

Framework for Involving Whānau/Families

Mental Health, Addictions & Intellectual Disability Service (MHAIDS) 3DHB

*Ko te Amorangi ki mua
Ko te Hapai o ki muri*

If the people at the back are okay,
the front will be okay

Ia o gatasi le futia ma le umele

The sinnet ring and the stand for the fishing rod must
be equally strong - STRONG PARTNERSHIP!

January 2017

Introduction

There is increasing evidence that well-being and outcomes for people using mental health services and their whānau/family are greatly enhanced when the latter are involved with their whānau/family member's care^{1,2}. Whānau/family offer a unique perspective and often have both an historical and intimate knowledge of their family member's health, behaviour and well-being. This knowledge helps to inform the clinical assessment and the development and review of the Partnership (treatment) Plan.

Within the Mental Health, Addictions and Intellectual Disability Service (MHAIDS) staff are required to work with whānau/family, encouraging and supporting them to participate in the recovery of their family member. This includes sharing information, involvement in care planning, decision-making and evaluation; and providing education and support, where required. Wherever possible, whānau/family will be involved at each stage of the person's pathway through the service.

NB This document is aligned to the MHAIDS Client Pathway (pending) and Whānau/Family Participation Policy thus should be read in conjunction with these documents. The term 'person' is used to refer to an individual using the mental health, addiction or intellectual disability service.

Purpose

MHAIDS 3DHB values and respects the vital role, knowledge and expertise that whānau/family bring. The purpose of this document is to provide a framework to ensure whānau/family inclusive practice in order to achieve positive health outcomes for both the person and their whānau/family.

Definition

Whānau/Family

MHAIDS 3DHB has adopted the following definition as recommended by the Ministry of Health²:

'A set of relationships a patient or proposed patient defines as whānau/family. It is not limited to relationships based on blood ties, and may include:

- the spouse or partner of the patient or proposed patient
- relatives of the patient or proposed patient
- a mixture of relatives, friends and others in a support network
- only non-relatives of the patient or proposed patient³.

NB Notwithstanding the definitions recommended, a competent patient may decide who their whānau/family is.

Key principles

The following key principles underpin this framework.

- A person has the right to decide how they wish their whānau/family to be involved in their care. The extent to which whānau/family are involved will be determined by the person and should be reviewed regularly.
- Whānau/family provide unique expertise due to their knowledge of their family member, thus play an essential role in the process of recovery and relapse prevention. For Māori and Pacific families, consideration should be given to the wider involvement of hapū, iwi or fanau if more expertise is needed.
- A three-way partnership between the person, their identified whānau/family and mental health and addictions staff greatly enhances the process of recovery.

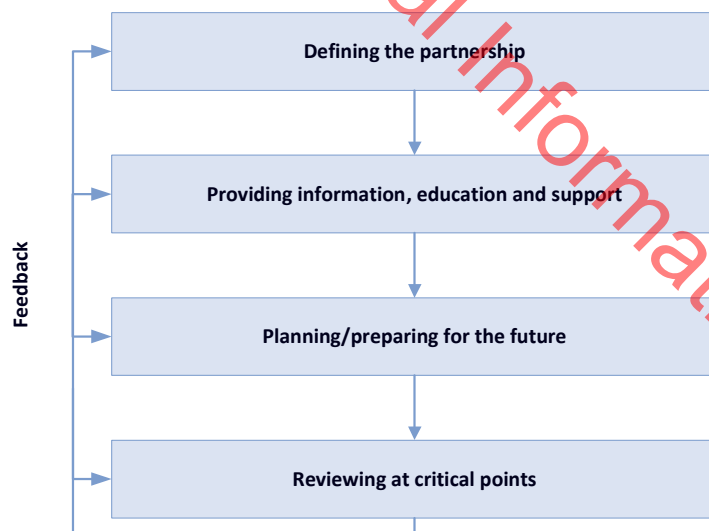
- Whānau/family have distinct and separate needs from the person using MHAIDS, and their own rights.
- Clear and open communication and the sharing of information is critical to ensuring quality care.
- Consultation, cooperation, mutual respect, equality, the sharing of complementary resources and skills, and clarity of expectations are key to developing effective working relationships between mental health staff and whānau/family.³
- The expertise of culturally specific services will be accessed, where required.
- The relationship between mental health services and whānau/family is affected by a range of legislation including the Privacy Act, 1993 and the Mental Health (Compulsory Assessment and Treatment) Act, 1992.
- The nature of whānau/family involvement may change during the course of a person's pathway through services e.g. as consent is given or withdrawn; however, the aim is to stay involved with whānau/family and ensure their support needs are met.

Framework for Involving Whānau/Family

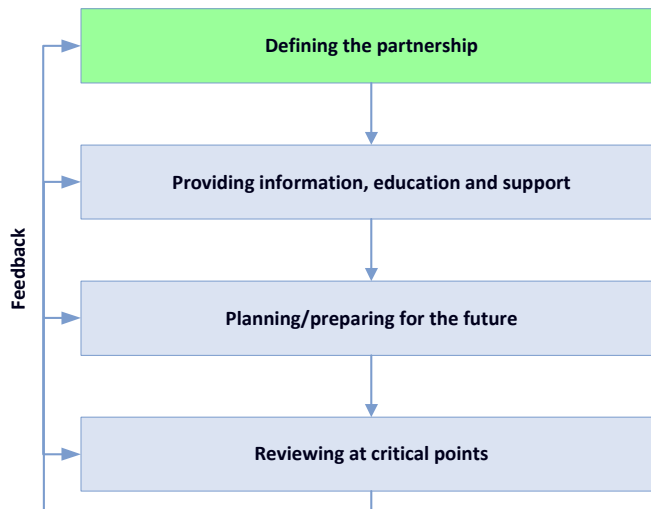
Unlike a person using MHAIDS, there is no clear pathway through services for whānau/family. Each whānau/family has unique needs and experiences thus the response of staff should be tailored accordingly.

The following framework³ has been adopted by MHAIDS to assist staff to work effectively in partnership with whānau/family.

The framework reflects the dynamic nature of the working relationships between staff and whānau/family. Each aspect is part of an ongoing cycle. Feedback received at any one point may help to inform the actions required in other aspects.



1.0 Defining the Partnership



Identifying Whānau/Family

- 1.1 At the earliest opportunity, staff will work with the person to identify whānau/family; including whether they are parents and any children for whom they are responsible for providing care to. They will seek to gain an understanding of how whānau/family member(s) are involved in the person's life and how they would like for them to be involved in their care and treatment. This information will be recorded in the clinical file.
- 1.2 The support of cultural advisors and kaimanaaki will be sought, where appropriate, to help facilitate the process of identifying whānau/family and enable safe and effective working practices. Any person working with Māori is required to make enquiries into their heritage and family links⁴. Guidance on working with Pasifika people and their fanau is also available through Te Pou⁵.

Consent

- 1.3 The person will be informed of their right to privacy and confidentiality.
- 1.4 The person's consent must be obtained and recorded in the clinical file prior to disclosing healthcare information to whānau/family. (Informed consent must be obtained in accordance with the DHB's *Informed Consent Policy* - see appendix 1 for flowchart of information sharing process.)

NB An exception to this is under section 7a of the Mental Health (Compulsory Assessment and Treatment) Act 1992 which requires mental health services to consult with whānau/family during the compulsory assessment and treatment process unless it is not in the best interests of the person or it is not reasonably practicable. In order to decide whether whānau/family consultation is in the person's best interests the clinician must first consult with the person.

- 1.5 Any parameters for the disclosure of information will be discussed, determined and documented.
- 1.6 The person can refuse consent for staff to share their healthcare information with their whānau/family subject to any exceptions provided for in the Health Information Privacy Code, 1994 and the Mental Health (Compulsory Assessment and Treatment) Act 1992.

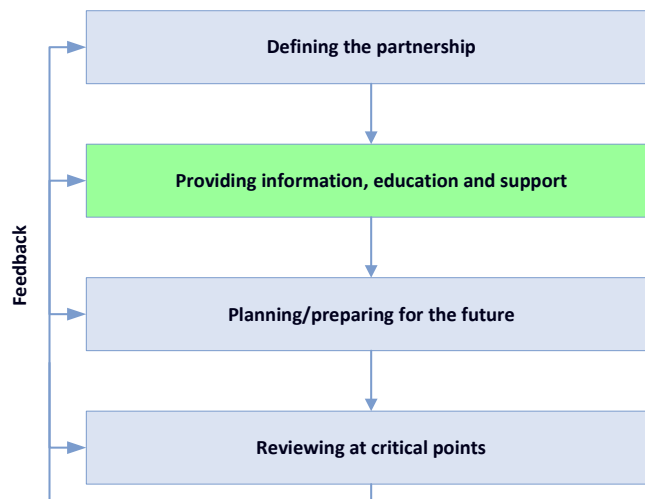
- 1.7 If a person refuses the involvement of whānau/family, the issue will be sensitively explored by the clinical team and the benefits of family involvement discussed, where appropriate.
- 1.8 If a person declines the involvement of whānau/family or permits only limited involvement this will be revisited regularly to establish whether the person maintains this view and to encourage greater involvement as appropriate.
- 1.9 The person will be made aware that they can revoke their consent at any time.
- 1.10 Where a person is unable to give informed consent, clinicians will check to see if a current, valid advance directive is in place which records how whānau/family are to be involved.
- 1.11 Regardless of whether consent is given by a person, whānau/family still have a right to be heard and can provide information and history to staff without staff breaching confidentiality.
- 1.12 In the absence of consent, certain information may be provided to whānau/family.

Introduction to Whānau/Family

- 1.13 Staff will be responsive to the language, cultural and spiritual needs of whānau/family for example conducting karakia, giving and responding to a mihi, identifying the lead person in the fanau who speaks on behalf of them. Kaumatua and interpreters will be used, where required.
- 1.14 Staff will introduce themselves to whānau/family and explain their role and responsibilities in relation to the person. Whānau/family will be informed of their rights and the supports available to them in the community.
- 1.15 The name and details of a contact person will be provided to whānau/family; this will usually be the care manager (community services), keyworker or social worker (inpatient services). The whānau/family will be informed that in the absence of the identified contact person, they may find it helpful to speak with the allocated nurse (inpatient services) or the clinical coordinator or duty worker (community services).

NB If the identified staff are unavailable or there is an urgent need for whānau/family to communicate critical information the most appropriate and available staff member must be identified and made accessible to the family.
- 1.16 Staff will invite family/whānau to consider their information, education and support needs (see appendix 2) and together develop an appropriate plan.
- 1.17 Details of further contact with whānau/family will be discussed and agreed including the frequency of the contact, who will make contact, how and when this is to occur, and the purpose of the contact.

2 Providing Information, Education and Support



Communication

- 2.1 Whānau/family will be informed of their right to information, the process for sharing and handling information and the legal constraints around the disclosure of information.
- 2.2 Communication will be a two-way, proactive process. Information will be exchanged with whānau/family to enable effective participation.
- 2.3 Information will be offered in a variety of ways including verbally and in writing.
- 2.4 Staff will listen and respect whānau/family views. A summary of the key points and agreed actions will be relayed to whānau/family at the end of each contact. Information will be shared within the team providing care and documented in the clinical record.
- 2.5 Clinicians will be mindful that different families need different information at different times. Care will be taken to avoid overloading whānau/family with too much information, particularly during times of crisis.

General Information

- 2.6 Identified whānau/family will be provided with an initial service specific information leaflet outlining key information within two days of contact.
- 2.7 The whānau/family of a person new to inpatient services will be given an orientation to the service at the earliest opportunity (see appendix 3).
- 2.8 Identified whānau/family will be given or provided website links to more in depth information resources within three days of their initial contact with services.
- 2.9 Regardless of whether the person consents to their personal healthcare information being shared with their whānau/family, the whānau/family has the need and right to certain information. Staff are required to provide the following information, as relevant:
 - general information about mental illness, addiction, treatments available, medication and side effects
 - how to support recovery
 - recognising early warning signs
 - wellness planning (general conversation about identifying and recognising early warning signs)

- how to access support
- how to respond to disturbed behaviour (if requested)
- how the service works
- coping strategies and looking after self
- relevant legislation such as the Privacy Act 1993, Mental Health (Compulsory Assessment and Treatment) Act 1992
- community resources available including Kina Families and Addictions Trust, Atareira / Supporting Families and Carers New Zealand.

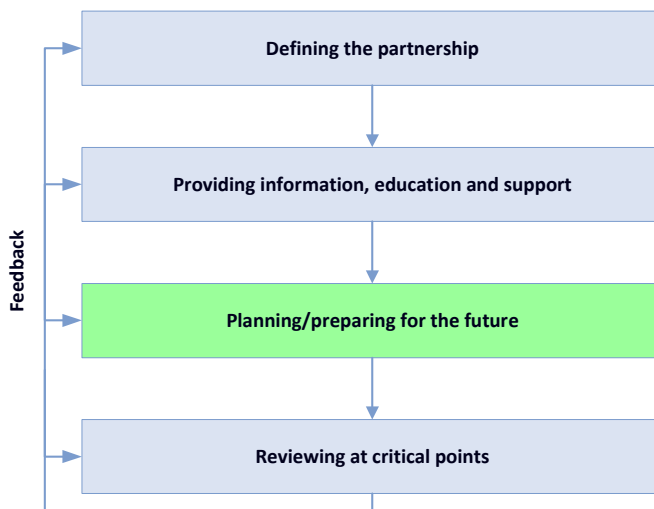
Personal Information

- 2.10 Information will be shared regularly at each stage of the client pathway (see draft Client Pathway) subject to the person's consent unless there are circumstances which permit disclosures to be made without the person's consent. Disclosures may only be made in accordance with the DHB's HIPC policy.
- 2.11 Clinicians will seek information from whānau/family in order to inform the assessment, treatment planning and review process.
- 2.12 When sensitive information is disclosed by whānau/family, staff will clarify with them what information may be shared with the person.
- 2.13 Where whānau/family have a primary caregiver role, clinicians will ensure sufficient advice, support and guidance is provided to enable them to fulfil this role. A contingency plan should be considered in the event that the primary care giver cannot continue to provide the same level of support.
- 2.14 Clinicians will be mindful of the financial and social aspects of caregiving and provide information where appropriate e.g. the availability of benefits and subsidies, support groups etc.
- 2.15 All contacts with whānau/family must be recorded in the clinical file.

Support

- 2.16 Staff will be mindful of the high levels of stress encountered by family members and the vulnerability of their mental health particularly when a person's mental health needs are long standing or an admission under the Mental Health (Compulsory Assessment and Treatment) Act 1992 is required.
- 2.17 Staff will also be cognisant of the particular support needs of children whose parents have a mental illness or addiction (see Supporting Parents, Healthy Children Procedure- to be developed).
- 2.18 Staff will listen, assess and address whānau/family member's support needs in order to enable them to continue to effectively support their whānau/family member.
- 2.19 Staff will proactively check how whānau/family are coping.

3.0 Planning/ Preparing for the Future



Assessment

3.1 As part of the comprehensive assessment of a person, the resources, strengths, ways of coping, social networks and support needs of family/whānau will be explored.

Planning

3.2 The expert knowledge, views and preferences of whānau/family and the person will be taken into consideration in the development of the Partnership (treatment) Plan.

3.3 The person will be encouraged to involve whānau/family in wellness planning.

3.4 Clinicians will make every attempt to involve whānau/family in discharge planning.

3.5 Whānau/family will be provided with a copy of the discharge plan subject to the person's consent. The plan will include an outline of any follow-up arrangements, contact details etc.

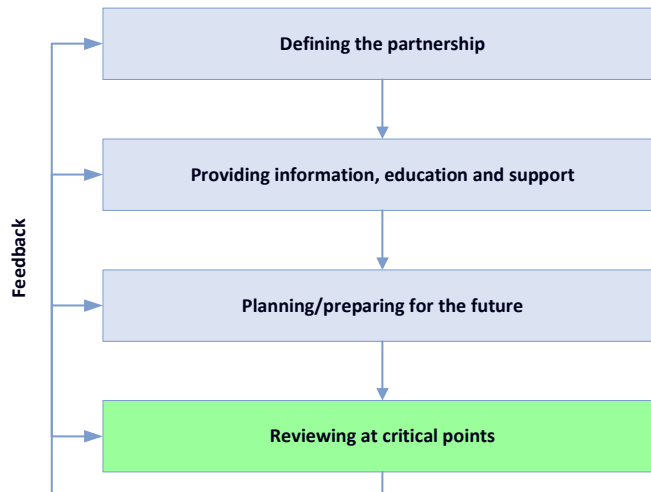
3.6 Clinicians will ensure that whānau/family are informed of the estimated discharge date and that they receive timely notification of discharge.

3.7 The involvement of whānau/family will be documented in the clinical record. Where whānau/family have not been involved in the development of the Partnership (treatment) Plan or discharge planning the reasons for this must be recorded.

Crisis Planning

3.8 Clinicians will work with person and their whānau/family to develop crisis management plans before a crisis occurs. The plan will include treatment and care to be provided, what information may be shared with whānau/family and the nature of their involvement, should the person become unable to consent.

4.0 Reviewing at Critical Points



4.1 Clinicians will seek to involve whānau/family in times of crisis and review processes. at a minimum of six monthly.

Partnership / Treatment Reviews

4.2 Clinicians will seek information from whānau/family relating to their observations of their family member. This information will be acknowledged and documented in the Partnership Review.

4.3 Clinicians will provide whānau/family with the additional opportunity to meet or speak separately, where appropriate.

4.4 Whānau/family will be consulted with when reviewing and updating the Partnership (treatment) Plan.

4.5 Clinicians will use the Review to:

- ensure that the team is in contact with 'current' family
- update contact details
- ensure that the team is meeting the needs of whānau/family, where possible.

Contact during Crisis

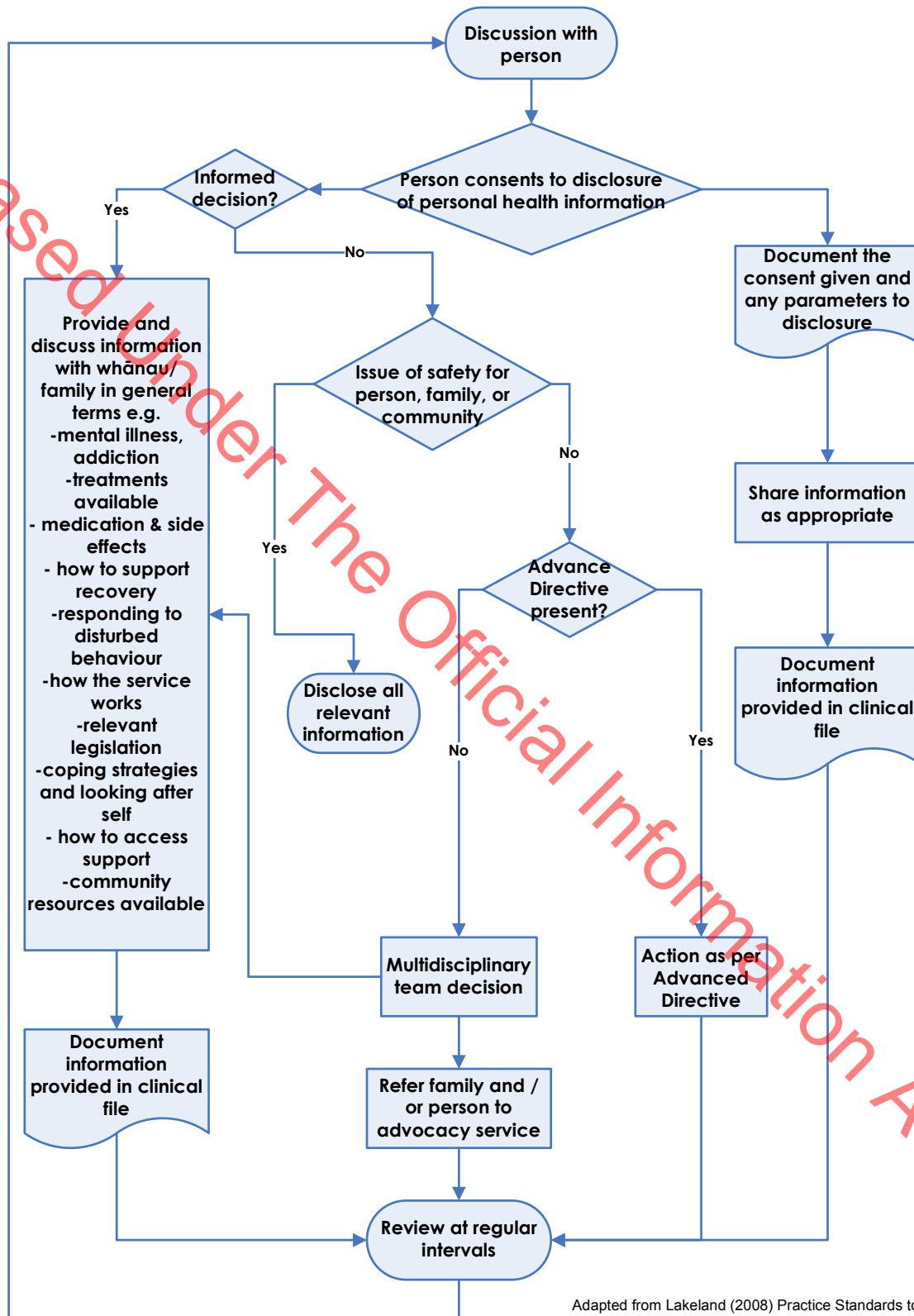
4.6 During times of crisis clinicians will remain in close contact with whānau/family to offer advice, assistance and support.

4.7 Careful consideration will be given by the clinician as to whether face-to-face contact is required and whether a home visit is indicated, for example, where infants or young children are involved.

References

1. Pharaoh, D.A., Mari, J., Rathbone, J. & Wong, W. Family Intervention for Schizophrenia. Cochrane Database of Systematic Reviews, 4. 2006
2. Pitschel-Walz, G., Leucht, S. Bauml, J., Kissling, W. & Engle, R.R The effect of family interventions on relapse and rehospitalisation in schizophrenia- A meta analysis Schizophrenia Bulletin 27(1) 73-92 2001
3. Royal Australian and New Zealand College of Psychiatrists (2000) Involving Families: Guidance Notes Ministry of Health: Wellington.
4. Ministerial Advisory Committee (1988) Puao-te-Ata-Tu (Day Break) Ministerial Advisory Committee on a Maori Perspective for the Department of Social Welfare. Ministerial Advisory Committee: Wellington.
5. Te Pou o te Whakaaro Nui (2010) Talking Therapies for Pasifika Peoples. Best and Promising Practice Guide for Mental Health and Addiction Services. Te Pou: Auckland.

Appendix 1 – Flowchart of Information Sharing Process



Adapted from Lakeland (2008) Practice Standards to Improve the Quality of Family and Carer Participation in Adult Mental Health Care: an Overview and Evaluation. International Journal of Mental Health Nursing 17: 44-56

Appendix 2

Checklist for Identifying Whānau / Family information, Education and support needs – Guidelines for use

Introduction

This Checklist has been designed to assist a conversation between whānau/family and services and help families think about what information, education and support needs they have at this time. This information will then be used to aid the development of an appropriate plan. Clinicians must exercise their professional judgement using the information available to them to determine how best to introduce the checklist, to whom it should be offered and when it should be offered.

NB The term 'person' is used to describe an individual using the Mental Health, Addictions and Intellectual Disability Service (MHAIDS) 3DHB.

Who should complete it?

1. Whānau/family involved with a person currently using MHAIDS, 3DHB should be offered the opportunity to meet and discuss their needs with an appropriate clinician; this would usually be the person's care manager or social worker.

When to complete it

2. Whānau/family should be invited to complete the Checklist at the start of an episode of care, once whānau/family have been identified and introductions have been made.
3. The Checklist may also be used with whānau/family of a person who has been using MHAIDS for some time, as needs may change during the course of care.

How to complete it?

4. Identified whānau/family should be invited to complete the checklist. Where whānau/family do not wish to complete the Checklist, the clinician should make whānau/family aware that should they change their mind, arrangements will be made to facilitate this. The clinician should document that the family member has declined the offer to complete the checklist at this time.
5. Where whānau/family agree to complete the checklist, their preferred method of completion should be discussed with them. Options to be considered include:
 - i. Whether they would prefer to do this in a face-to-face appointment with the appropriate clinician (this would usually be the care manager or the inpatient social worker). If whānau/family would prefer to complete the checklist with a clinician, they should be provided with the option to either discuss their needs separate to the person or with their family member
 - ii. Whether they would prefer to receive a copy of the Checklist to complete independently or with their whānau/family. In this instance, the family member should be encouraged to complete the ratings and to leave the action planning to the meeting with the care manager / social worker. A follow-up appointment must then be made with whānau/family to discuss their completed Checklist and agree a plan.
6. Where needs are identified appropriate options should be discussed and agreed with whānau/family. Actions may include tasks the family member or clinician will undertake. It may also include a referral to other services that may be better placed to address their needs, for example Atareira / Supporting Families.
7. Further contact with whānau/family should be agreed and a review timeframe established to ensure the action points are addressed.

What to do with the checklist?

8. Upon completion of the checklist a copy should be provided to the family member and the original placed on the file in the relevant section. Care must be taken to ensure the confidentiality of the family.

CONFIDENTIAL 3RD PARTY INFORMATION

CHECKLIST FOR IDENTIFYING FAMILY/WHĀNAU INFORMATION, EDUCATION & SUPPORT NEEDS

Name: Date:
 Address: Tel No: Email:.....
 Consumer's Name: Consumer NHI:

This checklist has been designed to assist a conversation between families and services and help families think about what information and assistance they may need at this time.

	Circle as appropriate	Agreed actions (where relevant)	Date achieved
Sharing information			
1. Do you have a contact person in the mental health service that you can contact with questions about your family member?	Yes / No		
2. Are you aware of how to share any important information or concerns about your family member?	Yes / No		
Education and training about mental illness and health			
3. Would you like to learn more about mental illness / addiction, treatment options, recovery and how best to support your family member?	Yes / No		

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	Circle as appropriate	Agreed actions (where relevant)	Date achieved
4. Would you like to talk with people who have been through a similar experience?	Yes / No		
Personal safety and risk management			
5. Do you have concerns about your or your family member's safety?	Yes / No / Sometimes		
6. Do you know what to do if you need to get help immediately- who to contact during the day and after hours, and how best to get help?	Yes / No		
Feedback			
7. Do you know how to give feedback including compliments and complaints, if you wish to?	Yes / No		
Advocacy			
8. Do you know who is available to support you in working with the mental health service and getting the best information and treatment for your family member?	Yes / No		
Responsibilities			
9. How are you involved in supporting your family member?			

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	Circle as appropriate	Agreed actions (where relevant)	Date achieved
<p>10. On a scale of 1 to 5, how satisfied are you with your current level of involvement?</p> <p>1- not at all 2- a little 3- somewhat 4-very 5-extremely</p> <p>Comments</p> <p>.....</p> <p>.....</p> <p>11. Is this likely to be different in the short /long term?</p> <p>How may it be different?</p> <p>.....</p> <p>.....</p>	<p>Yes / No / Not sure</p>		
Wider responsibilities			
<p>12. Has supporting your family member impacted on other responsibilities in your life (e.g. work, study, children, caring for other family members)?</p> <p>Comments</p> <p>.....</p> <p>.....</p>	<p>Yes / No</p>		
Practical and emotional support			
<p>13. Has family income been affected by illness?</p>	<p>Yes / No</p>		

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	Circle as appropriate	Agreed actions (where relevant)	Date achieved
Comments	Yes / No		
14. Do you know what WINZ subsidies or travel assistance you are eligible for (if relevant)?	Yes / No		
15. Identify friends and family who are helpful to you.	Yes / No		
16. Do your friends and family know about and understand your family member's issues and how this impacts on your family?			
Comments	Yes / No		
17. If you are busy with your family member, are others available to assist?			
Comments	Yes / No / Not sure		
18. Are you confident navigating the services and accessing other supports?	Yes / No		

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	Circle as appropriate	Agreed actions (where relevant)	Date achieved
19. Would you like to be referred to Atareira / Supporting Families in Mental Illness for ongoing or future support?	Yes / No		
20. If yes, do you consent to us providing your contact details to Atareira / Supporting Families?	Yes / No		
21. Do you agree to us sending a copy of this completed form to Atareira / Supporting Families?	Yes / No		
Physical and mental wellbeing			
22. Do you have concerns about your own health needs and stress levels, or any other member in your family? Comments	Yes / No		
23. Do you and your family have an opportunity to take time out? Comments	Yes / No		

Adapted from Boyd & Sigglekow (2011) Navigating Through Mental Health Services: Perspectives and Priorities of Family Members and Mental Health Services Staff. Families Commission: Wellington.

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A copy of the completed form should be offered to the family and a copy placed in the clinical file. Where the family agrees, a copy should also be provided to Atareira / Supporting Families.

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Appendix 3

Family/Whānau Orientation to Forensic & Rehabilitation Inpatient Services

Consumer's Name:

NHI No:

Family Member's Name:

Staff Name:

Date:

Item	Staff signature
1. Introduce to available staff	
2. Tour of unit (whānau room, staff office, emergency evacuation point, toilets)	
3. Emergency evacuation points	
4. Explain the unit's Visiting Policy including: - visiting times - children visiting - rooms available for visits - restricted items	
5. Name, email, address and telephone number of contact person	
6. Parking	
7. Offer opportunity to discuss information, education and support needs of family /whanau	
8. Provide: - service information booklet or website links to information - provide leaflet for Atareira / Supporting Families – check if referral required.	

Additional Information / Comments

To be completed and placed in the Referrals/ Correspondence section of the clinical file.

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Appendix 4

Guidelines for meetings with Whānau /Families

Meetings with whānau/families may be organised for many different reasons including: information gathering/assessment, Partnership (treatment) planning, reviewing progress and discharge planning.

The following guidelines have been developed to assist staff in facilitating meetings in a manner that will support effective family participation and partnership working.

NB The term 'person' is used to describe an individual using the Mental Health Addictions and Intellectual Disability Service (MHAIDS), 3DHB.

Prior to meeting

1. Establish the purpose of the meeting. What are the goals of the meeting from the perspective of:
 - the team
 - the person
 - whānau/family?
2. Identify who needs to be in attendance. Care should be taken to keep the meeting size to a minimum (staff attendance). If students would like to attend permission should be obtained from person and their whānau/family prior to commencing the meeting. Check with the person which whānau/family members they would like to attend this may also include a support person. Consider whether an interpreter is required. In addition to the scheduled meeting, check whether the family would like to meet independently of their family member.
3. Prior to the meeting: Identify with the person/ whanau/family any cultural processes that need to take place before and after and who will responsible for that. Family preparation re roles and responsibilities are in place before the meeting day.
4. Identify with the person and whānau/family if they wish to nominate a spokesperson who will be responsible for all the communications back and forth between them and services.
5. Scheduling the meeting. Arrange a suitable date and time when key participants will be able to attend giving as much notice as possible. Ensure meeting participants are aware of the purpose of the meeting and who will be attending.
6. Appoint a chairperson / facilitator and minute taker.
7. Convene the meeting in an appropriate space. Set up the room ahead of time and ensure there is adequate seating for all participants.
8. Confidentiality. Check with the person what personal healthcare information may be disclosed to the whānau/family. If whānau/family would like to meet independently of their family member check with them what information may be shared with their family member.
9. Provide information to family about how to prepare for the meeting (see appendix *).

Opening the meeting

10. Observe cultural practices where appropriate.
11. Welcome & introductions (if initial meeting with family all team members to explain role).

12. Confirm the purpose and timeframe for the meeting.

Agenda

13. Work through agenda items.

14. Seek the person's and whānau/family's view of current situation, proposed options and whether they have any concerns.

15. Assess the person's and whānau/family knowledge and provide information as required.

16. Check contact details remain current.

Any Other Business

17. Check with all participants whether there are any other items for discussion.

Closing the meeting

18. Summarise key points (including areas of agreement and dissent), decisions made and the agreed plan.

19. Thank family for attending.

20. Set date and time of next meeting (if applicable).

21. Observe cultural practices.

Documentation

22. Ensure attendance and views of all participants are clearly recorded particularly any areas of dissent.

23. Place a copy of the minutes in the clinical file and provide a copy to the person and their whānau/family.

Appendix 5

Preparing for a Meeting with the Mental Health Team

A meeting with your family member's care team or an individual clinician provides an important opportunity to:

- share information
- discuss and plan treatment together
- discuss what support might be needed for yourselves as family/ whānau.

To get the most out of your meetings with the mental health team, you may find it helpful to prepare.

Suggested Ways to Prepare

1. Clarify the purpose of the meeting and who will be attending

Consider what you hope to get from the meeting. Are there specific items you would like to add to the agenda? A template is provided for your use on page 5.

2. Check with your family member whether they consent for their personal health information to be shared with you

The mental health team will be able to share your family member's personal health information with you, if your family member consents to this. Please note, where consent is not given, only general information can be provided to you.

3. Write down the questions you want to ask

Don't rely on your memory. The following list of questions (page 2) may help you to prepare for your meeting with the mental health team / clinician and to work out what you need to know. You may not need answers to all of these questions and you may have other questions you would like to ask.

4. Ask

You have a right to get the information you need from the team. If a clinician gives you information you do not understand, ask him or her to explain it to you.

5. Share information

Consider whether there is any important information, you may have that the team may not be aware of e.g. things you may have noticed about your family member; changes in circumstance that may be affecting your family member. Keeping a record of your observations can be helpful.

6. Make notes

A record of the meeting will be maintained and a copy will be provided to you; however, you may like to make additional notes for your personal reference.

7. Support person

Consider whether you would like to bring a support person with you when attending meetings. For example, a friend, an organisation or an advocate.

What Do I Need to Know? (Questions to Ask)

Information Sharing

• How much / what information is my family member happy to share with me?	<input type="checkbox"/>
• Can I see you separately from my family member?	<input type="checkbox"/>
• Can I tell you things that will not be shared with my family member?	<input type="checkbox"/>
• Will the information I provide to the team be held confidentially?	<input type="checkbox"/>
• Will I be informed about important meetings concerning their care and treatment?	<input type="checkbox"/>

Health and Wellness

• What is my family member's diagnosis?	<input type="checkbox"/>
• What symptoms suggest this diagnosis?	<input type="checkbox"/>
• If a diagnosis has not been made, what are the possibilities?	<input type="checkbox"/>
• Why has this happened to them?	<input type="checkbox"/>
• Will they recover?	<input type="checkbox"/>
• Where can I get information about this condition?	<input type="checkbox"/>
• What assessments have been done and what further assessments will be needed?	<input type="checkbox"/>
• Are there any concerns about my family member's physical health? If so, what will need to be done?	<input type="checkbox"/>
• How do we get a second opinion if we want one?	<input type="checkbox"/>

Care and Treatment

• What are the aims of treatment?	<input type="checkbox"/>
• What are the treatment options?	<input type="checkbox"/>
• Would talking treatments be helpful (e.g. cognitive behavioural therapy, family therapy)? If so, are they available locally?	<input type="checkbox"/>
• What happens if my family member refuses treatment?	<input type="checkbox"/>
• Who will be involved in providing treatment?	<input type="checkbox"/>
• What is the role of the care manager?	<input type="checkbox"/>
• Can we have input into decisions around treatment?	<input type="checkbox"/>
• How long will my family member need treatment for?	<input type="checkbox"/>
• What supports are available to assist my family member during treatment?	<input type="checkbox"/>
• What can I / we do to help?	<input type="checkbox"/>
• Are there any local self-help or family support groups that can help me to understand the illness and give me support?	<input type="checkbox"/>
• How can we receive a copy of the treatment plan and if relevant, a crisis plan?	<input type="checkbox"/>

Medication

• Will medication be used and why?	<input type="checkbox"/>
• What should the benefits of this medication be: <ul style="list-style-type: none"> ○ In the short term? ○ In the long term? 	<input type="checkbox"/>
• What are the side effects?	<input type="checkbox"/>
• How long will my family member need to take medication?	<input type="checkbox"/>
• What will happen if the medication is stopped?	<input type="checkbox"/>
• What are the signs that the dosage may need changing?	<input type="checkbox"/>
• Are there other medications that can be tried if this medication does not work?	<input type="checkbox"/>
• Will it cost anything?	<input type="checkbox"/>
• Can we have written information regarding treatment options?	<input type="checkbox"/>

Hospital Treatment

• Do they need to be admitted to hospital? If so, for how long?	<input type="checkbox"/>
• Are there any alternatives to hospital admission?	<input type="checkbox"/>
• If they have to go into hospital, which one will it be?	<input type="checkbox"/>
• Will they be on a locked ward?	<input type="checkbox"/>
• If they have short-term leave from the hospital, when and how will I be informed?	<input type="checkbox"/>
• How often will I be able to see them?	<input type="checkbox"/>

Discharge

• When will my family member be discharged?	<input type="checkbox"/>
• Will I be involved in discussions about my family member's readiness to be discharged?	<input type="checkbox"/>
• If I am not able to look after my family member when they are discharged, what will happen?	<input type="checkbox"/>
• Will I be expected to help with anything e.g. medication?	<input type="checkbox"/>
• What follow-up will there be after discharge?	<input type="checkbox"/>
• Can we re-access this service in future?	<input type="checkbox"/>
• How can we receive a copy of the discharge summary and crisis plan?	<input type="checkbox"/>

Getting help

• Is there a key contact person we can speak to?	<input type="checkbox"/>
• How can I get in touch with you?	<input type="checkbox"/>
• Who do we contact if we have any concerns?	<input type="checkbox"/>
• Who do we contact in an emergency?	<input type="checkbox"/>
• How often will there be meetings?	<input type="checkbox"/>
• How do I make a complaint if I am unhappy with the service provided?	<input type="checkbox"/>

Meeting Plan

Appointment Details:

Appointment date and time:

Venue:

Meeting with:

Purpose of meeting:

Things I Want to Discuss:

Update: Write down any new information that the team may not be aware of

Specific Questions I Would Like to Ask:

1.

2.

3.

4.

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