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Exploring the Meaning of Collaboration in Rural Mental Healthcare Delivery From the Perspective of Mental Health Clinicians and Informal Carers of People Living With a Mental Health Illness—A Qualitative Study

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ABSTRACT

Mental health policies and practice guidelines emphasise the importance of collaboration with informal carers of people with mental illness, but this does not routinely occur in practice. Understanding the perspective of different parties regarding collaboration is a step towards ensuring an alignment between policy and routine clinical practice. This study explored the meaning of collaboration from the perspectives of informal carers and mental health clinicians in a rural Australian mental health service. This qualitative descriptive study used purposive sampling to recruit informal carers ($n=7$) and mental health clinicians ($n=14$) from an acute mental health inpatient facility. Data was generated from focus groups and semi-structured interviews and analysed using thematic analysis. Three overarching themes were identified: *three-way partnership, purposeful exchange and communication is everything.* Clinician and informal carer participants described collaboration as a respectful partnership that necessarily involves the consumer, their carers and clinicians. The purpose of the partnership was identified as providing holistic care *to the consumer,* which essentially includes support for their carer. Open and clear communication, as well as information sharing, were identified as important to collaboration. However, the experiences of informal carers did not reflect this description of collaboration. Adequate support for informal carers, recognition of their expertise and open and consistent communication are key to a collaborative process that delivers better outcomes for consumers and their carers. Proactive clinician training and a practical guide to inform the delivery of routine informal carer engagement in mental health services are required to achieve an effective three-way collaboration.

1 | Introduction

Informal carers, hereafter referred to as 'carers', play a significant role in the recovery of people with mental illness, particularly in remote and rural settings where there are limited mental health services (National Mental Health Alliance 2021; Svendsen et al. 2021). Carers are family members or friends who provide unpaid care and ongoing support to a person due to disability, chronic or terminal disease, mental illness or age-related frailty (Australian Government 2010; Roth et al. 2015). The support that carers provide to people with severe mental illness (hereafter referred to as 'consumers') varies depending on the level of the consumer's psychosocial difficulties. The support may include financial, housing, physical, social and emotional assistance (Deloitte Access Economics 2020; Sündermann et al. 2014).

The challenges of delivering mental health services in remote and rural settings mean that carer support is critical to bridging the gap between the consumer and the required professional services (Cruz 2020; Punton et al. 2022). The challenge of delivering mental health services in rural and remote Australia is complex and is exacerbated by socioeconomic, geographical and broader health system factors (Bourke et al. 2012; Perkins et al. 2013; Saurman 2016). The socioeconomic challenges include stigma, affordability of services, cultural beliefs and attitudes, awareness of healthcare access and increased concern about confidentiality (Kaukiainen and Kõlves 2020; Kavanagh et al. 2023; Perkins et al. 2013). Geographical factors include the distance from other population centres where most services are located, increased cost of delivering services to sparse populations and the burden of travel (Bourke et al. 2012; Saurman 2016). There are also broader health system challenges, including limited infrastructure, the inability to hire and retain specialists and experienced clinicians and an ageing population (Mental Health Commission of New South Wales 2018; Southern NSW Local Health District, n.d.). These challenges increase the reliance of rural and remote consumers on their informal networks, particularly their carers, for ongoing support.

The role of carers has gained recognition in many countries over two decades, with many countries, including Australia, the United Kingdom and the United States of America, legislating the recognition into law (International Alliance of Carer Organizations 2021). The national recognition of carers in Australia has led to the incorporation of carer involvement in the Mental Health Acts in many jurisdictions, as well as in policies, frameworks and practice guidelines. For instance, the New South Wales Mental Health Act (2007) (the Act) stipulates that a consumer has the right to nominate up to two designated carers whom clinicians can involve in the consumer's care (Australian Government 2010; New South Wales Government 2007, 2018). Hence, it is a requirement under the Act that mental health professionals engage with consumers' designated carers regarding the consumers' treatment. The *Act* outlines the circumstances in which mental health professionals must contact designated carers.

Equally, National Safety and Quality Health Service Standards (Australian Commission on Safety and Quality in Health Care, n.d.) and the National Framework for Recovery-Oriented Mental Health Services (Commonwealth of Australia 2013) contain components related to carer involvement in care delivery. The Australian National Framework for Recovery-Oriented Mental Health Services emphasises the importance of keeping the insights, experiences and well-being goals of consumers and their carers at the core of service delivery (Commonwealth of Australia 2013). It emphasised the need for shared decision-making that includes consumers and their carers at every phase of mental health service delivery.

Shared decision-making is a collaborative process where direction about care is mutually explored and agreed upon between healthcare users and health professionals (Charles et al. 1999; Walker 2019). Shared decision-making recognises and places equal value on consumers' and carers' input, their lived experiences and the expertise of health professionals (Clarke et al. 2017; Dixon et al. 2014). As such, shared decision-making is a major component of the recovery-oriented principle of care.

Literature on collaboration with carers is limited, but available research shows that consumers have improved outcomes and all collaborators benefit when carers are involved in the treatment planning and shared decision-making process (Goodwin and Happell 2007; Lobban et al. 2013; Svendsen et al. 2021). The World Psychiatry Association's survey of mental health service users, their carers and service providers across many countries found that carers were essential to the delivery of meaningful mental health services (Wallcraft et al. 2011).

However, implementation of collaboration with carers has been slow and inconsistent across mental healthcare settings despite the imperative from policy and evidence of the benefits (InforMH 2021; Maybery et al. 2021; Schuster et al. 2020). Schuster et al.'s (2020) cross-sectional study of caregivers in a mental health hospital in Germany found that contact between carers and psychiatrists occurred in only one-third of patients' cases. In other studies, carers have reported their struggles with the mental health system not listening to them, being treated as incidental and not being provided adequate information (Olasoji et al. 2017; Wainwright et al. 2015). Carers reported that they were excluded from the decision-making process regarding the treatment planning for consumers and that some clinicians did not understand their role (Doody et al. 2017; Eassom et al. 2014; Kokanović et al. 2018; Wainwright et al. 2015).

Studies that have explored carer involvement in mental health service delivery have identified barriers such as discrimination, stigma, different views on confidentiality and clinicians' lack of necessary skills (Cree et al. 2015; Doody et al. 2017; Kokanović et al. 2018). However, no study has explored the meaning of collaboration from clinicians' and carers' perspectives in a rural setting. Exploring collaboration from clinicians' and carers' perspectives could provide insight into why carer engagement at the desired level is elusive in mental health service delivery. Exploring this topic is particularly important for the effective delivery of mental health services in rural areas. Mental health clinicians are referred to as such in this study.

1.1 | Aim

This qualitative study aimed to explore the meaning of collaboration in care delivery from the perspective of clinicians and carers of people living with a mental health illness in a rural Local Health District (LHD) in New South Wales, Australia.

2 | Method

2.1 | Design

This was a qualitative descriptive study. Qualitative study design was appropriate for this study because it explored participants' subjective understanding of collaboration based on their experiences. Thematic analysis was used to analyse data generated through focus groups and semi-structured interviews. Ethics approval was obtained from the Greater Western Area Human Research Ethics Committee [2022/ETH01069], issued 12/09/2022, with site approval [2022/STE02046] issued 23/02/2023. Reciprocal ethics approval was approved by the University of Newcastle Ethics Committee [H-2023-0118] on 18/04/2023. The Consolidated criteria for reporting qualitative research (COREQ) was used for this paper (Tong et al. 2007).

2.2 | Sampling and Recruitment

Purposive sampling was used to recruit carers aged 18 or over, past consumers of an adult mental health inpatient unit and current or past clinicians from the unit. Carers were identified through the facility's electronic medical records and via the local Mental Health Carer Support Organisation. Potential participants were initially contacted by telephone, and a Participant Information Statement and consent form were emailed or posted to those who expressed an interest in the study. Clinician participants were recruited through the mental health facility's Clinical Nurse Educator and Medical Director.

2.3 | Data Collection

The primary means of data generation was focus groups. Individual interviews were conducted with participants who were unable to attend the focus groups. A focus group and interview guide were used to ensure consistency across focus groups and semi-structured interviews. The guide was developed in consultation with the research team (MO, DS), who are experienced in qualitative studies, and it was guided by a framework of introductory, transitional, summarising and concluding questions (Liamputtong 2016).

The first author, who is an experienced Accredited Mental Health Social Worker, co-facilitated focus groups with an associate who is an experienced mental health nurse manager. There was no prior relationship between the researchers and any of the carers. The first author worked in the same directorate as the clinician participants but had no direct working relationship with any of the clinicians. Focus groups and semi-structured interviews were conducted face-to-face at various meeting rooms across the local health district. The sessions were audio recorded and professionally transcribed. The first author and the participants in the semi-structured interviews verified the transcripts for accuracy. Focus group participants were not offered the opportunity to review their transcripts to preserve the confidentiality of other participants in case any participant misplaced the transcript.

All participants provided written informed consent to participate. Participants completed a sociodemographic survey with fixed item responses through a link sent via email two days prior to the focus group. Participants who were unable to complete the survey before the focus group completed a hardcopy survey at the focus group. The carer sociodemographic survey includes age, educational status, age group and frequency of admission of the person they cared for, while the clinician sociodemographic survey includes age, experience in mental health practice, employment status, experience in the facility, etc. Survey data is outlined in Tables 1 and 2. Focus groups and semi-structured interviews were approximately 75 min and 60 min long, respectively.

2.4 | Data Analysis

The transcripts were analysed using reflective thematic analysis. Reflective thematic analysis offers flexibility to explore the data inductively, and its recursive nature allows for rigorous and thorough analysis of the data (Braun and Clarke 2022). This study followed the six-phase thematic analysis outlined by Braun and Clarke (2006). Analysis was conducted using NVivo qualitative data analysis software and manual coding methods. NVivo helped maximise interaction with the data as the

TABLE 1 | Carer participants' sociodemographic characteristics.

Variable	($n=7$)
Age	
46–65 years	5
Over 65 years	2
Marital status	
Married in a de facto or registered marriage	5
Not married	2
Educational status	
Graduate level and above	2
Certificate level	3
Secondary education	2
Aged group of people cared for	
5–17 years old	2
18–64 years old	5
Living with the person cared for	
Yes	6
No	1
Frequency of admission to the facility in the last 5 years[a]	
Once	5
2 times or more	2
Gender	
I am a male carer	2
I am a female carer	5
Indigenous status	
I am an Aboriginal carer	2
Working status	
I am a working carer–working full-time or part-time	3

[a] From January 2017 to January 2022.

TABLE 2 | Clinician participants sociodemographic characteristics.

Variable	($n = 14$)
Age	
18–25 years	2
26–45 years	6
46–65 years	5
Did not specify	*1*
Experience in mental health practice	
Less than 1 year	2
1–2 years	6
Over 6 years	6
Length of service at the facility	
Less than 1 year	7
1–2 years	3
3–5 years	2
Over 6 years	2
Employment status	
Permanent part-time	3
Permanent full-time	5
Temporary full-time	4
Part-time/Locum	2
Role at the facility	
Registered nurse	6
Allied Health, including Peer-Workers	2
Psychiatrist	3
Psychiatrist registrar	3

analysis progressed through the phases of data analysis (Maher et al. 2018). Moving between manual and electronic data analysis enhanced reflection, insight and interpretation of the data.

The first author generated the initial codes with guidance from the second author. Initial codes were collated into clusters that formed the foundation of the thematic maps. Codes were moved into NVivo to enable all authors to access the codes and themes for a validity check of the themes regarding their quality and scope. Two groups of data interpretation (one for carers and one for clinicians) and two thematic maps were developed at the beginning. However, critical analysis and discussions among the authors created a richer understanding that both sets of interpretations described similar ideas. The two thematic maps were combined into one, providing a comprehensive description of the views of clinicians and carers on the subject matter.

The processes used in conducting the research were documented, traceable and logical, and mechanisms were in place to monitor and manage biases through reflexive conversations among authors (Liamputtong 2013; Padgett 2017).

3 | Results

Seven carers and 14 clinicians participated in this study. Tables 1 and 2 summarise the participants' sociodemographic characteristics.

Data analysis produced three core themes that accounted for participants' experiences and perceptions of collaboration: *three-way partnership, purposeful exchange* and *communication is everything*. The themes, their subthemes and their relationship to each other are represented in the Thematic Map (Figure 1).

3.1 | Theme 1: Three-Way Partnership

Clinicians and carers described collaboration as a partnership where the consumer, carer and clinician have equal contributions to decision-making, irrespective of their differing perspectives. Carers discussed the need for clinicians to respect their expertise; clinicians expressed the importance of consumer involvement, while both clinicians and carers described the need to clarify each collaborator's expectations, as this could mitigate differences in perspectives.

3.1.1 | Theme 1.1 Nothing About Us Without Us

Clinicians and carers described collaboration as a process where there is a genuine partnership between the consumer, carer and clinician in a decision-making process. They emphasised that a collaborative decision-making process is one in which *'all parties are invested' (Clinician #3)*, and all inputs are considered and explored respectfully to ensure the best interests of consumers are achieved in every decision.

> ...when consumer is not part of that, that's a real disadvantage... nothing about us without us, I really believe that.
>
> (Clinician #7)

Carers reported feeling 'on the outside' *(Carer #3)* when they were not included in the decision-making process, and this contributed to carers' anxiety.

> I kept you know, feeling my partner was going to die and that I would live with the memory that I didn't get stuff heard, you know for her.
>
> (Carer #1)

Clinician and carer participants noted that shared decision-making creates a sense of importance for all collaborators. This, in turn, empowered carers and made them feel 'that we are worth something to this problem.' (*Carer* #3).

> Well to me it's obvious, I mean in my partner's case some of the information that sort of went to the psychiatrist affected their decision-making. Now they could have had that information a long time

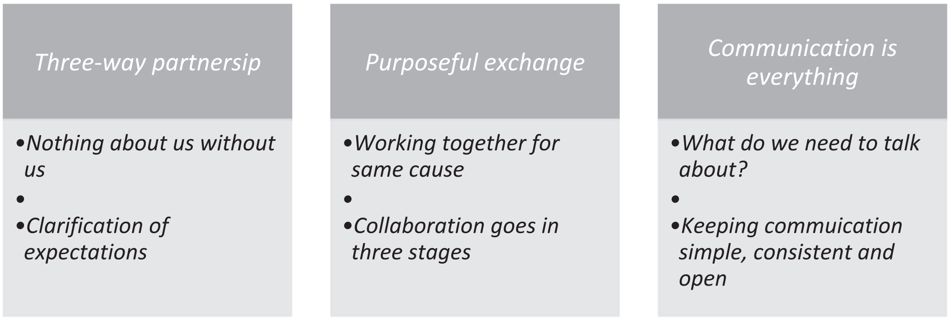

FIGURE 1 | Thematic map.

> earlier, and those conversations would've made me feel better
>
> (Carers #1).

3.1.2 | Theme 1.2 Clarification of Expectations

Participants identified that collaboration necessarily involved various perspectives,

> I believe that the collaborative process is a process of various perspectives, carer perspectives, and the various health workers perspectives.
>
> (Carer # 1).

Clinicians', carers' and consumers' perspectives on how the treatment should progress may not necessarily be the same, but that does not mean they were wrong. Perspectives may be different because:

> everybody's experience is different… depending on where they're at in the journey
>
> (Carer #2)

Different perspectives often translated into different expectations of what should happen; however, clarifying expectations helped all collaborators feel included in the decision-making process. The importance of exploring and clarifying these expectations in shared decision-making is illustrated in the quote by Clinician #12 '…the family wanted a different thing; the consumer wanted a different one but during that consultant review, there was a clearer idea of what had to happen next.'

While the need to consider different perspectives in collaboration was recognised, carers reported feeling that their expertise and experiences were not given the same respect as clinicians. Carers were emphatic in how they described their expertise and what they could contribute to the decision-making process.

> I'm not just a carer, I'm a partner. I am privy to quite detailed relational things… I am aware of her difficulties, struggles, and some of the qualities of that person.
>
> (Carer #1).

Carers described the emotional impact on them and consumers when clinicians did not listen to their concerns. They reported second-guessing themselves when clinicians did not listen to them or perceived them as having 'overreacted' (Carer # 6). This subsequently impacted carers' help-seeking and consumer's recovery.

> I've asked a clinician for one of my loved ones to be placed on a Community Treatment Order, and they told me I couldn't have that… My loved one came home, refused to speak with [mental health]. They became unwell, [committed an offence] and put in prison in a forensic hospital for 9 to 12 months and put me through more stress all because they wouldn't listen to something that I asked them to please help me with.
>
> (Carer #7)

Both clinician and carer participants acknowledged that respect for carers' expertise was important to genuine collaboration and to how carers experienced collaboration.

> Understanding, you know, that's the key aspect. Recognising or valuing carers' experience or expertise in the area of being a carer…
>
> (Carer #2)

3.2 | Theme 2 Purposeful Exchange

Clinicians and carers described the purpose of collaboration as working for the best interests of the consumer. Carer participants added that their interests and well-being were also important for the ongoing support of consumers. Clinicians and carers elaborated on this theme in two subthemes as described below.

3.2.1 | Theme 2.1 Working Together for Same Cause

The purpose of collaboration was viewed as a partnership that has the consumer's and their carers' best interest as the goal, 'to work out what's best for our loved ones …what helps, what doesn't.' (Carer #7) and the 'best interest of the carer as well, where they've been discharged to. (Carer #4). Clinicians noted the importance of working with carers in the development of care planning.

> work together to make, some of these inputs into what makes sense and best outcome for the individual in care.
>
> (Clinician #3)

Carers emphasised that the partnership between clinicians and carers was helpful not only while the consumer was in the hospital but also when the consumer was transferred to the community to be managed by community mental health services. Carers noted that collaboration enables continuity of care and allows all collaborators to know what to do and when.

> The discharge planning was brilliant. We worked together …. In days gone past, he'd be released and there wouldn't even be a follow-up [by the community mental health team] down here.
>
> (Carer #2)

Clinicians and carers agreed that the aim of the collaboration was not limited to consumer wellness but included their carer's well-being. Carers emphasised that recognition of carers' needs and provision of adequate support were essential in collaboration. Clinicians equally noted that offering emotional support to carers could be in the form of stopping to ask carers, 'How are you?' (Clinician #8) and connecting them with carer-specific services for ongoing support.

> I found there was really no support until probably towards the latter part of my son's journey, and [Carer Support Service] came alongside us and was able to guide our family and support our family, but up until that time, it was nothing.
>
> (Carer #3)

Clinician and carer participants identified that offering education about the consumer's diagnosis and prognosis was an important part of supporting carers in a collaborative process.

> If you can give a lot of psych education to the family, about relapse prevention, they know the early warning signs, it means they can, … get the care and help earlier and intervention can come earlier as well. Hopefully, we could ultimately change outcomes.
>
> (Clinician #5)

Overall, support for carers was identified as important to a collaborative process; it helps consumers' ongoing recovery after their discharge from an inpatient setting into the community.

3.2.2 | Theme 2.2 Collaboration Goes in Stages

There were distinct points of contact between clinicians and carers from the time consumers were admitted into a mental health facility through to their discharge. Clinicians described that collaboration happened in stages and predominantly for information and collateral purposes.

> Collaboration kind of goes in three stages. The first one would be with assessment, …we get more information and then the process, … like updating carers [how] the consumer is going…Giving them more information, educating them on … diagnosis.
>
> (Carers #4)

Clinician participants described their collaboration experience with carers in terms of the number and mode of carer contacts.

> It'd be quite regular for us to either, at the very least be having phone contact, and obviously when things are, particularly get more complicated. … If it's possible people come into the unit and have face-to-face meetings to talk about treatment, discharge planning…
>
> (Clinician #3)

Clinicians noted that the level and frequency of carer contact varies and depends on factors such as the consumer's consent, the consumer's situation, the length of admission and the level of carer interest.

> I think also it depends a bit on the clinical progress. So, when people are very unwell, I would often make sure that the carers are updated more frequently because understandably, they would be more concerned.
>
> (Clinician #4).

Carer participants noted that while it was important for clinicians to contact them at different stages of consumers' admission, they expected more from the contact. Carers expected more engaging and 'meaningful' (Carer # 1) contacts.

3.3 | Theme 3 Communication Is Everything

Collaboration was described as an engagement with *open, genuine, clear*, and '*useful communication*' between clinicians and carers. Carers identified the importance of communication and information sharing in collaboration. Carers who had regular communication with clinicians described their experience of collaboration as positive. 'Once he got to [the facility], it was terrific because they were just in constant contact [with me].' (Carer #2).

3.3.1 | Theme 3.1 What Do We Need to Talk About?

Information sharing between clinicians and carers is essential in collaboration, and it should be guided by 'what we need to talk about and what we need to know' (Clinician #7). Clinician and carer participants identified background information about the presenting concern, diagnosis, medication and treatment options as some of the essential discussion topics in the collaborative process.

> Talk about past history, past medications. There's a lot. The list goes on and on really
>
> (Carer #7)

Regular progress updates were identified as important for preventing the anxiety of 'not knowing' (Carer #4) and 'being in a vacuum' (Carer #1) for carers and 'assists in treatment planning, especially discharge planning' (Clinician #3) for clinicians.

Carers described how they had to 'fight' and 'fiddle around' (Carer #1) before they could share with or obtain information from clinicians. Carers reported that it would bring them some relief '...if I did not have to feel that I had to fight before I got information.' (Carer #4).

Clinicians and carers noted that one of the barriers to poor communication between carers and clinicians was '... not having the appropriate staff in place to make it happen. (Carer #7).

Clinicians were uncertain about whose responsibility it was to facilitate collaboration between carers and clinicians. Many of the clinician participants, except the psychiatrist, expressed a lack of confidence in speaking with carers.

> We don't want to give false expectations because it's, again, the doctors making the decision. We don't want to give them our perspective and give them or feel like they just rely on our information.
>
> (Clinician #12).

There were perceptions that psychiatrists predominantly had the authority to discuss treatment matters with the carers. Non-psychiatrist clinicians often recorded carers' requests for information or contact into consumers' files and handed them over from shift to shift with no clear understanding of whose responsibility it was to ensure that carers' requests were followed through or actioned promptly.

> It's a little bit of a hot potato thing that goes on where the nurses won't–they go "I can't tell you", so you have to speak to the doctor and the doctor tells you to speak to the social worker, you know, and around you go.
>
> (Carer #4).

Clinicians and carers suggested that '...having a middleman somewhere, one person dedicated to all the carers stuff, who only deals with carers so that whenever we get a handover, they can follow it up with whoever is' (Clinician #11) could be helpful in a collaborative process.

3.3.2 | Theme 3.2 Keep Communication Simple, Consistent and Open

Carers reported uncertainty and confusion when the information the clinicians provided to them was inconsistent and ambiguous.

> I didn't understand how it worked. Once I understood from what the doctor told me I should've gone to an emergency that first two weeks earlier, I stressed out for sort of two weeks longer than I should have.
>
> (Carer #5)

Carers expected information to be consistent across LHD and from shift to shift.

> You can sort of see those notices, they're stuck on the wall, you know. Or in the little quiet waiting rooms and they're all over the hospital ... promising this sort of seemingly smooth connection to information. And to be told 'Oh well we only give a report when a patient's condition changes', but I hadn't even had a report.
>
> (Carer #1)

The clinician noted that open communication could mitigate some of the communication challenges between clinicians and carers. Clinicians and carers described openness in communication as being 'transparent' (Clinician #9) and 'clear' (Carer #5) about what is going on. This includes discussions when the clinician and the consumer have different ideas about treatment plans or when any collaborator simply does not know or understand certain things.

> Just keeping communication open, ... had no idea of how the mental health system works, which you wouldn't if it was your first-time experience.
>
> (Carer #6).

Clinicians described the complexities of collaboration and the importance of openness about them. They noted that confidentiality was one of the complexities of collaboration, especially when an adult consumer chose not to include their carers. Careful navigation of these complexities could foster collaboration.

> I think it's, finding a path where possible for limitations around confidentiality...The least breach would be, not telling much about the patient but you're allowed to accept information from the carer pretty freely
>
> (Clinician #2)

4 | Discussion

This study provides insight into the understanding of the meaning of collaboration among clinicians and carers in rural mental healthcare delivery. Our findings regarding rural and remote carers' understanding and experience of collaboration align with existing research conducted with their city and metropolitan counterparts, who do not always experience collaborative decision-making with clinicians who may have a negative attitude towards shared decision-making with carers (Aldersey and Whitley 2015; Doody et al. 2017; Hamann and Heres 2019; Kokanović et al. 2018; Sari et al. 2023). However, there are new findings that include openness in communication to mitigate the complexities of collaboration, clinicians' acknowledgment of their limited understanding of their roles in the collaborative process, and a purposeful partnership that incorporates carers' support.

Needs-based, clear information sharing and openness about the complexities of collaboration matter in effective collaboration. This study found that consistent, easy-to-understand and timely communication was important to collaboration, but carer participants expressed frustration at not getting the information they needed about the consumer at the right time. This was consistent with Maybery et al. (2021), Olasoji et al. (2017) and Wainwright et al. (2015) findings, where carers reported that the information provided by clinicians was not useful because they did not understand it. Having the right and necessary information is particularly important for rural and remote carers due to their geographical location, the distance they often travel to access mental health care and the associated costs (Bourke et al. 2012; Saurman 2016).

Previous studies have found that clinicians were hesitant to provide information to carers largely due to concerns about confidentiality. Those studies have recommended clinician education about confidentiality and the development of resources to foster shared decision-making (Doody et al. 2017; Kokanović et al. 2018; Sari et al. 2023). This study identified a new concept of openness in communication between clinicians and carers. Both groups of participants noted that openness would enable all parties to discuss the inherent complexities of collaboration and their concerns without fear of being stereotyped or judged. This new finding could be explored further in future studies, as it may be useful for developing strategies to enhance collaboration between clinicians and carers.

Clarification of each party's roles is important in collaboration, but clinicians in this study described uncertainty about their roles and responsibilities within the collaborative process. Carers in previous studies identified that clinicians did not understand their roles as carers (Doody et al. 2017; Eassom et al. 2014; Kokanović et al. 2018; Wainwright et al. 2015), however, this study made it clear that clinicians did not understand their roles in the collaborative process either. Non-psychiatrist participants reported that psychiatrists were responsible for carer contacts, while the psychiatrists accepted the responsibility of discussing medical concerns with carers; they noted that other team members could discuss non-medical concerns with carers. Clinicians and carers in this study identified that the non-clarification of roles between clinicians often results in carers' questions and requests not being responded to promptly, loss of information between shifts regarding carers' requests and carers receiving inconsistent information. Previous studies reported that carers perceived mental health professionals as too busy to listen to their concerns (Maybery et al. 2021; Olasoji et al. 2017). This may be due to the non-clarification of roles among clinicians, but further study to explore role clarification among clinicians in the context of clinician and carer collaboration is required.

Both groups of participants described the purpose of collaboration between clinicians and carers as providing holistic support to the consumer that essentially includes support for their carer. Carers provided insight into their well-being needs and their expectations from clinicians, which may not be readily communicated. The burden of care on carers is well documented, with carers two and a half times more likely to have lower well-being than an average adult (Jones et al. 2022; Olasoji et al. 2016; Smith et al. 2014), and the physical, emotional and mental demands of caring are identified as risk factors for chronic diseases (Jones et al. 2022). Therefore, there is a need for greater understanding and empathy from clinicians as carers seek support to improve their physical and psychosocial well-being (Maybery 2023; Olasoji et al. 2017). Well-supported carers could provide ongoing support to consumers, resulting in improved outcomes for both consumers and carers (Aldersey and Whitley 2015; Jones et al. 2022).

4.1 | Limitation

Participants in this study were from a single geographical area of New South Wales, Australia. All the registered nurses who participated in the study were in their first two years of mental health practice, but other clinician participants had significant experience in clinical mental health care. This may limit the transferability of the findings to other population groups.

5 | Conclusion

Clinician and carer participants in this study described collaboration as a process where the expertise of clinicians, consumers and carers is equally respected, and each collaborator is supported to participate meaningfully in the decision-making process. However, carers have not experienced collaboration as described due to barriers such as poor communication, inadequate understanding of carer support needs and clinicians' limited understanding of their responsibilities in carer engagement. Proactive clinician training that incorporates an understanding of the carers' role in recovery and skill development in carer engagement, along with a practical guide, could enhance genuine collaboration with carers in mental health services.

6 | Relevance for Clinical Practice

A culture that fosters shared decision-making, which is inclusive of carers, should be embedded in routine practice through:

- Creation of a co-design practical clinician–carer collaboration guideline
- Inclusion of carer engagement as a core component in clinicians' training
- On-the-job training and supervision for clinical staff, which may include mentoring of junior clinicians and senior clinicians modelling good practice
- Creation of frontline carer liaison positions within the clinical team to facilitate and ensure that every carer is involved in care delivery to consumers from admission to discharge and incorporating carers' well-being as an important aspect of providing holistic care to consumers. Embedding carers' support in holistic mental health service delivery has

extensive implications for carers' well-being, consumers' recovery, the community and the healthcare system.

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Ethics Statement

Ethical approval was obtained from the Greater Western Area Human Research Ethics Committee [2022/ETH01069], issued 12/09/2022, with site approval [2022/STE02046] issued 23/02/2023. Reciprocal ethics approval was approved by the University of Newcastle Ethics Committee[H-2023-0118] on 18/04/2023.

Consent

Written consent was obtained from all participants.

Conflicts of Interest

First author worked as the Family and Carer Mental Health Program Coordinator of the Local Health District, where the study took place at the time of the study. The remaining authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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Supporting Information

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