Government of **Western Australia**
Department of **Health**
North Metropolitan Health Service Mental Health

Good Practice Guidelines for Engaging with Families and Carers in Adult* Mental Health Services

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May 2016

*** The guidelines may be applicable to other programs and age groups subject to amendments and/or addenda.**

Good Practice Guidelines for engaging with families and carers in mental health services

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Introduction

Families, carers and other people providing unpaid assistance and support ('support persons') often play a fundamental role in supporting people with mental illness, and can be a valuable resource to mental health services with their personal commitment, unique perspective, knowledge and expertise.

A collaborative approach to decision making in the treatment and care of the person with mental illness has broad benefits for everyone involved. Conversely, a lack of engagement and communication by mental health staff can lead to distress, resentfulness and frustration on the part of the person with mental illness and their support persons.[1]

Clinicians understand the benefits of working collaboratively with families, carers and other support persons, but face important dilemmas. The most important of these is balancing the person experiencing a mental illness' wishes and rights to confidentiality and privacy with the support persons' need for information. Clinicians are also mindful that disclosing information might compromise trust or attract litigation.

Western Australia's Mental Health Act 2014 (MHA 2014) now provides greater protection for clinicians and persons with a mental illness, and also facilitates the involvement of support persons.

Purpose of guidelines

These guidelines were designed to support mental health staff in engaging with support persons, while also recognising and respecting the rights of individuals with mental illness to decide who will be involved in their care.

The guidelines are evidence-informed and principle-based. A set of four modules have been created which reflect international good practice principles, and which can assist in the implementation of the MHA 2014 when communicating and engaging with support persons. The guidelines were derived from key literature searches conducted across 2012-2015 to scope the strengths and gaps in existing resources, current legislation and local guidelines (Appendix 1), and action learning exercise with key stakeholders.

The guidelines are in line with the ethical and legal principles underlying the MHA 2014. For further information about the MHA 2014, please see Appendix 2.

The information contained in these guidelines is for general guidance only and should not be taken as legal advice.

[1] Jungbauer et al., 2004

Key definitions

Personal support persons ('Support Persons')

Under the MHA 2014, a personal support person is a broad term referring to any of the following:

Carer

A carer is a person who provides personal care, support and assistance to another person who has a disability, a medical condition, a mental illness, an alcohol or other drug issue, or is frail.[2] Very often, a carer is a family member, legal guardian, friend, or someone from the community.

A person, however, is not to be considered a carer simply because they are a family member or legal guardian.[3] The person with mental illness may not have regular contact with their family or guardian. Alternatively, the family member or guardian may not identify themselves as the person's carer.

Family member

A family member is a member of the person's family: A spouse, partner, child, step child, parent, step parent, foster parent, sibling, grandparent, aunt or uncle, niece, nephew or cousin. If the person is of Aboriginal or Torres Strait Islander descent, family includes any person regarded under the customary law, tradition or kinship of that person's community[4].

Under the MHA 2014, a *close* family member is a member of the person's family who provides ongoing care or assistance.

Elder or traditional healer

Where the person with mental illness is of Aboriginal or Torres Strait Islander descent, a support person may also be an Aboriginal or Torres Strait Islander mental health worker, elder or traditional healer.

Nominated Person

A Nominated Person is an additional category of support person. Under the MHA 2014, a person with mental illness can choose one special person to help and support them while they are receiving treatment and care. The Nominated Person has a right to receive information and be involved in matters related to the person's mental health treatment and care.

In this document, the term '*Support Person'* is used to refer to any of the above mentioned categories.

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[2] Australian Health Ministers Advisory Council / National Mental Health Strategy (2013)

[3] Carer Recognition Act, s 5. The same Act also excludes people who provide services in a paid capacity or as a volunteer.

[4] Mental Health Act 2014, s 281.

Principles

The guidelines are informed by a number of key principles drawn from legislation, practice guidelines and existing frameworks.[5] They also reflect the MHA 2014's new Charter of Mental Health Care Principles (Appendix 3).

Principle	Interpretation
Collaboration	Acknowledging that support persons have an important role to play in an individual's journey of both personal and clinical recovery. It involves developing a sound and mutual working relationship with the support persons. Collaboration includes exchanging information at key points during care, listening to support persons' opinions, assisting them in identifying options and incorporating their preferences where possible.
Diversity	Appreciating that all stakeholders have different experiences and participation requirements. It involves acknowledging the diversity of people with mental illness and their support persons.
Respect	Fostering a positive and respectful attitude between different care stakeholders to enable better participation and problem-solving. The individual's right to privacy which must be upheld to the fullest extent possible. Support persons must be treated with respect, and their views can also be taken into account when decisions are made about an individual's care and treatment. Support persons should be treated with respect and dignity as per The Carers Charter.[6]
Flexibility	Commitment by all care stakeholders to a flexible and strengths-based approach that can adapt to an individual with mental illness' changing care needs over time. Support persons should be provided with information and orientation, and be guided to services that can help them undertaken their caring role.
Rights	Appreciating that the person with a mental illness has a right to choose who will be involved in their care under the MHA 2014. Appreciating also that support persons may be unable to participate, and have the right to decline to participate, in an individual's care. Support persons also have rights under the Carers Recognition Act 2004 which applies to all WA Health Services and those services it funds[6], and to make a complaint about the way they have been treated[7].
Involvement	Recovery oriented care includes the choice and determination, by the person with mental illness, of the involvement of other people. It can also involve forming partnerships with community-managed organisations to provide support and education to support persons, which is cost-effective and productive.

[5] Adapted from NMHS MH, Consumer, Family, Carer and Community Engagement Framework, 2015
[6] Carers Recognition Act 2004
[7] www.nmahsmh.health.wa.gov.au.au/community/complaints.cfm; or through the Health and Disability Services Complaints Office (www.hadsco.wa.gov.au/home)

What do support persons do?

The caring and support role differs from person to person, and changes over time, but may include the following (Table 1)[8].

Table 1: The caring role

Clinical support	Living assistance	Personal support
Monitor symptoms and access support	**Provide personal care** and activities of daily living	**Advocate** on behalf of the person with mental illness
Manage crises and personal safety	**Transport** to appointments and shops	**Care** for children and grand-children
Supervise medication adherence, dosages and timing	**Manage finances** and give money to assist in the purchase of food, medications and other essentials	Look after **pets**
Manage destructive behaviours	**Cook, clean and shop**	**Provide emotional** support and encouragement
Display calmness and **non-violent communication** during crises	**Provide reminders** to attend medical appointments, and to self-care	Discourage use of **alcohol**, **drugs** and other substances
	Help to complete applications for housing and other benefits	Assist with **emotion regulation**

Support persons develop a unique insight and knowledge about the person with mental illness and the most effective management strategies to use during a crisis. When shared with the clinical team, this information can inform recovery-oriented care.

[8] National Carer Recognition Act 2010; Veltman et al, 2002; Van der Voort et al. 2007

What do support persons want?

Carers and families do not stop caring when the person receives treatment and care for a mental illness. Some might want to continue to play an active role in the recovery of the person with a mental illness and assist the clinical team where possible.

Research shows that support persons want:

- **Timely information** from clinical staff who are knowledgeable about the person with mental illness' treatment and care.
- **Regular communication** and dialogue about clinical progress.
- **Meaningful involvement** in agreement with the person with mental illness.
- **Education** about the nature of the problem, treatment, expected outcomes, crisis management.
- **Information about support services** for themselves (respite, counselling) or other family members (e.g. young carers) (Appendices 6-10).
- **To be listened to** when they feel that the person with mental illness is at risk of harm to themselves or others, or when they want to share information which they feel is pertinent to the persons' treatment and care.
- **Validation** of their caring role and of their relationship with the person with mental illness.
- **A trauma-informed perspective** which acknowledges that caring can involve significant family trauma and that the family might be under stress.

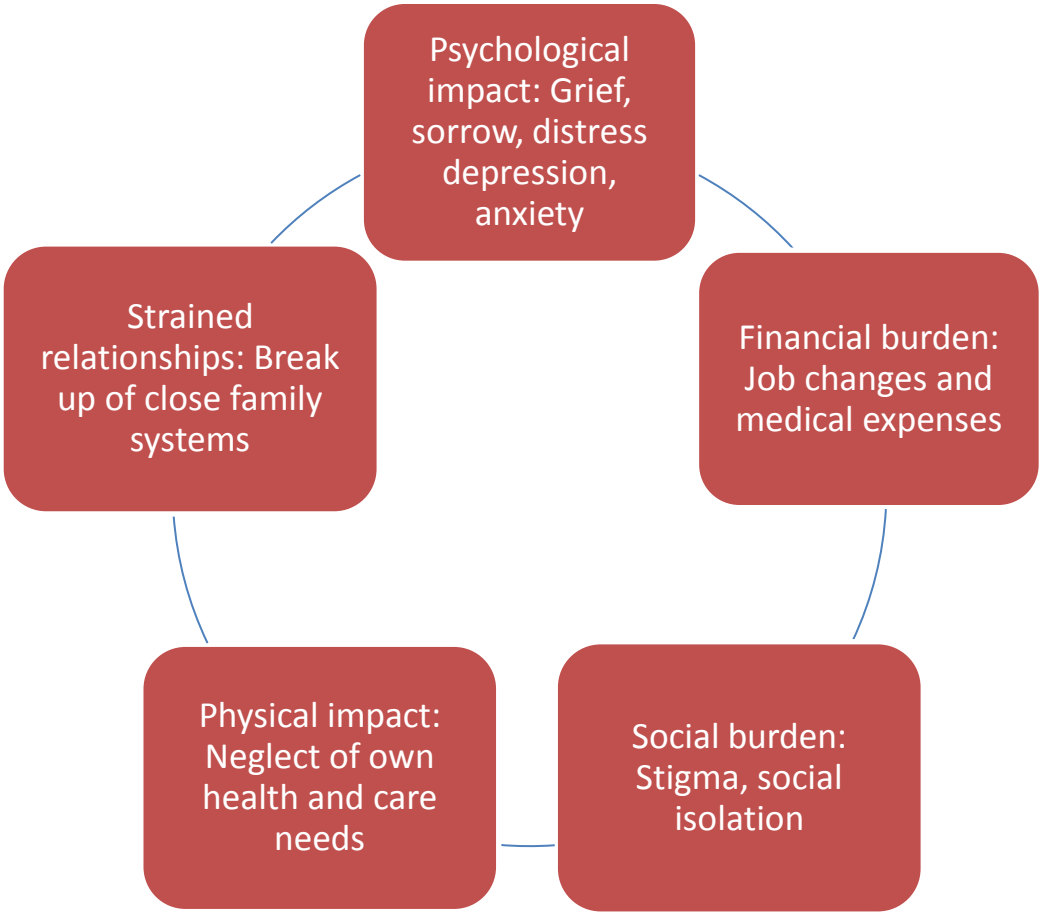
Proactive engagement with carers and families helps to foster trust towards clinicians and assists in better therapeutic relationships.[9]

[9] Slade et al., 2007; MacCourt, 2013; McGorry, 2004

The impact of caring

Support persons are vulnerable to a host of psychological, social and physical health problems.

Figure 1: The impact of caring[10]



Families and carers who receive help and who feel supported by clinicians are less prone to chronic consequences, and feel less isolated and unsupported, than those who feel excluded by the clinical team.

[10] Schultze & Rossler, 2005; Award & Vorunganti, 2008; Carers Victoria 2011; Cochrane et al, 1997; Dore & Romans, 2001; Holmes & Deb 2003; Jungbauer et al., 2004; Pinquart & Sorensen, 2007; Richardson, 2012; Song & Singer, 2006; van der Voort et al., 2007; van Wijngaarden et al., 2004; Ohaeri, 2003.

Benefits of strong partnerships with support persons

Improved outcomes occur for the person with a mental illness and their support persons when both are active participants in the treatment process. Clinicians and mental health providers also greatly benefit.

Table 2: Benefits of supporting families, carers and Nominated Persons[11]

For the person with mental illness	For support persons	For clinicians	For the facility / service
Improved mental state Decreased risk of relapse and hospital re-admission Support from a person who is trusted Day-to-day support in pursuing personal recovery goals Better quality of life Assistance with daily living tasks Reminders about the timing of medications Emotional support	Closer family relationships Improved relationships with clinicians Reduction in burden, stress, isolation and loneliness Increased sense of control Better understanding of triggers and warning signs associated with relapse Less risk of developing own mental illness	Increased treatment effectiveness (better clinical outcomes, decreased relapse rates, improved adherence to treatment) Improved rapport with the person with mental illness Improved relationships with support persons Decreased perception of barriers Increased role diversity Increased work satisfaction	Reduced rates of hospital re-admissions Decreased costs of treatment Improved delivery of preventative care services Positive community perceptions about the facility/service Major contribution to the mental health system which would be very costly to replace with paid services

[11] Chien & Norman, 2009; de Jesus et al, 1994; Dixon L et al., 2001; Falloon, 2005; Kreyenbuhl et al, 2010; Lenior et al. 2001; MacCourt, 2013; Miklowitz et al, 2003; Pitschel-Walz et al, 2001; Seikkula et al, 2006; Simpson & House, 2003; Sellwood et al., 2007

Modules

A series of modules were developed to assist in the implementation of the MHA 2014 with regards establishing effective communication with support persons, recognising their rights and need to know, and supporting them in their caring role.

Module 1	**Personal support persons**	• Early and accurate identification • Family/carers and their rights • The Nominated Person • Differences between family/carers and the Nominated Person • Helping the person with mental illness in choosing a Nominated Person • Recording and Identifying support persons and their involvement (checklist)
Module 2	**Information sharing**	• General vs personal information • Information that cannot be shared • Discussions about information sharing with the person with mental illness • When consent to share personal information is withheld
Module 3	**Ethical issues and confidentiality**	• What must I do? • What should I do? • Other confidentiality issues • If in doubt, who do I contact? • Using NMHS policy as a guide to decision making • Good practice checklist
Module 4	**Working with support persons: bringing it all together**	• Contact 1 – First contact • Contact 2 – Meeting with support persons (after consent has been established) • Contact 3 – Ongoing communication • Contact 4 – Discharge planning

Module 1: Personal support persons

This module is designed to help clinicians understand the various categories of support persons and their responsibilities towards each of them.

The default position of the MHA 2014 is that support persons[12] [13]:

- Should be informed, involved and included, wherever possible.
- Are entitled to information about their rights and those of the person with mental illness.
- Can choose how much information they want to receive, or refuse to be involved with the person's care.

1.1 Early and accurate identification

At admission, the service needs to identify support persons as early as possible.

- A record must be made of the name and contact details of each support person in the clinical records. The decision to withhold information must also be recorded[14].
- The person with mental illness should be made aware of their right to have a Nominated Person under the MHA 2014, and the effects of making the nomination.
- All WA public Patient Administration Systems (PAS) have the ability to record the details of support persons.
- The service should also discuss with the person with mental illness the extent to which they want support persons involved, and assess their capacity to decide on involvement.
- The service must also have regard to any advance health directive made by the person with mental illness, and any term of an enduring power of guardianship[15].
- Close family and carers do not need to be formally nominated with a special form (*Form 12A should only be used for the Nominated Person*), but a record must be made in the clinical records[16].

[12] Office of the Chief Psychiatrist, *Clinicians Practice Guide*, 2nd edition, October 2015, 23-24.
[13] See ss 286, 287, 288 and 289 of the MHA 2014; Also, major changes in the MHA Fact Sheet 2014
[14] The decision to withhold information must be recorded and filed, and the relevant people informed. Support persons have the right to ask for this advice in writing. MHA 2014, ss 142 and 143.
[15] See Division 4, section 8(2)(b) of the MHA 2014
[16] See NMHS MH Policy 'Release of patient information'

1.2 Family/carers and their rights

Close family members, guardians and other carers (including elder or traditional healer in some cases) are one category of personal support person.

They may be entitled to receive information and to be involved in the person's treatment and care. The best clinical outcomes often require their involvement.

Sometimes, the person with mental illness may identify close family members or carers, but does not want them directly involved in their care[17].

If the person is above 18 years of age, they have the right to choose who is involved in their care although this depends on the person's capacity and status (see Table 3)[18], whether the term of an enduring power of guardianship exists[19], and whether it is practicable to ascertain those wishes.

Whether or not the person consents to the involvement families and carers in their care, there are 25 notifiable events under the MHA 2014 of which support persons must be notified[20] (see Appendix 5).

Furthermore, even where the patient does not consent to their involvement of others in their care:

- Identified support persons are still entitled to **receive** (i) general information which builds on their existing knowledge (see Module 2), (ii) advice regarding where to obtain education, support or respite (Appendices 7-11) and what to expect from services.
- Identified support persons still have a right to **provide** information during treatment and care. This collateral information might uncover new diagnostic information or management strategies about the person with mental illness.

[17] In the case of no support person or Nominated Person, information about the Mental Health Advocacy Service should be provided.
[18] If the patient does not have capacity to make decisions, a legal guardian may be appointed. This guardian is then empowered to make decisions on the person's behalf. See Guardianship & Administration act, 2000.
[19] MHA 2014, ss 179
[20] Schedule 2 of MHA2014

Table 3: Person's capacity and status

If the person with mental illness is considered competent to make decisions regarding support person involvement… →	The refusal to involve close family members or carers must be respected[17].	For involuntary patient, the psychiatrist must decide whether the refusal to consent is reasonable and in the person with mental illness' best interest[21].
If the person with mental illness does not have capacity to make a decision regarding involvement… →	Support persons must be involved and informed, unless it is not the person's best interests.	

Table 4: Rights of identified support persons (with the person with mental illness' consent, subject to capacity and status)[22]

Be provided with information about:	Be involved:
The mental illness for which the person is being treated.	In matters relating to the person with mental illness' treatment and care.
The proposed treatment and care, and any other options reasonably available.	In discussions how to best support the person with mental illness.
The person's response to that treatment.	In the consideration of available treatment options.
Seclusion of, or use of bodily restraint on, the person.	The preparation and review of any treatment, support and discharge plan for the person
Services available to meet the person's needs	
If the person is an involuntary patient: the grounds on which (and the provision of the MHA 2014 under which) the involuntary treatment order was made.	

Support persons: What can't they do?
Apply for a person's admission or discharge on their behalf
Make a decision in regard to treatment (unless they are authorised to do so in another capacity[23]).

[21] MHA 2014, ss 142
[22] MHA 2014, s 285-289.
[23] Guardianship and Administration Amendment Act, 2000; Western Australia

1.3 Nominated Person

The concept of a Nominated Person was introduced to give the person with mental illness extra choices about who can be legally involved in their care.

Nomination assigns special rights to one person. The Nominated Person's role is to support the person with mental illness, receive and share information with the clinical team, assist in care planning and discuss available options (Table 5).

Who is the Nominated Person? [24] [25]

There are very few restrictions on who can be nominated. The Nominated Person is:

- Anyone the person with mental illness feels can help or support them, and who is willing and available to take on the role.
- One person, who is an adult (aged 18 or over), and with whom a relationship exists. It may be a partner, a friend, a member of one's extended family, or the person's enduring guardian.
- A person who has been validly nominated with Form 12A ('Nomination of Nominated Person', Appendix 4) and who has accepted that nomination.

Exceptions or changes to the nomination

- If it not in the person with mental illness' best interest[26]. A record of the reasons for this must be placed in their clinical records and a copy given to the person with mental illness.
- The person with mental illness can revoke the nomination and choose someone else. Mental health staff should take all reasonable steps to notify the Nominated Person.
- If the person with mental illness does not want a Nominated Person, they do not have to have one. They may be happy to have broad family and/or carer involvement, or no involvement of anyone. They might also wish to exclude particular persons from their care.
- The Nominated Person has the right to refuse their nomination, and resign in writing.

[24] MHA 2014, Part 16, Division 3 outlines the roles and responsibilities of the nominated person.
[25] A nominated person could also be the individual's enduring guardian or guardian, or the person responsible for the patient under the Guardianship and Administration Act 1994. MHA 2014, s 264(6).
[26] MHA 2014, s 262.

1.4 Differences between family/carers and the Nominated Person

Having a Nominated Person does not prevent the ongoing involvement of carers and family. Clear and up-front information should be provided to the person with a mental illness about the role of the Nominated Person, and how this differs from the role of carers and close family members:

Table 5: The Nominated Person and carers/family members – Role differences

Nominated Person:	Carers, family, other support persons:
Only one person can be nominated at any given time.	**The person with mental illness can have many carers, family members and other supporters.**
Is nominated by the person.	Are not automatically chosen as a Nominated Person.
Has to be nominated by a formal documented process (Form 12A).	Do not need to be formally nominated using a form, but a note is made on the person's clinical records.
Is entitled to receive information and be involved in the person's treatment and care.	Are entitled to receive information and to be involved with the person with mental illness' consent (subject to capacity and status, see Table 3).
Can formally resign in writing, and inform staff of this.	Can inform staff that they no longer wish to receive information or be involved.
The person with mental illness can revoke the nomination and either choose another person or none at all.	The decision to exclude family/carers must be upheld (depending on the person's capacity and legal status). However the person with mental illness must be asked periodically whether they have changed their mind.

1.5 Identifying a Nominated Person

It may be helpful to assist the person with mental illness in identifying an appropriate Nominated Person.

Clinicians must also have regard to the views of support persons when determining the patient's best interests.

Table 6: Rationale for identifying a Nominated Person

Explain that:	Rationale:
They can choose and nominate one special person who can help them look after their interest and wishes.	The person with mental illness receives clear upfront information that they have a choice.
The Nominated Person may be any person who the person believes can help and support them (including a partner or friend).	The person with a mental illness may not want to involve close family members or their carers.
There are many benefits of nominating a person.	The person with mental illness: • May be carer with dependent children, relatives, or may have pets, responsibilities (e.g. work) or personal effects, for which arrangements need to be made The Nominated Person: • Is able to upheld their interest and rights • Can be present at meetings for support. • Can assist in care, discharge, prevention and relapse planning • Can receive education and support
Discuss who might be an appropriate person to nominate.	The Nominated Person should not pose any risk to the person with a mental illness, and should also be willing and available to take on the role.

1.6 Recording and identifying support persons and their involvement (checklist)

At triage/admission:
☐ Ask if the person has a close family member and/or carer (if so, record their details)
☐ Ask if the person wishes to nominate a Nominated Person (if so, complete Form 12A)
☐ Consider: ✓ Whether the person has capacity to make decisions regarding the involvement of support persons ✓ Whether the person wants the involvement of support persons ✓ Whether support persons are entitled to be involved and informed (see p. 17)
☐ Initiate discussions and an agreement on the principles of why information is communicated, how it is to be done, and what sorts of information can be shared
☐ Make a record of: ✓ **Who** the support persons are (including the Nominated Person) ✓ **How**, and **when**, information was provided to the support persons (or why it was not) ✓ **What** information was discussed and shared ✓ Efforts to **contact** in relation to the person with mental illness ✓ Reasons why information was withheld at any time from personal support persons
Review the situation regularly.

Module 2: Information sharing

It can be difficult or frustrating for clinicians when the person with mental illness has the capacity but does not provide consent to involve support persons, particularly when:

- Clinicians feel that carer/family involvement would greatly benefit the person with mental illness and recognise the family/carers' need to know.
- Carers or family members perceive the lack of open communication from clinicians as obstructive or unhelpful.

The section below outlines a practical approach to interacting with families and carers where the person has not consented to their involvement[27]. Note that disclosure of information by case managers requires an ability to negotiate the ethical issues around confidentiality, which can be assisted with supervision with a more senior clinician.

2.1 General vs personal information

Differentiating between **personal information** and **general information** is one way to balance competing needs. As a general rule, whether information is 'general' or 'personal' is **case-specific**.

- General information refers to information that is already known to the support person.
- Personal information is NOT already known to the personal support person, and is therefore 'private' (e.g. living arrangements, sexual orientation or drug use).

Every situation is unique, but the following table gives some examples of what constitutes 'general' and 'personal' information.

In the clinical records, notes should be made of information that was discussed with support persons, with whom and when.

General information can be shared without permission whereas personal information cannot.

[27] See NMHS MH Guide to Information Sharing [in preparation] for further guidance on sharing information with different stakeholders

Table 7: Examples of general and personal information

General information	Personal information
Refers to factual information **that builds on the support person's existing knowledge**.	Refers to information that is **'new' and specific** to the person with mental illness, and which may be regarded as sensitive.
General information may include: • General information about the condition for which the person is being treated (if condition already known) • General information about treatments provided for the particular condition General information **also includes**: • Services available at the current facility/service • Information about the person's rights, and about the right of support persons.	Personal information **may be**: • Identifying information (e.g. living address) • Sexual preference and orientation • History of drug use • Criminal offences • Political or cultural beliefs or opinions

Other information which can be shared without permission, as is as follows:

- How to make a complaint to the service and/or to the Health and Disability Services Complaints Office (HaDSCO).
- How to access the Mental Health Advocacy Service.
- How to access the Mental Health Tribunal.
- Contact details for Carers WA and other community managed organisations who can provide them with specialised support.
- Information about patient's rights under the MHA 2014, and how those rights can be accessed and exercised.
- Information about the rights of the carer or close family member under the MHA 2014 and how those rights can be accessed and exercised.
- Notifiable events under the MHA 2014

2.2 Information that cannot be shared

Information that cannot be shared with support persons include:

- Personal information that the person with mental illness asked specifically not to share (see exceptions in Table 3)
- Information that is in the person's best interests to keep personal and private.

2.3 Discussion about information sharing with the person with mental illness

Another way to balance competing needs is to identify information which the person with mental illness may be willing to share under certain conditions. This section and the next provide some practical guidance which can be used to negotiate which information that can be shared and with whom.

Table 8 provides some discussion strategies which may be used to:

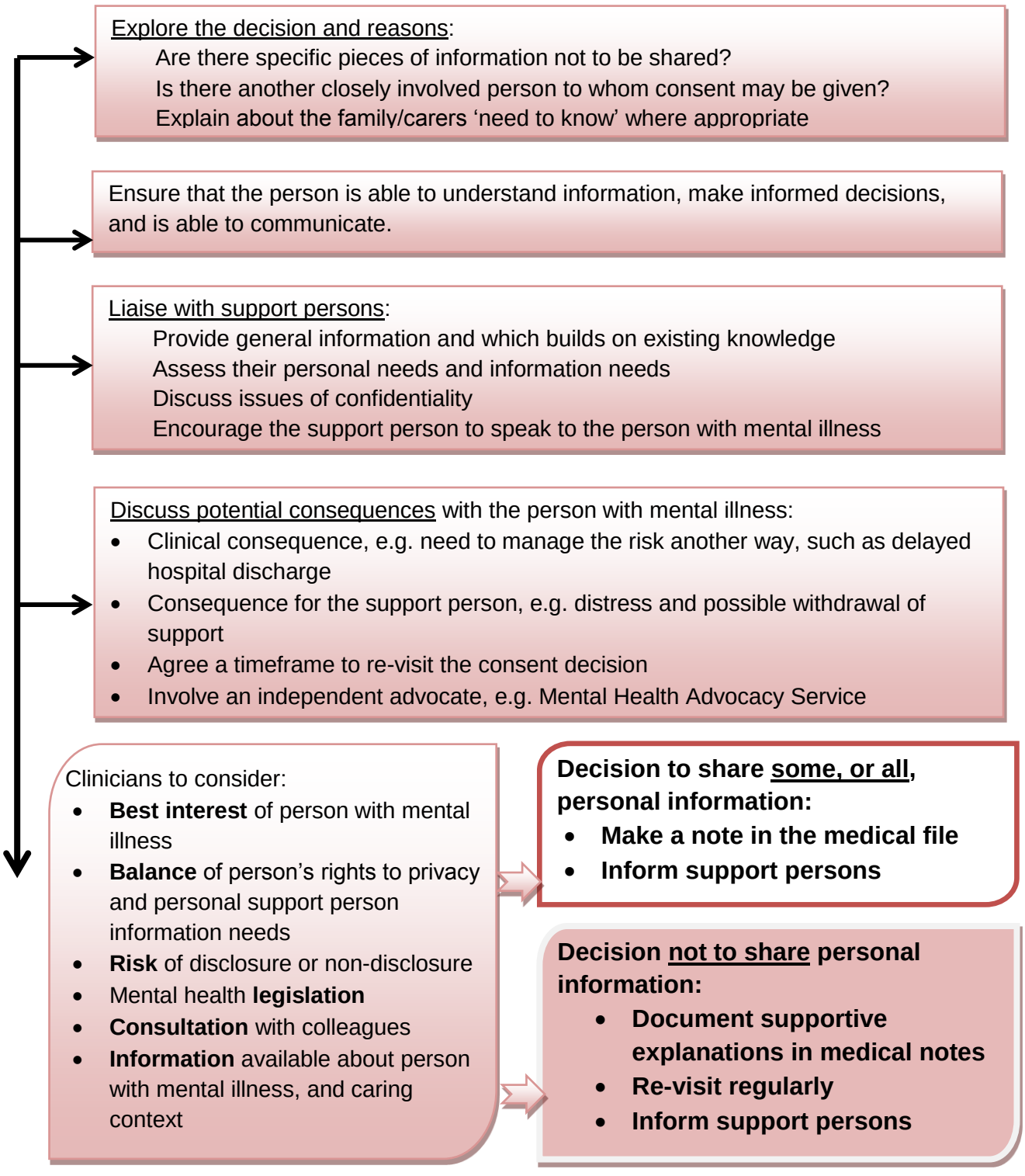
- Clarify the person with mental illness' wishes.
- Determine what personal information is already known to the support person.
- Ascertain what information can and cannot be shared, and with whom.

Table 8: Opening and sustaining discussion with the person with mental illness

- *'Do your carers or family know about your [history of drug use], [sexual preference]?'*
- *'Do you want me to discuss that with your partner, or would you rather that it remained private?'*
- *'Do you agree to let me (us) share this information with your Nominated Person?/ partner? / sibling?'*
- *This information would really help them to look after your child / pet / affairs at work.'*
- *'Is there information that you would rather not share - personal and sensitive information? We will keep this information confidential'.*
- *'You are entitled to privacy, and we can explain this to anyone who is supporting you.'*
- *'Your support person needs help in understanding your illness so that he/she can help you with your recovery. In order to do that, we have to give them some information, but it won't be anything personal.'*
- *'Legally, we have to tell your support person where you are – for example, if you leave here without telling anyone, or if we have to transfer you to another hospital. But we don't need to tell them anything that is personal about you if you don't want us to.'*

2.4 When consent to share personal information is withheld [28]

When the person with mental illness does not consent to sharing information, it is useful to explore this decision as it may be possible to negotiate what information may be shared, and with whom.



[28] Slade et al., 2007

Module 3: Ethical issues and confidentiality

This module introduces the clinician to ethical issues around the sharing of information.[29]

3.1 What must I do?

Comply with the law (including the MHA 2014), your professional obligations, and contract of employment. This may include information sharing with support persons who have been identified by the patient and are involved in their care with their consent. It may also include informing support persons of notifiable events if you are the clinician responsible for this task under the Act (see Appendix 5). Sometimes it may involve withholding information even from identified support persons, but this must always be clearly communicated and documented.

Provide the person with a mental illness with the opportunity to identify their choice of support persons, including nominating an appropriate person who is not a family member or carer, but who can assist them in making sure that their rights, interest and wishes are taken into account.

Provide support persons with information relating to the individual's treatment and care, as long as the patient has identified the person as someone who can be involved in their care. This is also subject to a 'best interests' exception, which must be documented and recorded.

Allow and encourage support persons to communicate with the person with mental illness. This is also subject to a 'best interests' exception, which must be documented and recorded.

Keep accurate records of communications involving all support persons, and document reasons for exceptions to information-sharing of any kind, including:

- Any conversation, visits (or restrictions on), or contact details
- All sharing of information with due regard for the patient's capacity and best interests, including that of notifiable events

[29] National Mental Health Consumer & Carer Forum 2011; Sharing – Consumers, Carers and Clinicians; Mental Health Council of Australia; Royal College of Psychiatrists.

3.2 What should I do?

Connect with identified support persons. This is the minimum level of service that should be provided. This should include an assessment of their needs and circumstances and discussions about past history of the person with mental illness, response to treatments, recent events and triggers.

Connect with excluded support persons while maintaining patient confidentiality. All families, carers and other support persons must be treated with respect, regardless of whether they are currently involved with a person's care or not. When a family member or carer is excluded by the patient from their care under the MHA 2014, this can be a difficult time for them. These family members and carers may be involved in the person's care and recovery at a later date, and should for the time being be given information on their rights under the MHA 2014 and how to access carer support services

For non-consented disclosure of confidential or personal information, clinicians should have regard to the necessity, proportionality and risks relating to the disclosure, as well as the complex set of diverse values operating in any particular situation.

3.3 Other confidentiality issues

- The confidentiality requirement may conflict with the clinician's other duties. For example, breaching confidentiality might be essential for diagnostic or risk assessment. These situations are matters of judgement and balancing of duties.
- Disclosure of a notifiable event despite refusal or withdrawal of consent is not a breach of confidentiality.
- The support persons may also have issues that they wish to keep confidential from the person being treated. However, they must be told that the information may be shared with the person with a mental illness, if clinicians judge that person with mental illness needs to know.

3.4 If in doubt, who do I contact?

- Talk to your manager or supervisor. Together, report to the program manager who will advise you on the best course of action.

3.5 Using NMHS policy as a guide to decision-making

There is legislation and NMHS MH policy already in place that cover good information sharing and the rights of support persons, and which protect the disclosure of confidential information by professionals in their professional capacity.

NMHS MH documents include:

- NMHS MH Public Patients' Charter
- NMHS MH Carer and Consumer Participation
- NMHS MH Consumer Feedback Management Guidelines 2014
- NMHS MH Adult Program – Carer and Consumers Rights and Responsibilities to Access Mental Health Services
- NMHS MH Adult Program – Consumer and Carer Participation
- NMHS MH Adult Program - Release of patient information
- NMHS MH Adult Program – Confidentiality of Health Information
- NMHS MH Authorisation to Release Information Form (PMR3)

Other documents include:

- WA DoH Language Service Policy 2011
- NMHS MH Guide to Information Sharing [in preparation]] for further guidance on sharing information with different stakeholders

See Appendices 1 and 2 for other useful documents which can assist to make the right decisions under the current legislation.

Good practice checklist: Carers and confidentiality in mental health[30]

A beneficial relationship between identified support persons (including Nominated Person), the person with a mental illness and clinicians includes:

- ☐ Open and honest discussions
- ☐ An agreement on the principle of why information is communicated
- ☐ How information is to be communicated
- ☐ What pieces of information do and do not need to be shared

Individuals identified as support persons are given general factual information about:

- ☐ The mental health diagnosis
- ☐ What behaviour is likely to occur and how to manage it
- ☐ Medications – benefits and possible side-effects
- ☐ Information about local support groups, and how to access them

Identified support persons are helped to understand:

- ☐ The current situation
- ☐ Any confidentiality restrictions requested by the person
- ☐ The individual's treatment plan and its aims
- ☐ Any written care plan, crisis plan or recovery program
- ☐ The role of professionals involved in the individual's care
- ☐ How to access help, for both the person with mental illness and for themselves, including out-of-hours services

Identified support persons are given:

- ☐ The opportunity to see a professional on their own
- ☐ The right to their own confidentiality when talking to a professional
- ☐ Encouragement to feel a valued member of the care team
- ☐ Confidence to voice their views and any concern they may have
- ☐ Information on emotional and practical support for both the person with mental illness and for themselves,
- ☐ An assessment of their own needs and referral to appropriate supports

Identified support persons are able to provide:

- ☐ Unique insights into the person with mental illness, their likes and dislikes and their personality
- ☐ Expertise by experience with regard to the best management strategies for the personal with mental illness.

[30] The Royal College of Psychiatrists, UK

Module 4: Working with support persons - bringing it all together

A good relationship with support persons requires maintenance and working together at all key contact points.

Contact Point 1 – First Contact

Topic	Suggested issues to discuss	Desired outcome
Information about the admission	**The reason** for admission is…… The key clinical **contact person** is……. An agreement is made regarding a **point of contact** for sharing information and organising meetings.	Information reduces feelings of distress and isolation in carers and family members

Contact Point 2 – Meeting the support persons during an episode of care (after consent has been established)

Topic	Suggested issues to discuss	Desired outcome
Connecting	**Introduction** of key stakeholders, key roles and responsibilities. **Information** regarding what to expect during an admission. **Opportunities** for support persons to provide relevant information about the person with mental illness. Their rights and the patient's rights.	Clear understanding of the role and responsibilities of each person, including the familial context which can be used to support treatment and care.
Assessing needs	**Assistance**: Language translation needs, cultural support, legal and financial issues (see DoH Policies). Needs of **dependent children** or other dependents. **Need for information,** support, respite and linkages	Information and referrals about community support organisations, programs and linkages
Confidentiality and information sharing	**Difference** between general and personal information **Confidentiality** - with due regard for the patient's capacity and best interests under MHA 2014. **At the minimum**, information is provided that is viewed as essential to continuing in caring role.	The parties come to an agreement on: * Why information is communicated * How it is done * What information can be shared

Contact Point 3 – Ongoing communication[31]

Topic	Suggested issues to discuss	Desired outcome
The care plan	**Consultation** with the support persons regarding treatment options, alternatives, and implementation strategies.	The support persons participate in and influence care planning.
Crisis care planning	Information is shared about actions to prevent relapse, crisis management, emergency services or support, intervention supports.	Support persons remain optimally engaged to facilitate or prompt action in the case of a crisis.
Progress, changes and ongoing care - sharing of information	**Opportunities** to discuss the progress and review estimated discharge date and the need for ongoing care or rehabilitation.	The support persons are informed, and are able to act on information if necessary.

Contact Point 4 – Discharge Planning[28]

Topic	Suggested issues to discuss	Desired outcome
Advanced care planning Care coordination	The person with mental illness is asked to review their choice of support persons and the extent to which they are to be involved in an Advanced Health Directive.	A care plan based on the individual's need and the support persons' abilities and resources.
Consultation about discharge planning	Support person is informed about discharge plans, including the **place, day and time of discharge**. **Discussions and planning** with regard options and implementation of strategies, and **level of support** that support person are able and willing to provide.	Consideration of the needs and preferences of personal support person, and to the extent to which they can provide support.
How to keep well	Education to support good mental health following discharge. Discussion of triggers, de-escalation, managing safety, and other useful approaches.	Keeping well and avoiding relapse.

[31] with due regard for the patient's capacity and best interests

Appendices

Appendices provide a list of resources that clinicians and families and carers might need to access.

Appendix 1 - Legislation, practice guidelines and frameworks for service providers

Family inclusive treatment methods have been recommended within legislation and multiple clinical practice guides, including:

Mental Health Act 2014: describes obligations regarding notifying, information and involving close family members and carers, in recognition of the knowledge, skills, experiences and practices that families and carers bring to individuals and service providers.

Clinicians Practice Guide to the Mental Health Act 2014: available from the Office of the Chief Psychiatrist, and can be downloaded from the website at. It will be updated as the Act becomes operational. http://www.chiefpsychiatrist.health.wa.gov.au/act/index.cfm

Carers Recognition Act 2004: recognises the role of carers in the community, and provides a mechanism for the involvement of carers in the provision of services that impact on carers and the role of carers. Its principles are encapsulated in the **Carers' Charter** (respect, dignity, inclusion in assessment, planning, delivery and review of services).

National Carer Recognition Act 2010: increases recognition and awareness of the role carers play in providing daily care and support with to people with disability, medical conditions, mental illness, or who are frail-aged.

National Carer Strategy: outlines priority areas for action to better support carers.

National Safety and Quality Health Service Standards 2012: to improve the quality of health service provision in Australia.

National Standards on Mental Health Services 2010 outlines a set of service standards for mental health services.

NMHS MH Adult Program, Consumer and Carer Participation Policy: a framework for mental health services, 2012-2014: stipulates best practice principles as including consumer and carers due to their lived experience of mental illness.

NMHS MH Consumer, Carer and Community Engagement Framework, 2011: reviewed examples and models of participation within Australia and evaluated current strategies used with NMHS MH.

Privacy, Confidentiality and Information sharing – Consumers, Carers and Clinicians: A position statement and issues paper (National Mental Health Consumer and Carer Forum).

Royal Australian and New Zealand College of Psychiatrists (RANZCP) Clinician Practice Guidelines for the Treatment of Schizophrenia and Related Disorders: which speaks of the need for genuine involvement of consumers and relatives in service development and provision.

Review of the Admission or Referral to and the Discharge of and Transfer Practices of Public Mental Health Services in WA (Stokes Review, 2012): calls for greater consumer, carer and close family involvement in mental health service delivery.

Appendix 2 – Information about Mental Health Act 2014

For clinicians

An Online e-learning package about the MHA 2014 is offered by the Mental Health Commission at: https://mha2014.e3learning.com.au/

All mental health clinicians in Western Australia are required to complete this online course. The course is also open to non-clinical staff and members of the public.

The following topics in the online course are of particular relevance for developing good practice with consumers, carers and support persons:

- Topic 1 - Patient Centred Approach
- Topic 2 - Patient Decision Making
- Topic 8 - Patient Rights
- Topic 9 - Family and Carer Rights

Other resources for mental health professionals are available on the following website:

www.mentalhealth.wa.gov.au/mentalhealth_changes/mh_act2014/resources_MHA2015.aspx

The website includes:

- A Mental Health Act Handbook
- A Clinicians' Practice Guide which sets out to explain the MHA 2014, how it should be interpreted, and practices clinicians should adapt when performing a function under the MHA 2014
- Checklists, flowcharts and posters

For support persons

Resources are available for support persons on the following website:

www.mentalhealth.wa.gov.au/mentalhealth_changes/mh_act2014/persons_supporting_a_person_with_mental_illness.aspx

- An interactive online e-learning package about how the MHA 2014 applies to them
- A carers handbook written by carers for carers with information about the MHA 2014
- Brochures which give an introduction to aspects of the MHA 2014 (Being referred to a psychiatrist for an examination, Community treatment orders, Information for support persons, Information for voluntary patients, Inpatient treatment orders, Nominated Persons)

Appendix 3 – Charter of Mental Health Care Principles, Mental Health Act 2014

Principle 1: Attitude towards people experiencing mental illness

A mental health service must treat people experiencing mental illness with dignity, equality, courtesy and compassion and must not discriminate against or stigmatise them.

Principle 2: Human rights

A mental health service must protect and uphold the fundamental human rights of people experiencing mental illness and act in accordance with the national and international standards that apply to mental health services.

Principle 3: A person-centred approach

A mental health service must uphold a person-centred focus with a view to obtaining the best possible outcomes for people experiencing mental illness, including recognising life experiences, needs, preferences, aspirations, values and skills, while delivering goal-oriented treatment, care and support.

A mental health service must promote positive and encouraging recovery focused attitudes towards mental illness, including that people can and do recover, lead full and productive lives and make meaningful contributions to the community.

Principle 4: Delivery of treatment, care and support

A mental health service must be easily accessible and safe and provide people experiencing mental illness with timely treatment, care and support of high quality based on contemporary best practice to promote recovery in the least restrictive manner that is consistent with their needs.

Principle 5: Choice and self-determination

A mental health service must involve people in decision-making and encourage self-responsibility, cooperation and choice, including by recognising people's capacity to make their own decisions.

Principle 6: Diversity

A mental health service must recognise, and be sensitive and responsive to, diverse individual circumstances, including those relating to gender, sexuality, age, family, disability, lifestyle choices and cultural and spiritual beliefs and practices.

Principle 7: People of Aboriginal or Torres Strait Islander descent

A mental health service must provide treatment and care to people of Aboriginal or Torres Strait Islander descent that is appropriate to, and consistent with, their cultural and spiritual beliefs and practices and having regard to the views of their families and, to the extent that it is practicable and appropriate to do so, the views of significant members of their communities,

including elders and traditional healers, and Aboriginal or Torres Strait Islander mental health workers.[32]

Principle 8: Co-occurring needs

A mental health service must address physical, medical and dental health needs of people experiencing mental illness and other co-occurring health issues, including alcohol and other drug problems.

Principle 9: Factors Influencing mental health and wellbeing

A mental health service must recognise the range of circumstances, both positive and negative, that influence mental health and wellbeing, including relationships, accommodation, recreation, education, financial circumstances and employment.

Principle 10: Privacy and confidentiality

A mental health service must respect and maintain privacy and confidentiality.

Principle 11: Responsibilities and dependants

A mental health service must acknowledge the responsibilities and commitments of people experiencing mental illness, particularly the needs of their children and other dependents.

Principle 12: Provision of information about mental illness and treatment

A mental health service must provide, and clearly explain, information about the nature of the mental illness and about treatment (including any risks, side effects and alternatives) to people experiencing mental illness in a way that will help them to understand and to express views or make decisions.

Principle 13: Provision of information about rights

A mental health service must provide, and clearly explain, information about legal rights, including those relating to representation, advocacy, complaints procedures, services and access to personal information, in a way that will help people experiencing mental illness to understand, obtain assistance and uphold their rights.

Principle 14: Involvement of other people

A mental health service must, at all times, respect and facilitate the right of people experiencing mental illness to involve carers, families and other personal and professional support persons in planning, undertaking and evaluating their treatment, care and support.

Principle 15: Accountability and improvement

A mental health service must be accountable, committed to continuous improvement and open to solving problems in partnership with all people involved in the treatment, care and support of people experiencing mental illness, including their carers, families and other personal and professional support persons.

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[32] WA Health Operational Directive OD0329/11 states that the preferred term in Western Australia is ‘Aboriginal’. However, the MHA 2014 uses the term ‘Aboriginal or Torres Strait Islander’ or ‘ATSI’, and as this is a piece of legislation, it overrides a previous policy decision. When referring to people under the MHA 2014, the term ‘Aboriginal or Torres Strait Islander’ or ‘ATSI’ can be used.

Appendix 4 – Nominated Person Form 12A

GOVERNMENT OF WESTERN AUSTRALIA

CHIEF PSYCHIATRIST OF WESTERN AUSTRALIA

WA MENTAL HEALTH ACT 2014

SECTIONS: 275

Please use ID label or block print

SURNAME	UMRN
GIVEN NAMES	CMHI
BIRTHDATE	SEX
ADDRESS	

FORM 12A – NOMINATION OF NOMINATED PERSON

I _____ (**name of person making the nomination**), nominate _____ (**name of nominated person**) to be my nominated person under the *Mental Health Act 2014*. This nomination authorises my nominated person to be provided with information, and to be involved in matters relating to my treatment and care to the extent determined by me, and so long as my psychiatrist believes this is in my best interests. The nominated person may be provided with information about my rights and the rights of the nominated person, and how those rights can be accessed and exercised.

Relationship of nominated person to myself (optional): _____

Signature of person making the nomination: _____

Name of witness to the making of this nomination: _____

Qualifications of witness: _____

Signature of witness: _____

I _____ (**name of nominated person**), am aged 18 years or over and accept this nomination. I understand that as the nominated person, it is my role to ensure that the rights of the person making this nomination are observed and the person's interests and wishes are taken into account by those providing the person with treatment and care under the *Mental Health Act 2014*.

Signature of person accepting the nomination: _____

Name of witness to the acceptance of this nomination: _____

Qualifications of witness: _____

Signature of witness: _____

Contact details of nominated person:

Preferred method of contact: _____

Address: _____

_____

_____

Home phone: _____ Work phone: _____

Mobile: _____ Other number: _____

Email: _____

Date nomination takes effect: Date: DD/MM/YY

If nomination ended, date and time nomination ended: Date: DD / MM / YY Time: HH:MM

How nomination ended: ☐Person made a new nomination ☐Person revoked the nomination ☐ Nominated person resigned ☐Other: _____

FORM 12A – NOMINATION OF NOMINATED PERSON

TRAINING PURPOSES

Penultimate Version (09.09.15). A final version will be released immediately prior to the commencement of the MHA 2014

Notes: Form 12A – Nomination of nominated person

Who can make a nomination:

- Any person, including a child, may nominate another person to be the person's nominated person using this form (s273).
- A person cannot make a nomination unless the person understands the effect of making the nomination (s273).

Who can be nominated:

- Only an adult is eligible to be nominated as a nominated person (s274).
- A person cannot have more than one nominated person at any time (s276).

Duration of nomination

- A nomination is valid until revoked by the person making the nomination, or until the nominated person resigns the nomination.
- A nomination may be revoked by the person who made it at any time and by any means whatsoever (s277).
- A nomination is revoked if the person who made it makes another nomination (s277).
- A nominated person may resign the nomination in writing signed and given to the person who made the nomination. The resignation takes effect on either the date when it is received by the person who made the nomination, or the date specified on the resignation, whichever is later (s278).

Role of nominated person:

The role of a nominated person is to assist the person who made the nomination by ensuring that any person performing a function under the *Mental Health Act 2014* :

- observes that person's rights under this Act; and
- takes that person's interests and wishes into account (s263).

Right of nominated person:

Unless the psychiatrist believes it is not in the patient's best interests, a patient's nominated person is entitled:

- to be provided with information relating to the patient's treatment and care, including information about these matters —
  - the mental illness for which the patient is being provided with treatment or care;
  - if the patient is an involuntary patient — the grounds on which, and the provision of this Act under which, the involuntary treatment order was made;
  - the treatment and care proposed to be provided to the patient and any other options for the patient's treatment and care that are reasonably available;
  - the treatment provided to the patient and the patient's response to that treatment;
  - the seclusion of, or use of bodily restraint on, the patient;
  - the services available to meet the patient's needs;

  and
- to be involved in matters relating to the patient's treatment and care, including these matters —
  - the consideration of the options that are reasonably available for the patient's treatment and care;
  - the provision of support to the patient;
  - the preparation and review of any treatment, support and discharge plan for the patient;

  and
- to be provided with information about the patient's rights under this Act and how those rights can be accessed and exercised;
  and
- to be provided with information about the rights of the nominated person under this Act and how those rights can be accessed and exercised (s266).

A patient's nominated person may indicate the extent to which the nominated person wants to be provided with the above information or to be involved in the above matters (s266).

Who can witness:

Only a person who is authorised by law to take declarations can witness the nomination.
Neither the person making the nomination nor the nominated person can be the person who witnesses the nomination (s275).

Any clinical notes regarding nomination:

TRAINING PURPOSES

Appendix 5: Notifiable events (MHA2014)

Referrals	Any decision by a psychiatrist after examining a patient referred to an authorised hospital, such as making them an involuntary detained patient, putting them on a CTO, extending the referral up to 72 hours from the time the patient was received, or making no order - **s 55(6)**
	Any decision by a psychiatrist after examining a referred person in another place, such as making them an involuntary inpatient in a general hospital, putting them on a CTO, referring them to an authorised hospital, or making no order - **s 61(5)**
	Revoking a referral order - **s 31(7)**
Detention orders	Detention to enable a patient to be taken to an authorised hospital or other place - **s 28(8)**
	Release of a patient from a detention order - **s 28(12)**
	Confirmation of inpatient detaining order following revocation of CTO made by AV examination - **s. 124(7)**
	Release of an involuntary detained patient at any time - **s. 89(6)**
Transport orders	Making a transport order for a referred person - **s 29(4)**
	Making a transport order for an involuntary community patient - **S 129(5)**
Inpatient treatment	Confirmation of inpatient treatment order - **s. 68(7)**
	The provision of urgent non-psychiatric treatment - **s. 242(5)**
	When an inpatient treatment order expires - **s. 93(4)**
Involuntary inpatients - leave	When an involuntary inpatient is absent without leave - **s. 97(3)**
	When an involuntary inpatient is given leave **s. 105(13)**
	When leave is varied or extended - **s. 106(4)**
	When leave is cancelled - **s. 110(5)**
Community Treatment Orders (CTO)	Changing the involuntary status from detained to a CTO - **s. 90(5)**
	When a CTO patient is released after being detained in a place specified in order to attend (eg., after 6 hours, without treatment, and/or without a further order being made) - **s. 130(5)**
	After an examination when a CTO is revoked and the patient is made no longer involuntary or made a detained involuntary patient - **s. 120(7)**
	At any time when a CTO is revoked and the patient is made no longer involuntary or made a detained involuntary patient - **s. 123(8)**
	For a CTO patient following a breach - making the person no longer involuntary or making an order for them to be a detained involuntary patient - **s. 131(8)**
Transfers	Transferring an involuntary patient between authorised hospitals - **s. 91(5)**
	Transfer of an involuntary detained patient from a general hospital to an authorised hospital - **s 66(5)**
	Transfer from hospital to an interstate mental health service - **s. 555(4)**
	Transfer from an interstate mental health service to hospital - **s. 557(6)**

Appendix 6: Community Managed Organisations for family/carers (Metro)[1]

	Phone	Information about mental health and treatment	Connecting with other families	Counselling	Advocacy	Respite	Crisis
Anglicare WA (www.anglicarewa.org.au)	08 9263 2050			√			√
Carers WA (www.carerswa.asn.au)	1300 227 377	√	√	√	√	√	
Commonwealth Respite and Carelink Centres	1800 052 222					√	√
HelpingMinds (formerly ARAFMI) www.helpingminds.org.au	1800 811 747	√	√	√	√	√	
Life Without Barriers (www.lwb.org.au)	1800 721 226			√		√	√
Lifeline (www.lifeline.org.au)	13 11 14						√
Medicare Local (www.medicarelocals.gov.au)	08 9201 0044	√					
WA Mental Health Law Centre www.mhlcwa.org.au	1800 620 285		√		√		
Mental Health Matters 2 (MHM2) (www.mentalhealthmatters2.com)			√		√		
MIFWA (Mental Illness Fellowship of WA) www.mifwa.org.au	08 9237 8900	√	√		√	√	√
Mind Australia www.mindaustralia.org.au	1300 550 265	√					
Perth Home Care Services www.phcs.org.au	08 9204 7800					√	√
Richmond Wellbeing (formerly Richmond Fellowship WA) www.rfwa.org.au	08 9350 8800	√			√	√	
RUAH Mental Health www.ruah.com.au/services/mental-health/	08 9485 3939	√	√	√	√		
SANE Australia www.sane.org	1800 187 263	√			√		
WAAMH (WA Association for Mental Health) www.waamh.org.au	08 9420 7277	√			√		
Workpower Respite Services www.workpowerrespitecare.com.au	1800 610 665					√	

[1] [1] *Best efforts were made to ensure that the details are correct at the time of publication but* it *cannot be guaranteed that the information provided is correct, complete or up-to-date*

Appendix 7: Community Managed Organisations for family/carers (Statewide)

	Phone	Info about mental health and treatment	Connecting with other families	Counselling	Advocacy	Respite	Crisis
Anglicare WA (www.anglicarewa.org.au)	08 9263 2050			√			√
Carers WA (www.carerswa.asn.au)	1300 227 377	√	√	√	√	√	
Commonwealth Respite and Carelink Centres	1800 052 222					√	√
HelpingMinds (formerly ARAFMI) www.helpingminds.org.au/	1800 811 747	√	√	√	√	√	
Lifeline (www.lifeline.org.au)	13 11 14						√
Life Without Barriers (www.lwb.org.au)	1800 721 226			√		√	√
Medicare Local (medicarelocal@health.gov.au)	08 9201 0044	√					
Mental Health Law Centre WA (www.mhlcwa.org.au)	1800 620 285				√		
Mental Health Matters 2 (MHM2) www.mentalhealthmatters2.com			√		√		
MIFWA (Mental Illness Fellowship of WA) Wheatbelt office (www.mifwa.org.au)	1800 985 944	√	√		√	√	√
Mind Australia (www.mindaustralia.org.au)	1300 550 265	√					
Perth Home Care Services -Wheatbelt Office www.phcs.org.au	08 9621 7900					√	√
Richmond Wellbeing (formerly Richmond Fellowship WA) (www.rfwa.org.au)	08 9350 8800	√			√	√	
RUAH Mental Health www.ruah.com.au/services/mental-health	08 9485 3939	√	√	√	√		
WAAMH (WA Association for Mental Health) www.waamh.org.au	08 9420 7277	√			√		
Workpower Respite Services www.workpowerrespitecare.com.au/	1800 610 665					√	

Appendix 8: Services for children and young people under 25 years of age

	Phone	Info about Mental Health	Connecting with services	Counselling	Sexuality Identity Bullying	Drugs and alcohol	Crisis
Alcohol and Drug Information Service (www.dao.health.wa.gov.au)	08 9442 5000 1800 198 024	√	√	√		√	
Anglicare WA (www.anglicarewa.org.au)	08 9263 2050			√			√
Carers WA (www.carerswa.asn.au)	1300 227 377	√	√	√	√		
Children of Parents with Mental Illness (www.copmi.net.au)		√	√		√		
Headspace (www.headspace.org.au)	08 9208 9555	√	√	√	√	√	
HelpingMinds (http://helpingminds.org.au/)	1800 811 747	√	√	√	√	√	
Kids Health (www.kidshealth.org)		√			√		
Kids Helpline (www.kidshelpline.com.au)	1800 55 1800	√	√	√	√	√	√
Lifeline (www.lifeline.org.au)	13 11 14						√
Life Without Barriers (www.lwb.org.au)	1800 721 226			√		√	√
MIFWA (www.mifwa.org.au)	08 9237 8900	√	√			√	√
Mind Australia (www.mindaustralia.org.au)	1300 550 265	√	√		√	√	
Reach Out (www.reachout.com)		√	√	√	√	√	
Suicide Call-Back Service www.suicidecallbackservice.org.au	1300 659 467						√
Young Carers (Carers Australia) www.youngcarers.net.au	1800 242 636	√	√		√		
Youth Focus (www.youthfocus.com.au)	08 6266 4333	√	√	√	√	√	
NMHS MH Youth Mental Health Services: Youth Axis, Youth Link, Youth Reach South (www.nmahsmh.health.wa.gov.au/services)	08 9227 4300	√	√	√			

Appendix 9: Services for Aboriginal Communities:

	Phone	Info, Support, Referral	Family Support services	Counselling	Advocacy	Mental Health Services
Anglicare WA (www.anglicarewa.org.au)	08 9263 2050	√	√	√		√
Aboriginal Alcohol and Drug Service (www.aads.org.au)	08 9221 1411	√	√	√	√	
Aboriginal Family Respite Service (http://www.unitingcarewest.org.au/services/indigenous-communities/aboriginal-family-respite-service/	08 9206 6200	√	√	√		
Aboriginal Health Council of WA (www.ahcwa.org.au)	08 9227 1631	√	√		√	
HelpingMinds (formerly ARAFMI) (www.helpingminds.org.au)	1800 811 747	√	√	√	√	
Karnany Aboriginal Centre (www.swanea.com)	08 9274 7929	√	√			
Kootamiara Quab	08 9451 4977	√	√			
Life Without Barriers (www.lwb.org.au)	1800 721 226	√	√			
Perth Aboriginal Resources directory (www.ruah.com.au/wp-content/uplods/ARD-final-2015.pdf)	08 9485 3939	√	√			
Ruah Mental Health Services (www.ruah.com.au)	08 9485 3939	√	√			
Specialist Aboriginal Mental Health Service (SAMHS) (www.nmahsmh.health.wa.gov.au/services)	08 9235 2400	√		√		√
Yorgum Aboriginal Corporation (www.yorgum.org.au	08 9218 9477	√	√	√	√	√

Appendix 10: Services for individuals from a non-English speaking background

	Phone	Info, Support, Referral	Family Support services	Counselling	Advocacy	Mental Health Services
Anglicare WA (www.anglicarewa.org.au)	08 9263 2050	√	√	√		√
Association for Services to Torture and Trauma Survivors (ASeTTS) (www.asetts.org.au/counselling-advocacy)	08 9227 2700	√		√		√
Carers WA CaLD Social Support Program (www.carerswa.asn.au)	1300 227 377	√	√	√		
Ethnic Disability Advocacy Centre (www.edac.org.au/)	08 9388 7455 1800 659 921	√	√		√	
HelpingMinds (formerly ARAFMI) (www.helpingminds.org.au)	1800 811 747	√	√	√	√	
Ishar Women Multicultural Carers Support and Skill Development Program(www.ishar.org.au)	08 9345 5335	√	√	√	√	
Life Without Barriers (www.lwb.org.au)	1800 721 226	√	√			
Mental Health in Multicultural Australia (MHiMA) (www.mhima.org.au)	1300 136 289	√	√			
Multicultural Mental Health Access Services (www.fmcwa.com.au)	08 9336 8282	√	√	√	√	
Ruah Mental Health Services (www.ruah.com.au)	08 9485 3939	√	√			
MAITRI Mental Health Services (www.mscwa.com.au)	08 9328 2699	√		√		√
Transcultural Mental Health Centre (www.health.wa.gov.au/multiculturalhealth/home/multicultural_resources.cfm)	08 9416 2817	√		√		√

Appendix 11: Alcohol and other Drug, Criminal Justice System, Prison System[1]

	Phone	Info, support, referral	Service for families	Counselling	Advocacy	Women	Information provided
Aboriginal Alcohol and Drug Service www.aads.org.au	08 9221 1411	√	√	√	√	√	Counselling, welfare assistance, referral
Accord West www.accordwest.com.au	08 9729 9000 1800 115 799	√	√	√	√	√	Information, support, referral
Anglicare WA www.anglicarewa.org.au	08 9263 2050	√	√	√		√	Relationships, finance, housing
Counselling Online www.counsellingonline.org.au/	1800 888 236	√		√		√	Counselling
Drug and Alcohol Information www.druginfo.adf.org.au	1300 85 85 84	√	√	√		√	Information, support, referral, drug court support
Family Drug Help www.sharc.org.au/program	1300 660 068	√	√	√		√	Support and information
Life Without Barriers www.lwb.org.au	1800 721 226	√	√	√	√	√	Support, housing, education, counselling, workforce
Green book – for Alcohol and Other Drugs and Service Providers www.greenbook.org.au		√	√			√	Information and services
Mental Health Law Centre WA www.mhlcwa.org.au	1800 620 285				√		Legal service
Mental Health Matters 2 (MHM2) www.mentalhealthmatters2.com		√	√		√	√	Mental health and criminal justice system
Next Step Drug and Alcohol services www.dao.health.wa.gov.au	08 9219 1919	√	√	√		√	Assessment and treatment and support for families
Outcare www.outcare.com.au	08 6263 8622	√	√	√		√	Criminal justice system
WA Network of Alcohol and other Drug Agencies (WANADA) www.wanada.org.au	08 6365 6365	√	√	√	√	√	Child care access, interpreter access, advocacy

[1] *Best efforts were made to ensure that the details are correct at the time of publication but* it *cannot be guaranteed that the information provided is correct, complete or up-to-date*

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Further reading on how to assist support persons (for trained therapists)

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