

Guideline



Health
Hunter New England
Local Health District

Mental Health: The Five Point Plan for Families and Clinicians. Implementation and Evaluation

Sites where Guideline applies	All Mental Health Sites
Target audience	All Mental Health staff
Description	This guideline supports the implementation of the tool titled "Phases of Family Engagement" (A Five Point Plan). This tool provides a framework for working with and partnering with families and carers of mental health consumers or patients in order to ensure they are included within the clinical phases of care in both inpatient and community care settings.

[Hyperlink to Guideline](#)

Keywords	Five Point Plan; Engagement; Families; Carers; Service Provision; National Standard 2; Partnering with consumers
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Replaces existing document?	No
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Related Legislation, Australian Standard, NSW Ministry of Health Policy Directive or Guideline, National Safety and Quality Health Service Standard (NSQHSS) and/or other, HNE Health Document, Professional Guideline, Code of Practice or Ethics:

- See references on page 6

Tier 2 Director responsible for non-clinical guideline and authorised by	Dr Martin Cohen Director HNE Mental Health Services
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Note: Over time links in this document may cease working. Where this occurs please source the document in the PPG Directory at: <http://ppg.hne.health.nsw.gov.au/>

GUIDELINE

What is the Five Point Plan?

The Five Point Plan is a map which indicates specific points across the care of the consumer (from admission through to discharge) and which:

1. Outlines the responsibilities of staff of our Mental Health Service (MHS) at those specific points
2. Articulates to carers and family what they can expect from the MHS at those points.

Consisting of two complementary documents (one for families and one for clinicians) it establishes best practice for HNE Health.

Compliance

It is an expectation that staff will comply with this guideline. It is recognised that some patients/consumers do not have supportive family or carers and that there are instances where treatment offered may preclude the application of all phases of the 5 point plan. Staff must have sound reasons for not implementing standards or practices set out within the guideline and these must be clearly documented.

Rationale

The engagement of families/carers in the phases of clinical care for consumers is essential to the provision of evidence based quality care to mental health patients. Partnering with families/carers of consumers is a requirement of the National Standards for Safety and Quality in Health Care and additionally sits within the provisions of the NSW Mental Health Act. Within the National Standards for Safety and Quality in Health Care, health organisations must demonstrate genuine consumer and community partnership in planning services, designing care and monitoring and evaluating our services. The NSW Mental Health Act acknowledges the role of carers and family members through specific provisions for collaborating with a carer or supportive family members regarding the consumers care and treatment. Failure to engage carers and or supportive family members in the provision of care, and its associated processes, place consumers at risk of harm or relapse. It should be noted that where abusive relationships exist within families care should be taken to ensure communication only occurs with non-abusive carers/family members.

Effective partnership embraces a philosophy of 'working with' people, rather than 'doing to' people, and has been shown to bring significant benefits in clinical quality and health outcomes. There are also improvements to people's experience of care, lower costs and broader individual and community benefits.

Risk Category: Clinical Care and Patient Safety;

Risk Statement: Evidence demonstrates that the failure to engage carers and families in critical points along the care continuum can compromise the safe and appropriate care of mental health consumers. The Five Point Plan for Families and Clinicians identifies those critical points and articulates the responsibilities and expectations at each point for both groups.

IMPLEMENTATION PLAN

Unless otherwise indicated, at admission to each service carers/family members/guardians will be provided a Five Point Plan document in the admission pack. Not all phases of treatment will occur in one setting but may occur over a number of settings.

Excellence

The Five Point Plan indicates the appropriate use of Excellence tools and tactics and Patient Care Essentials that can assist with the implementation and measurement of engagement throughout the care continuum. Clinicians are expected to utilise these strategies as appropriate.

Procedure

This procedure is applicable to both inpatient and community settings

Note: The following should be applied in the case of voluntary or involuntary patients.

On presentation to a Mental Health Service (inpatient or community) the identification of people to contact such as supportive family members that may additionally be designated carers/and or a principal care provider is required (see MHA 2007).

A person (consumer/patient) may nominate up to two “designated carers” and an authorised medical officer can additionally identify another carer “principal care provider”. Both are entitled to receive information about the consumer’s treatment.

A ‘*Designated Carer*’ can be a guardian, parent, spouse/partner, relative or close friend; meaning a friend or relative who maintains both a close personal relationship with the person through frequent personal contact and a personal interest in their welfare, and who does not provide support to the person completely or usually on a paid basis (e.g. care worker, lawyer, etc). **This however should not prevent discussions with community partners or other Government agencies that support care co-ordination processes or discharge planning.** The “designated carer” was previously known as the “primary carer”.

Please note: a relative of a patient who is an Aboriginal person or a Torres Strait Islander includes a person who is part of the extended family or kin of the patient according to the indigenous kinship system of the patient’s culture.

A ‘*Principal Care Provider*’ is the person who is primarily responsible for providing supportive care for a consumer (other than completely or usually on a paid basis). **This however should not prevent discussions with community partners or other Government agencies that support care co-ordination processes or discharge planning.** The nomination of a principal care provider is accepted only from an authorised medical officer and allows that person to be provided with the same information about the consumer to the designated carer. The quality and nature of the relationship between the consumer and potential principal care provider is paramount in clinical decision making regarding a principal care provider and should be determined in conjunction with the multidisciplinary team. For example, a medical officer should not determine the partner of a consumer to be a Principal Car Provider if domestic violence has been disclosed, suspected or confirmed within the relationship.

Note: Although a **person** (consumer/patient) has the right to exclude individuals from receiving information about them, an authorised medical officer or a director of community treatment is not required to give effect to a nomination, an exclusion or a variation or revocation of a nomination, if the officer or director reasonably believes:

- (a) that to do so may put the patient or nominated person or any other person at risk of serious harm* (as per MHA 2007), or
- (b) that the person who made the nomination, variation or revocation was incapable of making the nomination, variation or revocation.

*Serious harm is a broad term that can best be understood in terms of its everyday usage. It can include:

- physical harm
- harm to reputation and relationships
- financial harm
- self-neglect
- neglect of others, e.g. the person’s children.
- history of relapse,
- noncompliance,
- a risk to themselves or others
- exclusion compromises treatment planning

Phase one – Presentation/Allocation

At introduction of a consumer to the Service the Clinician will:

- Identify the family member(s)/carer(s) for contact by completing the designated carer/s nomination form with the patient/consumer. Alternatively, if family member(s) or carer(s) have already been nominated by the patient/consumer as designated carer(s) establish contact with those nominated. Please note that a patient/consumer may additionally have a principal care provider as defined above.
- Contact family member(s) or carer(s) to confirm nomination, note contact in Care Coordination Planning Checklist.
- Ask family/carers for collateral history and request information that may assist initial assessment. Document in A1
- Acknowledge family/carers concerns and offer support
- Relay relevant information re patient and carer rights, patients condition, admission and plan
- Provide carer information with service contact details (service/unit brochures and information); explain process of admission, immediate treatment plans, acknowledge and document concerns.
- Where relevant ensure completion of A1 sections on children; family/carers responsibilities
- Ensure mandatory child protection notifications and screening for domestic violence are completed and documented when required.
- Complete Identification of Principal Care Provider Form (Medical Officer only) if required and follow the above mentioned sequence.
- Document a rationale for nominating a person as a Principal Care Provider if the patient/consumer had wished to exclude that person from information about their treatment. See above **notations* for possible rationale

Phase two – Building Relationships

The Clinician will:

- Orientate family/carers to the Service including key staff members, contact details of treatment team and relevant procedures
- Explain the purpose of case management/treatment provided and how it will be applied in their unique circumstances
- Address family/carers expectations and ascertain their capacity to “manage”
- Provide and update on patients/consumers condition and proposed treatment options
- Acknowledge family/carers concerns and offer support
- Provide a family/carers pack, introduce family/carers support map and refer to relevant websites

Phase three – Inclusive Assessment

The Clinician will:

- Request knowledge and observations of the family/carers that may be relevant to consumers treatment and care
- Elicit and respond to any family/carers concerns particularly regarding risk or safety
- Provide information about family/carers services and pathways for specialist support

Phase four – Treatment

The Clinician will:

- Continue to offer information about care and, where appropriate, treatment.
- Consult with the family/carers about treatment and care plans.
- Ask about family/carers perception of wellness, risk, current problems/needs.
- Family/carers to be invited to care planning meetings and appropriate reviews.
- Notify family/carers of Mental Health Tribunals and be given the opportunity and support to attend this

process.

- Continue to assess capacity of family/carer and reinforce the need for to care for themselves. Provide information about family/carer services and pathways for specialist support

Phase Five – Discharge Planning

The Clinician will:

- Include family/carer in discharge planning.
- Give the family/carer information that includes; care provided, follow-up services and service providers and crisis contact numbers such as the MH Access Line PH 1800 011 511. A discharge summary and or wellness plan is to be provided to the family/carer.
- Give carers the opportunity to provide feedback via:
 - family/carer survey
 - through discussion
 - follow up phone calls
 - complaint/compliment mechanism

Escalation of Care by family/carers to staff in inpatient settings:

If a family member/carer escalates concerns to a staff member about a deterioration of the patients' physical or mental condition, staff are required to act on that concern. The required outcome is the appropriate care of the patient to the family/carers satisfaction. Any action taken to address family/carer concerns has to ensure that appropriate care is delivered.

Clinicians are required to:

- Discuss with the family/carer the nature of their concerns
- Assess the patient
- Respond in accordance with clinical guidelines which may mean a discussion with the team and in some cases requesting a medical review
- At all times feedback to the family/carer must be provided and, should a family/carer not be satisfied with the response to their concerns, they must be able to escalate the issue to a higher level (e.g. the nurse in charge, After-hours Nurse Manager, on-call doctor etc. depending on the setting)

All actions must be documented in the clinical record.

Specific populations

Non-admitted presentations: In circumstances where people present to Emergency Departments/PES best effort should be made to contact family/carers to notify presentation and health status of their loved one and to request a collateral history. Staff should document family/carer concerns and provide information to address issues related to presentation. A collaborative approach should be taken in regard to the formulation of any plan.

Young carers: Sometimes young people are carers for a parent or an older relative. Staff should be mindful of this and seek to clarify the role of young people in the consumer's life. Where people are identified as young carers offer support, education and information to better assist them to understand their parent or family member's illness and care needs.

Aboriginal and Torres Strait Islander population: Aboriginal and Torres Strait Islander people have a diverse culture with a rich and compelling history. The impact of colonisation, legislation and the stolen generation created significant hardships for Aboriginal and Torres Strait Islander people. These problems continue today and impact on Aboriginal and Torres Strait people and their mental health. The impact of history is associated with problems such as anxiety, post-traumatic stress disorder and depression.

Critical points identified within the Five Point Plan can assist staff to elicit and address the needs of Aboriginal and Torres Strait Islander people. Considerations such as who may be caring for the consumer or who should participate in care planning needs should be done in a culturally respectful manner incorporating aspects of the Respecting the Difference training for Health staff. Aboriginal and Torres Strait Islander people are resilient and tolerant and are able to cope with adversity with the support of their strong kinship systems and their acceptance of diversity.

To successfully engage Aboriginal and Torres Strait Islander people in services, staff should adopt a “whole of family” approach to working with indigenous people and their families. The wellbeing of an individual is linked to the wellbeing of all significant others within the family unit. Extended family or kin of the consumer according to the indigenous kinship system of the consumer’s culture is considered a relative and as such is the person(s) for contact.

Culturally Diverse populations: Family/carers from culturally and linguistically diverse backgrounds may face more barriers than other carers. These barriers may include:

- Language and communication difficulties
- Lack of understanding of the health, community care, aged care and disability systems
- High levels of stigma surrounding disability and mental illness in some communities
- Fear of the lack of confidentiality, particularly in smaller communities
- Lack of information in their own language

If the consumer or a carer or both, identify themselves as being from culturally and linguistically diverse background it is mandatory to check whether they are fluent in English. Health professionals have a responsibility to provide a health care interpreter for the care of patients/clients/residents /carers with limited English or who are deaf.

Note: Staff are required to undertake the following language assessment:

1. Identify country of birth and language spoken at home or preferred language
2. Complete Interpreters Action Checklist in patient’s file and/or CHIME
3. Assess and rate the level of English language skills as either: Excellent; Good; Basic; Survival or None. The following scale is used as a guide to assessment:
 - A) Excellent – speaks and understands English fluently including medical and health terminology.
 - B) Good - speaks and understands concepts including health terminology and symptomatology.
 - C) Basic – can hold simple conversations but not detailed concepts regarding health conditions, symptoms of illnesses.
 - D) Survival – a few basic phrases and words.
 - E) None – speaks no English at all.

If English language skills are Survival, Basic or None a Health Care Interpreter MUST be organised

Lesbian, Gay, Bisexual, Transgender and Intersex populations (LGBTI):

LGBTI individuals face health inequalities linked to societal stigma, discrimination, and denial of their civil and human rights. Discrimination against LGBTI persons has been associated with high rates of psychiatric disorders, substance abuse, and suicide. Experiences of violence and victimization are frequent for LGBTI individuals, and have long-lasting effects on the individual and the community. Personal, family, and social acceptance of sexual orientation and gender identity affects the mental health and personal safety of LGBTI individuals.

Staff should ask about how being LGBTI affects the consumer/patients relationships with their family, parents, foster parents, and/or caregivers. It is important to engage families as allies to promote support for their LGBTI child/adult and staff need to help families identify supportive behaviours that help protect against risk and help promote their LGBTI loved one’s well-being.

EVALUATION PLAN

Evaluation will be by means of:

- Local mental health services with co-located inpatient units - random sample 10 admissions for each inpatient service including short stay (48 hour admissions) identifying two components for each admission as follows:
 - A) Source of information of the Mental Health Assessment (A1) details the Carers (designated and or principal care provider) have been documented as providing collateral information for the assessment
 - B) Nurse Unit Manager to audit the Care Coordinator Planning Checklist identifying that Carers (designated and principal care providers) have been informed at the point of the patients discharge of the patient's plans for treatment and management
- Local mental health community teams - random sample 10 Mental Health Assessment (A1) per month using parameters relating to evidence of family/carer inclusion and collaboration in the assessment process.

Note above audits to be sent to the Executive Leader Quality Risk Compliance & Audits for tabling at the overarching Mental Health Clinical Quality and Patient Care Committee
- Quarterly reports of above audits to be presented at the Clinical Quality & Patient Care Committee. The aim of 85 % compliance of all admissions having gathered collateral history from designated/principal care providers which includes the Nurse Unit Managers (NUMs) reporting using the Care Coordinator planning checklist that patients being discharged have had their designated/principal care providers contacted and informed of the patient's discharge, their treatment and plans for management.
- YES survey results using two parameters relating to family involvement
- HNEMH Family/Carer survey results
- Complaint and compliment data% of chime activities identified as either: AA (Educate) Family Psycho-social; AA (Other) Family Consultation or AA (Therapy) Family

REFERENCES

- NSW Mental Health ACT 2007 Section 74
- The *Mental Health (Statutory Amendment) Bill 2014*
- NSW Mental Health Commission (2014). Living Well: A Strategic Plan for Mental Health in NSW.
- NSW Children and Young Persons (Care and Protection) Act 1998 No 1Five7
- NSW Aboriginal Health Plan 2013 -2023
- National Standard 2: Partnering with Consumers
- http://www.safetyandquality.gov.au/wp-content/uploads/2012/10/Standard2_Oct_2012_WEB.pdf
- Hunter New England Local Health District Strategic Plan Towards 2016
http://www.hnehealth.nsw.gov.au/_data/assets/pdf_file/0007/9Five06Five/strategic-plan-towards-2016.pdf
- Domestic Violence Identifying and Responding
- A Framework for Partnering with Patients and Community – 2014
- Children and Adolescents - Guidelines for Care in Acute Care Settings PD PD2010_034
- Care Planning in Mental Health PCP PD 2011_01Five
- PD 2008_067 PCP2 Mental Health: Working with Carers from Culturally and Linguistically Diverse (CALD) Backgrounds PCP
- Provision of Culturally and Linguistically Appropriate Care to Clients from Multicultural Backgrounds and the Deaf PD2012_020:PCP 1
- HNELHD _POL 1204 Minimum standards of Patient Care for Adult Mental Health Patients
- HNELHD pol 14_0Five PCP Five MH Children Visiting an Inpatient Mental Health Ward
- Open Disclosure PD2014_028

CONSULTATION WITH KEY STAKEHOLDERS

This document is the result of consultation with numerous stakeholders including consumer and carer representatives, Mental Health Service management and senior clinical staff.

FEEDBACK

Any feedback on this document should be sent to the Contact Officer listed on the front page.



Phases of Family Engagement – A FIVE Point Plan for Families

<p>Phase 1: The Beginning</p> <p>A team member will contact you as part of the entry into service of your loved one/friend They will:</p> <ul style="list-style-type: none"> • Acknowledge your strengths and input. • Provide you information on patient and family/carer rights regarding confidentiality and privacy within the service. • Acknowledge and respond to your concerns and provide relevant information about services and treatment. • Explain what happens next. • Try to meet cultural needs when possible while gaining your input. <p><i>When talking with team members be sure to tell them if:</i></p> <ul style="list-style-type: none"> • <i>There are any linguistic or cultural issues or needs</i> • <i>There are children or older people in the family that need to be considered.</i> • <i>There are safety concerns for yourself or others</i> • <i>You are a Young Carer</i> <p><i>You may be asked these questions more than once during the admission to service.</i> <i>If your family member/friend is admitted to an inpatient unit and you noticed a deterioration in their health please raise your concerns with a member of the treating team.</i></p>	<p>Phase 2: Building Relationship</p> <p>You will be orientated to the mental health service and provided with a <i>Family/Carer Pack</i> and details of the treating Dr and others who will be involved in their care.</p> <p>Designated carers and principal care providers (including Young Carers/ persons responsible/guardians) are always the primary point of contact for the team.</p> <p>Your contact details and those of other key family members/guardians will be documented. <i>This will include names and ages of any children.</i></p> <p>For those under the Mental Health Act:</p> <p>The team will provide information about patient and carer rights, MH Act proceedings (eg MH Tribunal/Community Treatment)</p>	<p>Phase 4: Treatment</p> <p>You will:</p> <ul style="list-style-type: none"> • Receive information about care and treatment. • Have the opportunity to consult with the team about treatment and care plans. • Be asked about your perception of wellness, risk, current problems and needs. • Be invited to care planning meetings and reviews within inpatient units and some community teams. • Notified of Mental Health Tribunals and be given the opportunity and support to attend this process. • Provided information about family/ carer services and pathways for specialist support. 	<p>Phase 5: Discharge & After</p> <p>You will:</p> <ul style="list-style-type: none"> • Be included in planning for discharge from the service. • Be given information about care provided, follow-up services and service providers. • Be provided with crisis contact numbers such as the MH Access Line PH 1800 011 511. • Be given the opportunity to provide feedback . You or your loved one should receive a follow-up phone call 24-48 hours after discharge from the inpatient unit <p><i>If you do not understand any aspect of this process or plan please ask the team!</i></p>
	<p>Phase 3: Inclusive Assessment</p> <p>You will be asked if you have:</p> <ul style="list-style-type: none"> • Any concerns or needs (including support options and cultural needs). • Any concerns about risk or safety. • Any other information that is relevant to treatment and care. <p>You WILL be included in the care planning.</p>	<p>Hunter New England Mental Health service would like to acknowledge the traditional custodians of this land and pay respect to the elders past and present of this nation. We would also extend that respect to other Aboriginal people present on this nation.</p>	<p>In recognising, supporting and including families and carers in treatment, planning and service provision we also believe an individual's family/carer or close friend are very good judges of a decline in a loved one's health.</p>

Developed by Family and Carer Advisory Committee 2015



Phases of Family Engagement – A FIVE Point Plan for Clinicians

<p>Phase 1: Presentation</p> <ul style="list-style-type: none"> Identify and contact designated and or principal care provider / supportive family member Request information that may assist initial assessment Relay relevant information re patient and family/carer rights, patients condition, admission and plan Provide family/carer with contact details of service Acknowledge family/carer concerns and offer support <p>KEY NOTES FOR ASSESSMENT:</p> <ul style="list-style-type: none"> Are there any cultural issues? Are there children or older people in the family that need to be considered? Are there safety concerns for the patient, family/carers or others prior to any contact Is this a Young Carer? <p>Appropriate Excellence tools to use</p> <ul style="list-style-type: none"> HAIDET CLINICAL HANDOVER WITH CARER <p>For information and resources for carers http://www.hnehealth.nsw.gov.au/mh/mhpublicresources/mhfc and http://www.kidsfamilies.health.nsw.gov.au/</p>	<p>Phase 2: Building Relationship</p> <ul style="list-style-type: none"> Orientate family /carer to the Service including layout, key staff members, contact details of treatment team and relevant procedures and visiting hours Provide and update on patients condition and proposed treatment options Acknowledge family /carer concerns and offer support Provide carer pack , carer /family support map and pamphlet <i>Recognising Deterioration in Patients/Consumers</i> (located in hnehealth ink provided) <p>For those under the Mental Health Act:</p> <ul style="list-style-type: none"> Explain the relevant details about MHA proceedings, patient and carer rights and responsibilities and provide written information 	<p>Phase 4: Treatment</p> <ul style="list-style-type: none"> Offer information about care and treatment. Consult with the family/carer about treatment and care plans. Ask about family/carer perception of wellness, risk, current problems/ needs. Invite family/carer to care planning meetings/reviews within all inpatient units and some community settings Notify carer of Mental Health Tribunals and be given the opportunity and support to attend this process. Provide information about family / carer services and pathways for specialist support (<i>Carer Pack and Family/Carer Support Map</i>). If a family member raises concerns regarding a deterioration in health you are required to act on those concerns. <p><i>In the case of incidents whilst in care:</i></p> <ul style="list-style-type: none"> Advise carer of incident and current condition and offer support Open disclosure if appropriate <p><i>Note: If a family member raises concerns regarding a deterioration in health you are required to act on those concerns</i></p> <p>Appropriate Excellence tools to use are:</p> <ul style="list-style-type: none"> HAIDET CLINICAL HANDOVER INCLUDING PATIENT & CARER PATIENT CARE BOARDS FAMILY/CARER ROUNDING 	<p>Phase 5: Discharge Planning</p> <ul style="list-style-type: none"> Include family/carer in discharge planning. Give information that includes: care provided, follow-up services and service providers and crisis contact numbers such as the MH Access Line PH 1800 011 511. Give family/carer the opportunity to provide feedback . Advise of the follow-up phone call within 24-48 hours (inpatient). <p><i>Take time to ensure the carer understands all aspects of this process and plan</i></p> <p>Appropriate Excellence tools: to use are</p> <ul style="list-style-type: none"> HAIDET CLINICAL HANDOVER INCLUDING PATIENT & CARER PATIENT CARE BOARDS FAMILY/CARER ROUNDING FOLLOW UP PHONE CALL DISCHARGE SUMMARY <p>Recognising, supporting and including families and carers in treatment, planning and service provision. See Guidelines <i>Mental Health: The Five Point Plan for Families/Carers and Clinicians. Implementation and Evaluation</i></p>
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