clinical review meeting prior to the Mental Health Review Tribunal (MHRT) hearing, as well as the hearing itself as per s.78(1)(h) of the MH Act.
- Detailing the visits booking procedure, ensuring that visitors are made aware of the identification requirements, processes for Biometric Recognition System (BRS) registration and prohibited and controlled items in accordance with the *Prohibited and Controlled Items Policy – Forensic Hospital*. The SW should also provide the hospital's address and transport options and ascertain whether arrangements need to be made for disabled parking and access.
- Ensuring the Aboriginal Mental Health Worker and/or Peer Worker are included in family meetings and visits where appropriate.
- Providing a thorough clinical handover inclusive of family and carer information and contacts to the SW on the next ward upon a patient's transfer.

The CC and/or other members of nursing staff are responsible for:

- Communicating sensitively and respectfully with families and carers as they contact the unit;
- When designated, updating designated carer(s) and/or principal care provider(s) of events affecting a patient in accordance with s.78 of the MH Act.
- Facilitating and encouraging patient contact with their families and carers, where active encouragement is clinically indicated in the patients TPRIM.

The Ward Clerk is responsible for:

- Referring new visit requests to the MDT for approval;
- Arranging visit bookings for approved visitor and notifying the SW of the visit;
- Providing updated contact details to the PAS Inpatient/Appointment Coordinator and the Data Management Coordinator for updates to PAS and PIRC respectively.

3.10. Mental Health Review Tribunal (MHRT) Hearings

MHRT Hearings are a significant, formal opportunity for family and carer inclusion. Where there is an upcoming MHRT, the relevant clinician/delegate must:

- Notify the designated carer and principal care provider of the upcoming MHRT as per s.78(1)(h) of the MH Act;
- Aim to explain the aims and procedures of the MHRT, where possible, and answer any questions the family/carer may have;
- Notify the MHRT of any highly sensitive information and/or family/carer conflict which could impact negatively on the hearing in which case, teleconference or videoconference may be arranged;
- (Forensic Hospital and LBH) Notify the Mental Health Liaison and Reports Coordinator of any families/carers who plan to attend the MHRT either in person, by teleconference or videoconference;

- (Forensic Hospital) arrange an appropriate clinician/s to support the family and/or carer by meeting them prior to the hearing, escorting them to the hearing and addressing any issues which arise;
- Provide the family/carer an opportunity to "de-brief" following the MHRT which recognises the complexity of their circumstances with sensitivity.

Note 5: IB2017_027 *Right to access medical records by legal representative - Mental Health Review Tribunal* requires that the following carer related documentation at a minimum is to be provided to a patient's legal representative in the context of MHRT hearings:

- Nomination of Designated Carer form/s (including any exclusions) and,
- If nomination is refused, documentation of any determination by an authorised medical officer or Director of Community Treatment in relation to their appointment of a Principal Care Provider; evidence of further attempts to have the person nominate a Designated Carer.

3.11. Children and Young Persons

Visits both by and to children and young persons is an important part of the recovery process and may support the reduction of stress and disconnection often experienced by patients, families and carers when an individual experiencing mental illness is accommodated in a secure setting.

All professional engagements with children and young people across the Network must be underpinned by Policy 5.015 *Child Protection Implementation Guide* which provides staff with guidance and direction to protect the safety and wellbeing of children in accordance the *Children and Young Persons (Care and Protection) Act 1998.*

Depending on the setting within which staff work, they must refer to local policies and procedures such as *Policy 1.070 - Child Residents (In Adult Correctional Centres) – Clinical Responsibilities* and *Forensic Hospital Visits – Approval Procedure* which details all aspects of FH visits by and to children and young persons, including approval processes, location of visits and staff roles and responsibilities.

3.11.1 Children of Parents with a Mental Illness (COPMI)

Children can also be carers. One of the instances in which this occurs is when the parent has a mental illness. These children have a heightened risk of experiencing a range of behavioural, education, social and developmental challenges, as well as a higher risk of experiencing their own mental health (Reupert, Maybery & Kowalenko, 2012). As *Children of Parents with a Mental Illness (COPMI) Framework for Mental Health Services* propose, prevention is possible and professionals play an essential role and should take a family-based approach to ensure resilience, strengths and vulnerabilities are identified and responded to.

While Designated Carer(s) under mental health legislation cannot be under 18 years of age, children and young people may still engage in the caring role with their parent and staff should consider this in respect to their safety, wellbeing, perspectives and input.

3.12. Meeting Diverse Needs

In line with *National practice standards for the mental health workforce 2013* (Standard 3), the Network must:

- acknowledge and articulate diversity among people, carers, families and communities in areas including age, gender, class, culture, religion, spirituality, disability, power, status, gender identity, sexuality, sexual identity and socioeconomic background;
- facilitate care, treatment and support in a manner that demonstrates respect for the diversity of families and carers;
- recognise that a positive, secure cultural identity is a protective factor for the mental health and wellbeing of the person, family and carers;
- implement culturally specific practices and service delivery as described in relevant national, state and local guidelines, policies and frameworks;
- liaise and work collaboratively with culturally and linguistically appropriate care partners such as religious ministers, spiritual leaders, key Aboriginal elders, traditional healers, local community-based organisations, and mental health workers, health consumer advocates, interpreters, bilingual counsellors and other resources where appropriate;
- communicate effectively with family members and/or carers through the assistance of interpreter services and bilingual counsellors; and
- monitor its performance in relation to the above criteria and employ data collected to improve performance as part of service development and quality improvement.

3.13. National Disability Insurance Scheme (NDIS)

The *National Disability Insurance Agency* (NDIA) recognises the importance of the caring role and aims to work with families and carers to support family wellbeing. How families and carers are supported in their caring role should be set out in the patient's NDIS plan.

Network clinicians involved in applying for or supporting an NDIS plan should always engage the designated carer and principal care provider in identifying a formal nominee or in supporting family and carer inclusion in the NDIS planning process.

The NDIS provides information on how they can support families and carers. The Network's intranet also provides information on the NDIS in relation to the Network.

3.14. Network Events

There may be Network events throughout the year that aim to provide valuable opportunities to families and carers to experience normalised activities with their relative/friend (the patient), share common experiences with each other and gain enhanced understanding of the rehabilitation programs available in an inclusive context. Any events that are inclusive of families and carers should be consumer (patient and carer) focused and where possible, aim for consumer co-production. Events include but are not limited to Mental Health Celebration Day and yearly Network Carer Events.

3.15. External Agencies

Under the *Family and Carer Mental Health Support Programs*, NSW Health funds five non-government organisations (NGOs) to deliver family and carer support through education and training and support for advocacy services within each LHD: *AfterCare*, *CatholicCare Wilcannia-Forbes*, *Mission Australia*, *One Door Mental Health* and *Parramatta Mission*. The Network has memoranda of understanding with these organisations.

Staff should engage these, and any other services deemed appropriate, where families and carers are requiring community-based support. The Family and Carer Consultant who is funded by this program, should be contacted where further information, support and resourcing is required or where staff require support engaging these organisations.

3.16. Information provision to designated carer and principal care provider

Staff should refer to the *NSW Health Privacy Manual for Health Information* and Network policy 4.030 *Requesting and Disclosing Health Information.* The Ministry of Health is committed to safeguarding the privacy of patient information, and has implemented measures to comply with its obligations under the *Health Records and Information Privacy Act 2002*. All staff must comply with this legislation.

However, the confidentiality principle must also be considered in the context that families and carers often know the patient best, being positioned to provide information relevant to safe and effective care planning for the patient. Staff should consider the significant and supportive role family and carer information provision can play in relation to MHRT hearings, clinical assessment, treatment, risk management and the promotion of recovery and relapse prevention.

With regard to the sharing of patient information with a carer:

- the patient's informed consent must be sought *except* in specific circumstances established within s.71 to s79 of the MH Act;
- Where patient capacity is in doubt, a professional assessment of capacity to make decisions regarding the disclosure of information must be undertaken by the psychiatrist or their delegate;
- If it is determined that the patient does not have this capacity, these decisions are delegated to the authorised representative or carer for the patient;
- Where practicable, it should be explained to the patient that disclosure of his or her information to the carer is part of the Network's duty of care in relation to patient safety and well-being. Privacy law also allows for the disclosure of personal health information to lessen or prevent a serious and imminent threat to the life, health or safety of any person. Exemptions therefore exist to the confidentiality principle depending on the scale of the risk of harm to the patient. Refer to section 11, *Using and Disclosing Personal Health Information (Privacy Manual for Health Information).*

4. Definitions

Must

Indicates a mandatory action to be complied with.

Should

Indicates a recommended action to be complied with unless there are sound reasons for taking a different course of action.

Carer (*NSW Carers (Recognition) Act 2010*)

(1) For the purpose of this Act, a *carer* is an individual who provides personal care, support and assistance to another individual who needs it because that other individual:

(a) has a disability; or

(b) has a medical condition (including a terminal or chronic illness); or

(c) has a mental illness; or

(d) is frail and aged.

(2) An individual is not a *carer* in respect of care, support and assistance he or she provides:

(a) under a contract of service or a contract for the provision of services; or

(b) in the course of doing voluntary work for a charitable, welfare or community organisation; or

(c) as part of the requirements of a course of education or training.

(3) To avoid doubt, an individual is not a *carer* merely because he or she:

(a) is the spouse, de facto partner, parent, child or other relative of an individual, or is the guardian of an individual; or

(b) lives with an individual who requires care

5. Legislation and Related Documents

Legislation	*Carers (Recognition) Act 2010* *Children and Young Persons (Care and Protection) Act 1998* *Health Records and Information Privacy Act 2002* *Mental Health Act 2007* *Mental Health (Forensic Provisions) Act 1990* *Mental Health Regulation 2013* *Health Records and Information Privacy Act 2002* *Work Health and Safety Act 2011* *Work Health and Safety Regulation 2011*
The Network Policies and Procedures	1.037 *Long Bay Hospital Admission Policy (Referral, Admission and Assessment) (Adults)* 1.036 *Health Assessments (Adolescents)* 1.070 *Child Residents (In Adult Correctional Centres) – Clinical Responsibilities* 1.075 *Clinical Handover* 1.080 *Clinical Services Provided by Justice Health & Forensic Mental Health Network* 1.085 *Consent to Medical Treatment - Patient Information* 1.230 *Health Care Interpreter Services – Culturally and Linguistically Diverse*

	Patients and d/Deaf Patients 1.225 *Health Assessments in Male and Female Adult Correctional Centres and Police Cells* 1.300 *Remote Off-Site and After Hours Clinical Services Policy* *1.335 Referrals of Young People to the Community Integration Team* 1.336 *Referral (Adults and Adolescents) Forensic Hospital* 1.337 *Admission (Adults and Adolescents) Forensic Hospital* 1.338 *Transfer of Care (Adults and Adolescents) Forensic Hospital*. 1.443 *– Custodial Mental Health Referral and Case Management Policy* 4.030 *Requesting and Disclosing Health Information Policy* *Forensic Hospital Telephone Calls and Audio Visual Contact Policy* *Forensic Hospital Visits Policy* *Forensic Hospital Visits – Approval Procedure* *Prohibited and Controlled Items Policy – Forensic Hospital*
The Network Forms	SMR025.170 *Nomination of Designated Carer(s)*
NSW Health Policy Directives, and Guidelines	PD2019_025 *Aboriginal Cultural Activities Policy* PD2012_16 *NSW Aboriginal Health Plan 2013-2023* PD2013_007 *Child Wellbeing and Child Protection Policies and Procedures for NSW Health* GL2019_008 *Communicating Positively: A Guide to Appropriate Aboriginal Terminology* GL2014_002 *Mental Health Clinical Documentation Guidelines* GL2014_002 *Mental Health Clinical Documentation Guidelines* IB2017_027 *Right to access medical records by legal representative - Mental Health Review Tribunal* *NSW Health Privacy Manual for Health Information* *Using and Disclosing Personal Health Information (Privacy Manual for Health Information).*
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