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# **ORIGINAL ARTICLE**

# **Caring for Someone with Depression: Attitudes and Clinical Practices of Australian Mental Health Workers**

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Many people who support a person with depression report struggling with the carer role and being dissatisfied with the inclusivity and lack of support provided by clinicians. However, little is known about what influences the support provided to Australian carers of people with depression. To investigate this, 119 Australian mental health workers completed a self-report questionnaire to gather information on their attitudes towards, barriers experienced and current clinical practices when working with carers of people with depression. Participants' attitudes towards family members and carers were generally positive. Reported inclusive clinical practices varied. Participants identified a number of barriers to inclusive practice that were predominantly organisational in nature. Participants who perceived more barriers reported providing more clinical interventions. Attitudes and barriers were associated with the inclusive clinical practice of participants who worked with mental health consumers, but not participants who worked with family members and carers. Even among this sample of self-selecting clinicians, there was room for significant improvement in rates of carer inclusive practice. Further research should explore not only what inhibits but also what enables the participation of family members and carers in the care and treatment process for people with depression.

Key words: attitudes; barriers; carers; clinicians; depression; treatment.

#### What is already known on this topic

#### 1 Family members and carers of people with a mental illness (including depression) report being largely dissatisfied with the level of inclusivity and support provided by mental health services

#### What this paper adds

- 1 This study provides the first snapshot of Australian clinicians' self-reported practice with and perceptions of carer inclusive practice as relevant to depression.
- 2 It highlights that carer inclusive practice with this target group does not yet appear to be routine (even among this selfselecting sample) and that participants identified numerous (primarily organisational) barriers to engaging in carer inclusive practice.
- 3 Further research is needed to identify not just what hinders carer inclusive practice, but also what enables it.

Depression is a common mental illness and a leading contributor to the disability experienced in Australia (ABS, 2008). It tends to be recurrent in nature and affects people of all ages and socioeconomic backgrounds. Depression affects a person's quality of life and frequently their relationships, work participation, and general well-being. However, the impact of depression is not limited to the person experiencing the illness. Depression also impacts the lives of those who support a person with depression. Family and friends provide the majority of day-to-day care and support to people in the community experiencing depression. While many people who provide this type

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of support do not identify themselves as carers, they would meet the criteria used in Australian legislation to identify carers. This definition states: "carers are people who provide personal care, support and assistance to another individual in need of support due to disability, medical condition, including terminal or chronic illness, mental illness or who is frail and aged" (*Carers Recognition Act, 2010*; McMahon, Hardy, & Carson, 2007).

Carers of people with depression provide a range of practical and emotional support. For example, they may take on increased responsibility for household tasks, facilitate access to treatment, listen to and encourage the person they support, and provide "moral" support during crisis periods (Muscroft & Bowl, 2000). However, carers of people with depression also describe many difficult emotional experiences. They commonly report feeling confused or overwhelmed by the depressive symptoms, being worried about stigma, the future and suicide, and experiencing guilt and a sense of responsibility for the person they support (Highet, McNair, Davenport, & Hickie, 2004). Carers of people with depression also consistently report feeling isolated and that their relationship with their loved one has changed as a result of the depression (Harris, Pistrang, & Barker, 2006; Highet et al., 2004). Furthermore, the consequences of the carer role for carers of people with depression appear to be similar, and equivalent, to the consequences reported by carers of people with schizophrenia (van Wijngaarden et al., 2009). The recurrence of depression also means that the care and support role can be an intermittent, but enduring, one.

The carer role can take its toll on the mental health and well-being of carers. Carers of people with depression are consistently found to have elevated rates of depression and anxiety compared with the general population, with upwards of 40% of sample participants reporting significant depressive or anxious symptoms themselves (e.g., Coyne et al., 1987; Ostman & Hansson, 2001; Spangenberg & Theron, 1999). Many carers of people with depression report feeling that they were unprepared for the challenges presented by the carer role or were not offered specific or adequate support (Highet et al., 2004).

Family and carer inclusive practice refers to collaboration between service providers and family members and carers in the assessment, care planning, and treatment of people with a mental illness. It refers to practices such as identifying who the primary support people are for a person with mental illness; discussing with a client the benefits of, or concerns about, involving a carer or support person(s) in care planning and treatment sessions; engaging in respectful and responsive communication with carers about issues relevant to the well-being of the person being supported; providing information to carers about the illness, treatments, and services available to support the care recipient and themselves; discussing the carer's role in crisis situations and/or relapse prevention; acknowledging the potential impact that providing support to a person with mental illness can have, and, where appropriate, supporting a carer to address these difficulties, through information provision, collaborative problem solving, or advice about and referral to other support services; and where indicated and subject to the client's consent, involving carers more intensively in treatment activities.

Currently, the health and community service system in Australia is designed to provide treatment to people with mental illness (including depression) through public and private mental health service providers. Carers may be invited to participate in assessment, treatment, and care planning by the person they are supporting, or, where permission has been sought, by a treatment provider. Carers can access carer-specific support through counselling services provided by carer associations, some nongovernment agencies and some community health agencies. Some mental health services have also established specific supports for carers through group programmes, family workers, and carer consultant roles. The nature of the support provided by these different services is varied, with different intended outcomes (e.g., increased understanding of the illness; reduction in carer stress), delivery strategies (e.g., individual counselling, groups, peer consultation), and level of independence from the treatment for the person being supported.

The importance of including family members and carers in the assessment and treatment of people with mental illness is becoming more widely acknowledged. There is increasing evidence to indicate that supporting family members and carers of people with depression is associated with faster and better recovery of the person with depression (Shimazu et al., 2011), similar to the well-established benefits of incorporating family interventions into treatment options for people with schizophrenia. Consumers frequently want, or are open to, family members, carers, or support people being involved in care planning, and when this is the case and it is offered, consumers report significantly higher satisfaction with care (Bolkan et al., 2013; Murray-Swank et al., 2007). Furthermore, Australian government policy at federal and state levels has emphasised the importance of acknowledging the role of carers of people with mental illness. These policies commit mental health services to involving carers at systems and individual treatment levels. Thus, within Australia, there is an expectation that carers of people with mental illness (including depression) should be involved in the treatment for the person they care for, if not provided with individual support themselves. Despite this, little is known as to what influences the actual support provided to Australian carers.

To date, clinicians' perceptions of carer inclusive practice have only been investigated in a very limited way, and all studies have focused on the support provided to carers of people with mental illness in general. Rates of contact with family members of people with mental illness vary, with between 15% and 80% of mental health clinicians reporting some recent contact with client family members, albeit usually of a limited and infrequent nature (Dixon, Lucksted, Stewart, & Delahanty, 2000; Kim & Salyers, 2008; Marshall & Solomon, 2004). Interestingly, these relatively low rates of contact are usually in the context of positive clinician attitudes regarding the value, importance, and potential benefits of carer inclusive practice (Dixon et al., 2000; Goodwin & Happell, 2007; Kim & Salyers, 2008), which has led to research regarding barriers to family and carer inclusive practice.

The most common barriers identified by clinicians to carer inclusive practice are typically organisational in nature. They include lack of resources and funding to provide a carer-focused service, conflicting priorities and the inflexibility of service delivery systems (Beecher, 2009; Goodwin & Happell, 2008; Kim & Salyers, 2008). Clinician level barriers have also been identified, although clinicians usually rate the impact of these barriers lower, including issues such as lack of training or skills in working with family members or not seeing the value of involving carers (Kim & Salyers, 2008; Wright, 1997). Barriers relevant to consumer or carer preferences and capacity have also been identified in studies involving clinicians and consumers (Kim & Salyers, 2008; Murray-Swank et al., 2007). For example, family members may not be interested or want to be involved in the treatment process, or consumers may refuse to have their loved ones involved. Other issues such as stigma associated with accessing a mental health support service or whether a person identifies as a "carer" (or not) may also affect a family members' willingness to engage with services. Furthermore, the issue of confidentiality has been specifically identified by both clinicians and carers as being a matter that can inhibit carer inclusive practices (NMHCCF, 2011). Clinicians identify worries about losing the trust of clients and legal ramifications if they have contact with family members or carers, and little is understood about the difference between "general" information which can be provided to a carer and "personal" information which cannot, in the event of a client not providing permission to discuss their well-being with family members (Slade et al., 2007).

To date, research in Australia has focused on the carers' experience of mental health services or qualitative investigations of clinician perceptions of carer participation. There have been no studies that have quantitatively investigated the nature of carer inclusive practice for people with depression and its relationship with attitudes or perceived barriers of Australian mental health workers. While previous researchers (e.g., Kim & Salyers, 2008; Wright, 1997) have identified that clinician discipline (e.g., social worker, psychiatrist, nurse) and previous training may affect the frequency of reported carer inclusive practice, how clinician attitudes or barrier perceptions may be influenced by primary client group (mental health consumers or family members and carers) has not been investigated, nor the relevance of these factors for Australian clinicians. Developing a better understanding of the nature of inclusive practice for depression and what influences it within Australia will provide a step towards ensuring that those people whose lives have been affected by depression receive the best possible support.

The current study was exploratory in nature. The purpose of the study was to provide a snapshot of the attitudes of, barriers experienced, and current clinical practices of Australian mental health workers who provide support to carers of people with depression. Participants completed a cross-sectional questionnaire that examined their attitudes, perceived barriers, and clinical practices. Comparisons were made between clinicians' primary client group (family members and carers or mental health consumers) and exposure to training that was specific to providing support to family members or carers of people with depression.

## Method

## **Study Design and Setting**

This study used a cross-sectional design. Data were collected on one occasion using a self-administered questionnaire. It was undertaken in the context of the national dissemination training initiative of the *Partners in Depression (PID)* programme and used a convenience sample. The *PID* dissemination initiative involved providing training and support to health and community professionals across Australia to deliver a group education programme developed specifically to address the needs of carers of people with depression.

## Participants

One hundred and nineteen mental health and community workers participated in the study. They were drawn from government (59%), non-government (29%), private (4%), and other (3%) mental health and health services across Australia, with a small proportion of participants (5%) working across sectors. Public mental health services represented the largest participant group (46%), followed by participants from divisions of general practice (11%), carers' organisations (8%), and public community health services (8%) (see Table 1 for other demographic details). Participants worked directly with consumers (n = 70) or family members and carers (n = 37), with 10

**Table 1**Demographics of Participants

	PID trained	Non-PID trained	Whole sample	
Number of participants	55	64	119	
Gender- % female	89%	89%	89%	
Average age- years	46.81 (SD11.8)	39.87 (SD10.63)	43.04 (SD11.66)	
Average years of experience	12.02 (SD9.35)	9.88 (SD 8.09)	10.87 (SD 8.72)	
Primary client group				
Mental health consumers	47%	70%	60%	
Family members and carers	47%	19%	32%	
Work with both client groups	6%	11%	8%	
Discipline				
Psychologists	22%	55%	40%	
Social workers	19%	11%	14%	
Occupational therapists	4%	5%	4%	
Nurses	13%	9%	11%	
Counsellors	18%	9%	14%	
Other community roles*	24%	11%	17%	

*Note.* \*Included carer consultants, carer support workers, community development workers, educators, and trainers.

participants working directly with both client groups and two participants who did not respond to this question.

Nearly half (46%) of the sample had attended *PID* facilitator training. To attend *PID* facilitator training, clinicians had to have appropriate mental health knowledge and group work experience and indicate commitment to delivering the *PID* programme at least three times in their local community. Information about the training had usually been disseminated by service managers, after approval from state level policy managers. There was a significant age difference between those participants who had completed the *PID* facilitator training compared with those participants who had not completed the facilitator training, t(119) = 3.30, p = .001, 95% confidence interval (CI), with *PID* participants being significantly older than non-*PID* facilitators. There were no other significant differences on demographic characteristics between the two groups.

#### Procedure

Multiple recruitment strategies were used to ensure a diverse range of mental health workers were recruited. This included advertising the study on the Hunter Institute of Mental Health website and promotion of the study by Hunter New England Health local heads of disciplines, professional associations, and various service managers. Interested clinicians could access the information and consent forms and complete the questionnaire online via the Hunter Institute of Mental Health's website, or by contacting the project team and requesting a hard copy of the materials be sent to them.

Table 2	Attitudes	Towards	Family	Members	and Carers	of Peo	ple with [	Depression
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Proportion of the sample agreeing with the following statements ( $n = 119$ )	Disagree <sup>a</sup> %	Neutral %	Agree <sup>b</sup> %
Partnering with carers			
16. Providing information and skills for carers helps to reduce relapse rates for their loved ones		20%	80%
17. Carers are an important source of information for clinicians		4%	96%
<ol> <li>I work hard to involve (or support involvement of) carers in the treatment for the person diagnosed with depression</li> </ol>	4%	16%	80%
19. Carers are co-partners with clinicians in the rehabilitation/recovery of the person with depression	3%	15%	82%
20. Carers are an important resource for clinicians in advocating for change in the mental health system		5%	95%
24. Many carers have learnt to manage the depression fairly well	21%	56%	23%
Perceptions of carers			
21. Supporting someone with depression can have an impact on the carer's own mental health		2%	98%
22. Family members of people with depression often have their own mental health issues	8%	31%	61%
26. Carers generally have little knowledge or understanding about depression	24%	40%	36%
29. The involvement of carers in the care planning process is often harmful to the person with depression	84%	11%	5%
31. Carers are too emotional to deal with information about depression	79%	15%	6%
32. Carers are generally satisfied with the level of support they are provided with	58%	33%	9%
Working with carers			
23. Carers want to work more closely with staff	4%	25%	71%
25. Carers often have unrealistic expectations for the person's (diagnosed with depression) improvement	7%	49%	44%
27. Carers have difficulty communicating with clinicians	24%	36%	40%
28. Carers are often resistant clinicians' suggestions	53%	37%	10%
30. Carers are generally cooperative in the treatment process of the person with depression	5%	33%	62%

Note. <sup>a</sup>The disagree category represents the total proportion of the sample who responded negatively (disagree and strongly disagree); <sup>b</sup>The agree category represents the total proportion of the sample who responded positively (agree and strongly agree).

People who had attended the *PID* facilitator training were specifically invited to participate in the study. They were provided with a hard copy of the information sheet, consent form, questionnaire, and an unmarked envelope at training, or invited to participate in the study via an email from the project team. After training, participants returned the hard copy questionnaire on the day, posted it back to the researchers in a reply paid envelope, or completed it online. Those who did not want to participate either did not take a questionnaire, placed a blank survey in the collection box, or simply did not respond to the email invitation. Participation was voluntary and it did not have any bearing on their *PID* training if they chose not to take part.

Fifty-seven per cent of the questionnaires were completed online. Response rates of non-*PID* participants were unable to be calculated as it was unknown as to how many people information about the study was disseminated. A total of 55 participants who attended the *PID* facilitator training completed the questionnaire, representing a response rate of 13.55%.

#### Measures

A self-administered questionnaire was adapted for the purposes of this study. The questionnaire covered clinicians' attitudes, barriers, beliefs, and perceived confidence in working with people who care for a person with depression. The questionnaire was based on a questionnaire developed by Kim and Salyers (2008), which has been shown to have good internal reliability and validity. For this study, the questions were modified to refer to individuals diagnosed with depression rather than severe mental health problems.

Participants provided background information including their discipline/profession, years of working, main area of work, and

caseload numbers. The second part of the questionnaire comprised the adapted Kim and Salyers (2008) questionnaire. First, participants answered a range of questions about their attitudes towards carers and including them as part of their clinical practice. All responses were multiple choice and measured on a Likert scale from 1 (strongly disagree) to 5 (strongly agree). An overall attitudes score was calculated using the total sum of scores for the 17 items in the scale, with relevant items reverse coded. Higher total scores indicate more positive attitudes towards family members and carers. The scale had acceptable reliability (Cronbach's alpha = .63). A principal components analysis with varimax rotation identified three factors accounting for 41% of variance. This included partnering with carers, perceptions of carers, and working with carers, accounting for 20%, 11%, and 10% of variance, respectively (see Table 2 for items relevant to each factor). Second, participants answered questions about perception of barriers to including carers of people with depression in their clinical practice. Answers were multiple choice and rated on a Likert scale from 1 (not at all) to 4 (great *impact*). An overall barriers score was calculated using the total sum of scores for the 16 items in the scale, with relevant items reverse coded. Higher total scores indicate greater perceived impact of barriers. The scale had excellent reliability (Cronbach's alpha = .86). A principal components analysis with varimax rotation identified four factors accounting for 60% of variance. This included family/client and operational barriers, clinician/staff barriers, service/agency barriers, and service accessibility barriers, accounting for 33%, 10%, 10%, and 7% of variance, respectively (see Table 3 for items relevant to each factor).

The third part of the questionnaire focused on clinical practices. As participants in the current study were either employed to work directly with the person affected by mental illness

Table 3         Barriers to Carer Inclusive Practice for People with Depression
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Proportion of the sample who rated the following as a barrier to the inclusion of family members and carers of people with depression ( $n = 119$ )	Not at all %	Minor impact %	Moderate or great impact %
Family/ client and operational barriers			
37. Consumers refusing to allow involvement of carers	1%	23%	76%
38. The complexity of the work required for clinicians when carers are involved	7%	35%	59%
39. The lack of knowledge/understanding that carers have of depression	4%	17%	79%
40. Lack of knowledge or scepticism about the benefits to be obtained by involving carers	6%	18%	75%
<ol> <li>Lack of interest from carers in being involved in the care planning for the person with depression</li> </ol>	11%	27%	62%
42. Carers' difficulties in communicating with clinicians	6%	22%	72%
44. Confidentiality regulations make it too difficult to involve carers	12%	34%	54%
Clinician/ staff barriers			
36. Not knowing how to work with a person's culture to encourage carers	19%	44%	37%
46. Limited skills and confidence in working with carers	11%	20%	69%
48. A lack of interest in wanting to work with or involve carers of people with depression.	17%	29%	53%
Service/ Agency barriers			
43. A lack of agency support to provide services for carers	4%	13%	83%
45. A lack of guidance and leadership from my organisation about how carers should be involved	36%	22%	42%
47. Mental health workers have too many other demands with their workload to work with carers of people with depression	2%	14%	84%
Service accessibility barriers			
33. Organisations not able to provide services		14%	86%
34. Services not being available in certain areas		4%	96%
35. Carers not able to afford services	4%	17%	79%

(including depression) or carers of people affected by illness (including depression), there were two variations of questions included to accommodate this. In contrast to the Kim and Salyers (2008) study which asked participants to indicate how often they had provided specific interventions in the past 6 months, participants were asked to use the example of the most recent family member, carer, or support person of a person with depression, or the last person with depression they had worked with, and indicate which of the listed interventions they had completed. The list of activities were adapted from the Kim and Salyers original questionnaire. The number of activities completed were summed to give a total score. The scale had good reliability (Cronbach's alpha = .76).

#### Ethics

The study was approved by both the Hunter New England Human Research Ethics Committee and the University of Newcastle Ethics Committee.

## **Data Analysis**

Descriptive and inferential statistics were used to investigate the data. All variables were tested for normality, homogeneity, and symmetry. Independent *t*-tests and analysis of variances (or non-parametric equivalents) were used to identify whether attitudes, barriers, or reported inclusive practice differed by primary client group (mental health consumers or family members and carers) or exposure to training (non-*PID* or *PID*). Participants who identified as working with both mental health consumers and family members or carers were excluded from the client

group comparative analyses. Bivariate correlations were used to investigate the relationships between the dependent variables. Regressions were used to further explore these relationships.

## Results

## **Inclusive Clinical Practice**

Of those clinicians who worked with mental health consumers, 55% reported including family members or carers of people in the assessment or treatment of a person with depression only sometimes, rarely, or never (see Figure 1). Figure 2 provides an overview of the proportion of participants who reported that they had completed the listed activity with their last relevant client, divided by primary client group.

#### **Clinician Attitudes**

The distribution of responses to the attitudes questions can be viewed in Table 2. Overall, attitudes of clinicians towards carers of people with depression and inclusive practice were generally positive. There was a significant difference between the attitudes total score of those working directly with families and carers and those working directly with mental health consumers, t(97) = -2.68, p = .009, d = -0.56, 95% CI [-1.70, -0.81]. Those who worked with family members and carers had significantly more positive attitudes (M = 64.53, standard deviation [SD] = 4.27) than those working with mental health consumers (M = 61.92, SD = 4.87). There were no significant differences between the attitudes of the *PID*-trained and non-*PID*-trained participants, t(107) = -1.18, p = .24, d = -0.23, 95% CI [-1.11, -1.42].

Supporting carers of people with depression



**Figure 1** Percentage of Clinicians Working with Mental Health Consumers who Involved the Family Member/Carer in the Assessment/Treatment Process as Part of Routine care (n = 70).

#### **Perceived Barriers**

Distribution of responses to the barriers questions can be viewed in Table 3. Nearly all items were identified as constituting a barrier by at least some of the sample. The most frequently identified barriers were organisational in nature.

There was a significant difference in the total barriers scores reported by those working directly with families and carers compared with those working directly with mental health consumers, t(98) = -3.67, p = .001, d = -0.77, 95% CI [-2.64, -1.04]. The mean score for those working directly with mental health consumers (M = 45.75, SD = 7.98) was significantly lower than for those working directly with carers (M = 51.25, SD = 5.59). Thus, those working with families and carers perceived greater impact of barriers on capacity to engage in inclusive practice than those working with mental health consumers.

There was also a statistically significant difference in the total barriers score reported by those who were *PID* trained and those that were not *PID* trained, t(107) = 2.39, p = .019, d = -0.46, 95% CI [-1.56, -2.41]. The mean of the *PID*-trained group was significantly higher (M = 49.96, SD = 7.65) than the non-*PID*-trained group (M = 46.38, SD = 7.96), meaning the *PID*-trained group reported greater impact of barriers on capacity to engage in inclusive practice.

#### Relationship Between Attitudes, Barriers, and Clinical Practice

A bivariate correlation indicated that there was no significant relationship between the attitudes and barriers scores for the whole sample, r(109) = .10, p = .30. There was also no significant relationship between the attitudes of clinicians working with consumers and their clinical practices, r(39) = -.11, p = .51, or their total barriers score, r(63) = .03, p = .84. For clinicians working with family members or carers, there was no significant relationship between their attitudes and their clinical

practices, r(25)=.18, p = .40. However, there was a moderate, positive relationship between the barriers perceived by those working with family members and carers and their clinical practices, r(28) = .38, p = .047, with higher scoring of barriers being associated with a greater number of interventions having been provided to family members and carers. While perceived barriers were significantly associated with inclusive clinical practice scores for those working directly with family members and carers,  $\beta = 31.48$ , t(1)4.35, p = .03, they only explained a small proportion of variance (14%), *R squared adjusted* = .137, *F*(1, 27) = 5.297, p = .03.

## Discussion

The attitudes of participants were largely positive towards inclusive practice and working with family members and carers of people with depression. While participants reported that they were engaging in inclusive practice, it did not appear to be necessarily routine practice and a number of barriers were identified. Participants were largely consistent in their reported attitudes, the barriers they identified, and the types of support provided to carers of people with depression. The barriers identified as hindering inclusive practice were primarily associated with perceived organisational factors, rather than clinicianrelated variables. Interestingly, there were some differences in the total impact of barriers identified by those who worked directly with families and carers compared with those who worked directly with mental health consumers, but there were few differences in the type of support they offered to family members and carers of people with depression.

#### **Clinical Practices**

In this participant group, over half of the clinicians reported that they did not regularly include family members or carers in their routine assessment and treatment process for a person with depression. This rate appears consistent with carers' experience of "patchy" inclusive mental health service practice as reported in the 2012 *Mental Health Carers Report Card* (MHCA, 2012) and suggests that there may be some way to go in improving the frequency of inclusive care for people with depression.

When asked to reflect back on what support they had provided to the last relevant client they had seen who had depression, the frequency of some completed activities were more promising. Eighty per cent of the sample indicated that for the last relevant client, they had provided information about the illness and treatment to the carer, given an orientation to relevant services, included the carer in treatment planning for the person with depression, and discussed how to respond in a crisis situation. This is somewhat higher than expected. Kim and Salyers (2008) found that only about one third of their sample reported providing these interventions to family members and carers on a regular basis. Similarly, it contradicts the experience of disengagement described by carers in the literature (e.g., Goodwin & Happell, 2006; Highet et al., 2004). This disparity may be accounted for by the fact that the current study asked about a specific case rather than usual practice. Alternatively, social desirability pressures or the self-selecting nature of this sample may have influenced the finding. Thus, while promising,



Figure 2 Percentage of Participants who Indicated They had Completed Each Activity with the Family Members of the Last Client They Saw with Depression.

the degree to which these rates represent typical practice in the mental health sector is unknown.

#### Attitudes

Consistent with previous research (Goodwin & Happell, 2007; Kim & Salyers, 2008; Wright, 1997), this sample reported positive attitudes towards including family members and carers when working with a person with depression. Participants largely recognised the impact of depression on family members and carers and appeared to value carers' input into the treatment process. In contrast to Kim and Salyers's (2008) study of American mental health clinicians, a much larger proportion of this sample identified that they believed carers were unlikely to be satisfied with the current level of support provided to them, and those exposed to carer-specific training did not report more positive attitudes. Clinicians who worked directly with carers, however, did report more positive attitudes than clinicians who worked primarily with consumers. This finding is not surprising. It may be a consequence of the carer-specific group having pre-existing more favourable attitudes about the importance of supporting carers or they may have experienced the value of inclusive practice first hand more frequently resulting in more positive attitudes. Alternatively, clinicians working with consumers may naturally focus more on the needs of the mental health consumer and not value as highly the importance of carer inclusive practice. The lack of a training effect might be a consequence of the self-selection bias of the sample. Regardless, this finding highlights that more frequent contact with carers was associated with a higher value attributed to inclusive practice.

#### Barriers

The most frequently identified barriers were, for the most part, organisational in nature (e.g., service unavailability, workload, agency support). Clinician-related variables were identified less frequently (e.g., lack of knowledge or interest, limited skills). This pattern is consistent with previous research conducted overseas and as relevant to providing support to carers of people with mental illness generally (Dixon et al., 2000; Goodwin & Happell, 2008; Kim & Salyers, 2008). Combined with the findings from previous studies, this study provides further evidence to suggest that organisational barriers have a specific and important effect on individual clinicians' capacity to engage in carer inclusive practice.

Participants who worked with carers and family members and those who had attended *PID* training had higher barrier ratings that those who worked with consumers or who had not attended the training. This may be a consequence of these groups having more contact with carers and family members and therefore becoming more aware of the difficulties impeding the delivery of carer inclusive support. It highlights that clinicians who provide more support or are interested in providing more support, to carers of people with depression may also be more likely to identify a greater impact of barriers on their capacity to engage in carer inclusive practice.

Just over half of the sample indicated that confidentiality regulations had had a "great impact" on capacity to engage in inclusive practice. This is perhaps less than would have been expected based on the frequency with which confidentiality has been identified as a barrier in previous studies (e.g., Kim & Salyers, 2008; NMHCCF, 2011). However, a greater proportion of the sample (76%) identified consumers refusing to allow carer involvement as having a major effect on carer inclusive practice capacity. It is possible that it is the combination of these two issues that becomes particularly problematic for service providers, in that, it is not clear how a service provider can maintain a carer inclusive approach when their client has indicated that they do not wish family members or support people involved in their treatment provision or care planning. In light of this issue, the National Mental Health Consumer and Carer Forum (2011) have recommended that ethical guidelines explicitly address what can be communicated to carers when no consent has been provided by a client, and recommended that additional training and workforce support would assist service providers in addressing this barrier.

## Relationship Between Attitudes, Barriers, and Inclusive Practice

The lack of significant associations between attitudes and barriers scores suggests that attitudes towards family members and carers were not related to perception of barriers. The relationship between attitudes and clinical practices was also not significant for participants working with family members and carers or for participants working with mental health consumers, such that the clinical interventions offered to family members and carers by this sample were independent of their attitudes.

However, for participants working with family members, perception of barriers and reported clinical practice were significantly related, with the more barriers identified by clinicians who worked with family members and carers, the more interventions they reported providing. It would have been reasonable to speculate that the more barriers perceived, the fewer interventions provided, with the number of barriers representing the deterrent. However, the current finding indicates that if professionals were providing more interventions, they were also more aware of the issues faced by family members and carers, although this relationship was not seen for those working with consumers. Perhaps this can be explained by the fact that those working directly with mental health consumers may be less familiar with the issues experienced by family members and carers due to their reduced contact. The alternative implication is that it is not necessarily barriers that hinder inclusive practice, rather it may be that those who work with family members and carers (and are more aware of the barriers) are enabled in some way to support this target group. Thus, it may be important for future research to consider not only what inhibits family inclusive practice, but also what enables it to occur.

## Implications for the "Real World"

Based on the findings from this study, it would appear that it is not necessarily the attitudes of clinicians or the perceived barriers that determine whether inclusive practice is engaged in or not. In this study, attitudes, and to a lesser degree, barriers were not significantly related to the support clinicians reported they had provided to the last relevant client. Therefore, it seems necessary to investigate other potential contributing factors. This may involve investigating the enablers that provide capacity for family inclusive practice to occur, despite the barriers faced.

While barriers did not predict clinical practice in the way expected in this study, the nature of the barriers identified by this sample provides further evidence that organisational issues influence individual clinicians' capacity to engage in carer inclusive practice. After the unavailability of services, the participants in this sample identified the barriers of workload pressures and lack of agency support most frequently. This seems to suggest that competing priorities may mean that carer collaborative support is seen as an add-on rather than core business for mental health service clinicians. The Report Card on Mental Health and Suicide Prevention (NMHC, 2012) suggested that a "new way of thinking" and a "new way of working" was needed for mental health services to become carer inclusive (p. 39). It also highlighted the need for specific research into models of effective inclusive practice, so that appropriate models could be identified and then implemented in a broad fashion. Thus, carer inclusive practice may not just be about clinicians more regularly and effectively engaging with carers, it may also be about implementing models of care that specifically identify or recruit family members and carers to participate in a specific way with the service. This may not be possible without specific investment and prioritisation.

#### Strengths, Limitations, and Future Research

It is important to acknowledge the limitations of the current study. The sample size was relatively small meaning power issues might limit the conclusiveness of null findings. There was also a small response rate of participants (even for the captive audience of PID facilitators), meaning that great caution must be used when generalising results to clinicians across Australia. Further, while the recruitment strategy enabled capture of a diversity of inclusive practice, it also represents a significant limitation of the study. The sample was self-selecting and this means that only limited inferences can be made about inclusive practice among the general mental health workforce. In fact, it is likely that the results from this study represent the attitudes, perceived barriers, and clinical practices of only the most interested family and carer inclusive clinicians. This could mean that attitudes would have been poorer and barriers greater, if a broader sample had been recruited. It is also possible that the frequency with which carer inclusive clinical practice was reported may have been lower if participants had not been self-selecting.

Researchers may wish to further investigate the inclusive practice of family members and carers of people with mental illness within Australia more generally, in order to identify the degree to which there are similarities or differences across carer groups and whether providing support to carers of people with depression represents a large proportion of carer work, in light of the prevalence of depression. The use of other measures and further development of the scale used could also strengthen this study. For example, it would be useful to consider using a more sensitive attitudes scale, a scale with a greater scope for incorporating barriers specific to the Australian context, and to identify other ways to capture clinical practice rather than through

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retrospective self-report. Finally, it is important to acknowledge that we do not currently know how self-identification (or not) of being a carer or family member of a person with mental illness affects access, interest, or willingness to engage with the range of support options available. This will be an important area for future study.

## Summary

Overall, the findings from this study are consistent with previous research and build on the existing body of research by specifically exploring Australian mental health professionals' perspectives on supporting family members and carers of people with depression. The findings from this study regarding clinician attitudes and perceived barriers in working with carers of people with depression were comparative to those reported in studies conducted overseas, and with reference to supporting carers of people with a range of psychiatric diagnoses. This study provides a snapshot of a group of interested clinicians' attitudes towards and actual clinical practices with people who care for a loved one with depression. While in many ways promising, the findings need to be replicated with a non-self-selecting sample to be confident in the generalisability of the conclusions.

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## References

- Australian Bureau of Statistics (ABS) (2008). 2007 National survey of mental health and wellbeing: Summary of results (4326.0). Canberra, Australia: Author.
- Beecher, B. (2009). Mental health practitioners' views of the families of individuals with schizophrenia and barriers to collaboration: A mixed methods study. *Journal of Family Social Work*, 12(3), 264–282. doi:10.1080/10522150802654260
- Bolkan, C. R., Bonner, L. M., Campbell, D. G., Lanto, A., Zivin, K., Chaney, E., & Rubenstein, L. V. (2013). Family involvement, medication adherence, and depression outcomes among patients in Veterans Affairs primary care. *Psychiatric Services*, *64*(5), 472–478. doi:10.1176/appi.ps.201200160
- Carers Recognition Act (2010). Retrieved from http://www.comlaw .gov.au/Details/C2010A00123
- Coyne, J. C., Kessler, R. C., Tal, M., Turnbull, J., Wortman, C. B., & Greden, J. F. (1987). Living with a depressed person. *Journal of Consulting and Clinical Psychology*, 55(3), 347–352. doi:10.1037/0022-006X.55.3.347
- Dixon, L., Lucksted, A., Stewart, B., & Delahanty, J. (2000). Therapists' contacts with family members of persons with severe mental illness in a community treatment program. *Psychiatric Services*, *51*(11), 1449–1451. doi:10.1176/appi.ps.51.11.1449
- Goodwin, V., & Happell, B. (2006). Conflicting agendas between consumers and carers: The perspectives of carers and nurses. *International Journal of Mental Health Nursing*, 15(2), 135–143. doi:10.1111/j.1447-0349.2006.00413.x
- Goodwin, V., & Happell, B. (2007). Psychiatric nurses' attitudes towards consumer and carer participation in care: Part 1-exploring the issues. *Policy, Politics and Nursing Practice*, *8*, 276–284. doi:10.1177/1527154408315640
- Goodwin, V., & Happell, B. (2008). Psychiatric nurses' attitudes toward consumer and carer participation in care: Part 2—barriers to

participation. *Policy, Politics and Nursing Practice*, *9*, 249–256. doi:10.1177/1527154408316064

- Harris, T., Pistrang, N., & Barker, C. (2006). Couples' experiences of the support process in depression: A phenomenological analysis. *Psychology and Psychotherapy: Theory, Research & Practice*, 79, 1–21. doi:10.1348/147608305X41218
- Highet, N. J., McNair, B. G., Davenport, T. A., & Hickie, I. B. (2004). "How much more can we lose?": Carer and family perspectives on living with a person with depression. *Medical Journal of Australia*, 181(7), 56–59.
- Kim, H. W., & Salyers, M. P. (2008). Attitudes and perceived barriers to working with families of persons with severe mental illness: Mental health professionals' perspectives. *Community Mental Health Journal*, 44, 337–345. doi:10.1007/s10597-008-9135-x
- Marshall, T., & Solomon, P. (2004). Provider contact with families or adults with severe mental illness: Taking a closer look. *Family Process*, 43(2), 209–216. doi:10.1111/j.1545-5300.2004.04302006.x
- McMahon, J., Hardy, J., & Carson, L. (2007). *Identifying the carer project: Final report and recommendations*. Canberra, Australia: Department of Health & Ageing.
- Mental Health Council of Australia (MHCA) (2012). Recognition and respect- Mental health carers report 2012. Canberra, Australia: Author.
- Murray-Swank, A., Glynn, S., Cohen, A. N., Sherman, M., Medoff, D. P., Fang, L. J., & Dixon, L. B. (2007). Family contact, experience of family relationships, and views about family involvement in treatment among VA consumers with serious mental illness. *Journal of Rehabilitation Research and Development*, 44(6), 801. doi:10.1682/JRRD.2006.08.0092
- Muscroft, J., & Bowl, R. (2000). The impact of depression on caregivers and other family members: Implications for professional support. *Counselling Psychology Quarterly*, 13(1), 117–134. doi:10.1080/09515070050011105
- National Mental Health Commission (NMHC) (2012). A contributing life: The 2012 national report card on mental health and suicide prevention. Sydney, Australia: Author.
- National Mental Health Consumer and Carer Forum (NMHCCF) (2011). Privacy, confidentiality and information sharing- Consumers', carers and clinicians' position statement and issues paper. Canberra, Australia: Author. [12 July 2013] Retrieved from http://www .nmhccf.org.au/documents/NMHCCF%20P&C%20ps%20&%20ip.pdf
- Ostman, M., & Hansson, L. (2001). The relationship between coping strategies and family burden among relatives of admitted psychiatric patients. *Scandinavian Journal of Caring Sciences*, 15, 159–164. doi:10.1046/j.1471-6712.2001.00020.x
- Shimazu, K., Shimodera, S., Mino, Y., Nishida, N., Kamimura, N., Sawada, K. & Inoue, S. (2011). Family psychoeducation for major depression: randomised controlled trial. *British Journal of Psychiatry*, 198, 385–390. doi:10.1192/bjp.bp.110.078626
- Slade, M., Pinfold, V., Rapaport, J., Bellringer, S., Banerjee, S., Kuipers, E., & Huxley, P. (2007). Best practice when service users do not consent to sharing information with carers national multimethod study. *The British Journal of Psychiatry*, 190(2), 148–155. doi:10.1192/bjp.bp.106.024935
- Spangenberg, J., & Theron, J. (1999). Stress and coping strategies in spouses of depressed patients. *The Journal of Psychology*, 13(3), 253–262. doi:10.1080/00223989909599738
- van Wijngaarden, B., Koeter, M., Knapp, M., Tansella, M., Thornicroft, G., Vázquez-Barquero, J. L., & Schene, A. (2009). Caring for people with depression or with schizophrenia: Are the consequences different? *Psychiatry Research*, *169*(1), 62–69. doi:10.1016/j.psychres.2008.06.013
- Wright, E. R. (1997). The impact of organisational factors on mental health professionals' involvement with families. *Psychiatric Services*, 48(7), 921–927.