



**Part B**  
Implementation framework



## Contents

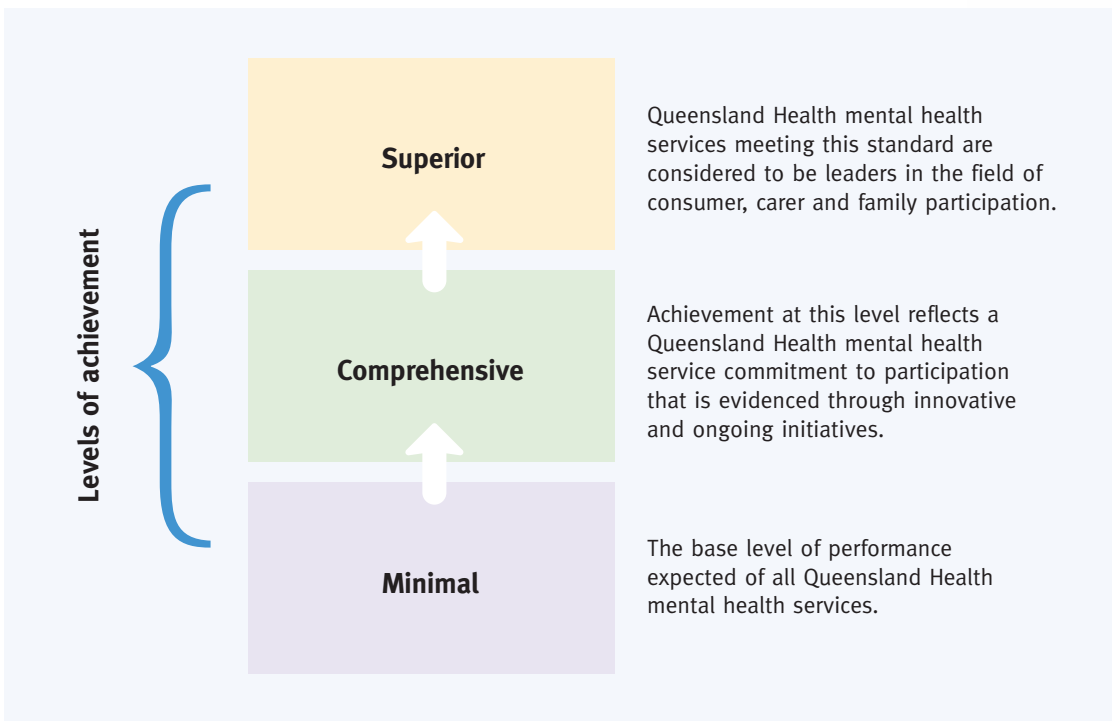
---

Introduction.....	20
Priority area 1	
Enhanced consumer, carer and family participation in initial and ongoing mental health assessment processes.....	21
Priority area 2	
Consumer-directed recovery planning and carer and family participation in recovery planning processes.....	25
Priority area 3	
Enhanced consumer, carer and family participation within service development and evaluation activities.....	28
Priority area 4	
Strengthened partnerships.....	32
Priority area 5	
Enhanced consumer and carer workforce recruitment and development.....	34
Priority area 6	
Enhanced mental health workforce recruitment and development.....	38
Priority area 7	
Enhanced mental health organisational culture and leadership.....	41
Priority area 8	
Consumer and carer leadership.....	43
Priority area 9	
Enhanced consumer and carer participation in research, policy and legislation development activities.....	46
References.....	49

### Introduction

Part B of the Consumer, Carer and Family Participation Framework outlines the strategic intent of Queensland Health for mental health consumer, carer and family participation. Queensland Health is currently enacting participation through various statewide and local level initiatives. This section seeks to build on these achievements (Figure 3) by offering a range of implementation strategies to strengthen participation at all levels (individual care, service delivery, organisational and systemic policy levels).

**Figure 3:** Levels of achievement (consumer, carer and family participation)



This collection of implementation strategies is in no way exhaustive. Consumer, carer and family participation will look different depending on the community in which local mental health services operate. Local mental health services are encouraged to adapt and develop implementation strategies to respond to their local context.

The nine priority areas identified in the implementation framework are underpinned by recommended implementation strategies, each of which has been aligned to standards contained in the National Standards for Mental Health Services (2010) (NSMHS).<sup>1</sup> Consequently, the Consumer, Carer and Family Participation Framework has been designed to support services in preparing for accreditation.



## Priority area 1 Enhanced consumer, carer and family participation in initial and ongoing mental health assessment processes

### Desired outcomes

- Consumers, carers and families are listened to and included from initial contact and throughout mental health assessment processes.
- Initial and ongoing assessments are conducted in places that are comfortable or familiar to the consumer and/or carer.
- Consumers, carers and families are informed of their rights and responsibilities.
- Carer and family involvement in mental health assessment processes is consistent with Part 7 (Confidentiality) of the Queensland *Health Services Act 1991*.<sup>2</sup>

### Priority area 1

Enhanced consumer, carer and family participation in initial and ongoing mental health assessment processes

Level of achievement	Implementation strategy
Minimal achievement	1.1 Respectfully and clearly communicate with consumers, carers, family and significant others at all times. <b>NSMHS (2010)</b> <sup>1</sup> —1.1/6.1/10.1.2
	1.2 Develop clinical procedures that make explicit collaboration with consumers, carers, families and significant others during assessment processes. <b>NSMHS (2010)</b> <sup>1</sup> —1.10/6.7/7.1/10.4.3
	1.3 Discuss with consumers the potential benefits of carer and family involvement, and invite them to nominate people they want to be involved in their assessment process. <b>NSMHS (2010)</b> <sup>1</sup> —1.11/1.12/6.11/7.1/7.2/7.3/10.4.3/10.4.8
	1.4 Create accessible, welcoming and age-appropriate reception areas and assessment spaces for consumers, carers and families that ensure privacy. <b>NSMHS (2010)</b> <sup>1</sup> —1.1/1.8
	1.5 Provide accessible written information for consumers, carers and family about their rights and responsibilities, confidentiality and information sharing procedures, and feedback processes. Provide more information about mental health assessment and treatment processes, the role of a case manager/clinician and the <i>Mental Health Act</i> . Provide this information as soon as it is possible, in a way that is understandable to the individual consumer, carer and family member. Provide further explanation at regular intervals throughout care. Provide this information in an age-appropriate and culturally-appropriate way. <b>NSMHS (2010)</b> <sup>1</sup> —1.4/1.16/6.3/6.4/7.4



## Part B Implementation framework

### ► Priority area 1

Enhanced consumer, carer and family participation in initial and ongoing mental health assessment processes

Level of achievement	Implementation strategy
Minimal achievement	<p>1.6 Ensure that the assessment process responds to any specific needs the consumer, carer and family may have about age, gender, cultural, communication and/or language preferences.<sup>3</sup> Provide information about how to access a cultural informant or support person to enable cultural safety. <b>NSMHS (2010)<sup>1</sup>—1.4/1.7/4.1/7.5</b></p>
	<p>1.7 Provide information about any potential side-effects of medication. <b>NSMHS (2010)<sup>1</sup>—2.4/6.9/10.5.6/10.5.10</b></p>
	<p>1.8 Provide information to consumers, carers and families about local support groups, organisations, relevant websites and resources at an appropriate time. Provide Queensland Health consumer and carer workers' contact details where available. <b>NSMHS (2010)<sup>1</sup>—1.15/4.3/6.10/7.13/10.1.9/10.5.12/10.5.13</b></p>
Comprehensive achievement	<p>1.9 Allow enough time during assessment processes to enable consumer, carer and family participation. Provide follow-up and feedback to consumers, carers and family after an initial assessment. <b>NSMHS (2010)<sup>1</sup>—1.10/1.12/6.7/7.10/10.4.3</b></p>
	<p>1.10 During ongoing assessment processes, enable consumers to describe their own understanding of their mental health experiences. Engage carers and family to describe their understandings of the consumer's mental health experiences, and their own experiences of caring for and supporting their loved one. <b>NSMHS (2010)<sup>1</sup>—1.10/1.11/1.12/6.11/7.2/7.3</b></p>
	<p>1.11 Share accessible explanations of assessment outcomes with the consumer, carer and family consistent with Part 7 (Confidentiality) of the <i>Health Services Act 1991</i>. If detailed assessment outcome information is unable to be provided due to confidentiality requirements, provide the carer and/or family with information communicated in general terms to support them in their support role. <b>NSMHS (2010)<sup>1</sup>—6.9/6.11/7.2/7.3/7.9</b></p>
	<p>1.12 Provide relevant consumer developed information and resources to consumers. <b>NSMHS (2010)<sup>1</sup>—1.4/3.1/6.10</b></p>
	<p>1.13 Provide referral options for individual advocacy and support for consumers, carers and family. <b>NSMHS (2010)<sup>1</sup>—1.15/3.4/10.5.12/10.5.15/10.5.13</b></p>



► **Priority area 1**

Enhanced consumer, carer and family participation in initial and ongoing mental health assessment processes

Level of achievement	Implementation strategy
Superior achievement	1.14 Mobile assessment teams are available for consumers, carers and family to participate in assessment processes in familiar, comfortable and safe environments. <b>NSMHS (2010)<sup>1</sup>—1.9/2.1/10.2.4/10.4.2</b>
	1.15 Develop ongoing holistic assessments that incorporate nominated key stakeholders' contributions. This could include general practitioners, private psychiatrists, support workers, school staff and significant others. <b>NSMHS (2010)<sup>1</sup>—1.10/9.4/9.5</b>
	1.16 Encourage ongoing professional development and training opportunities for staff to enhance their skills of collaboration, partnership and effective communication. Train staff in recovery-based and strengths-based models of mental health assessment processes. Train staff in culturally appropriate assessment processes with Indigenous and culturally and linguistically diverse consumers. <b>NSMHS (2010)<sup>1</sup>—4.3/5.6/8.6/8.7/10.1.1</b>
	1.17 Consumer Companions are employed in acute mental health units to provide initial practical information and peer support. <b>NSMHS (2010)<sup>1</sup>—4.3/8.6/8.7</b>

**Examples of practice**

'Generally speaking, when meeting a consumer referred to ongoing case management, I ask them, "I would like to hear what you think has been happening and why you think you have been referred to (or why you have presented to) our mental health service?" I then ask other open-ended questions like — "Why do you think this has happened now?" and/or "What do you think has led to this?" I always attempt to document a consumer's narrative in my formulation and use their language. I believe this practice is respectful to the consumer's journey and results in a more genuine assessment of their experiences.'  
**(mental health clinician)**

'When I am referred a consumer with an extremely large file, that indicates a long history with our service, I offer the opportunity to meet and talk through their perspective of their journey before I read the clinical history documented in their file. I find this is a non-judgmental method that assures consumers and their families that they have an opportunity to provide me with their account of their recovery journey.'  
**(mental health clinician)**

'I find some family members who are caring for their loved one experience guilt when providing me with recent "updates", especially if their family member is starting to experience significant symptoms. In most cases I have consent from their loved one to share this information. But the family members can still feel extremely uncomfortable about sharing these stories in front of their loved one, especially if the consumer has not referred to the recent changes themselves. To alleviate their distress, I provide

## Part B

### Implementation framework

opportunities for the carer/s to call me and speak about the issues confidentially or I arrange a specific appointment just to hear their concerns – informing the consumer that I continue to have ongoing contact with their carer/s. I feel that practising this way is respectful of all involved because it acknowledges the expert stories provided by family/carers.

‘In most cases, I also attempt to provide a safe place to discuss these concerns out loud (between the family/carer and the consumer) when appropriate, to encourage an honest/genuine relationship and to provide an opportunity for growth. At times, I am required to mediate if differences in opinion become heated. My training in psychotherapy, in particular family therapy, has been invaluable in this role.’ (mental health clinician)

‘Initially, I was trained to develop formulations and proposed diagnoses independent of the consumer or their carer/s. In more recent years as a case manager, I inform consumers of the purpose and intent of clinical reviews and discuss the content of my formulation. I frequently discuss the differences in diagnostic criteria with consumers and their families (when consent is given) and always remain recovery-oriented in my practice. I try to validate experiences, but remind all involved that a person does not become their illness and that diagnoses can create harmful labels or roles that are hard to shift at times.’ (mental health clinician)





## Priority area 2 Consumer-directed recovery planning and carer and family participation in recovery planning processes

### Desired outcomes

- Consumer-directed recovery planning processes are supported by clinicians.
- Consumers, carers and family are central participants in recovery planning.
- Consumers, carers and family are able to make informed choices about their treatment and care options.
- Consumers, carers and family are included in quarterly reviewing and monitoring of care planning processes.
- Carer and family involvement in recovery planning processes is consistent with Part 7 (Confidentiality) of the *Health Services Act*.<sup>2</sup>

### Priority area 2

Consumer-directed recovery planning and carer and family participation in recovery planning processes (recovery planning is inclusive of individual care, recovery relapse prevention and discharge planning)

Level of achievement	Implementation strategy
Minimal achievement	2.1 Develop clinical procedures that make explicit consumer-directed recovery planning and review processes. <b>NSMHS (2010)<sup>1</sup>—1.10/6.7/10.1.1</b>
	2.2 Develop clinical procedures that outline the involvement of carers, family and significant others in recovery planning and review processes. <b>NSMHS (2010)<sup>1</sup>—1.11/6.11/10.4.3/10.4.8</b>
	2.3 Provide user-friendly information about clinical and non-clinical treatment options to consumers, carers and families. Ensure that consumers, carers and families can make informed choices about these options. <b>NSMHS (2010)<sup>1</sup>—1.7/6.9/6.10/7.10/10.5.3</b>
	2.4 If a consumer asks that confidential information not be disclosed to a particular carer or family member, offer support and information communicated in general terms to relevant carers and family. <b>NSMHS (2010)<sup>1</sup>—1.11/6.11/7.3/7.9</b>
	2.5 Explain the usefulness of self-reported outcome measures to consumers and carers. Encourage consumers and carers to complete the relevant self-reported outcome measures quarterly or as required. Explore the results of these outcome measures with consumers and carers. Provide copies of the outcome measure reports to consumers. Use the report to reflect on how the recovery planning helps them to work towards recovery-oriented goals. <sup>4</sup>



## Part B Implementation framework

### ► Priority area 2

Consumer-directed recovery planning and carer and family participation in recovery planning processes (recovery planning is inclusive of individual care, recovery relapse prevention and discharge planning)

Level of achievement	Implementation strategy
Comprehensive achievement	<p>2.6 Recognise the lived experiences and individual strengths of consumers, carers and family in recovery planning processes. Ensure recovery plans are personalised and responsive to the changing needs and goals of the consumer. <b>NSMHS (2010)<sup>1</sup> —1.10/6.7/7.10/10.1.3/10.1.4</b></p>
	<p>2.7 Provide consumers and carers copies of recovery plans. Ensure plans are written in accessible language and incorporate a consumer’s own words. Provide an explanation of plans as required. <b>NSMHS (2010)<sup>1</sup> —1.10/1.12/6.7/6.9/7.10/7.11</b></p>
	<p>2.8 Provide education to carers and families about mental illness, treatment options, recovery and support strategies. <b>NSMHS (2010)<sup>1</sup> —7.1 / 7.2 / 7.7 / 7.17</b></p>
	<p>2.9 Provide information about the role of advanced directives to consumers, carers and families. Explain how consumers can state who they would like involved and how they want to be treated. <b>NSMHS (2010)<sup>1</sup> —1.15/8.1/9.5</b></p>
	<p>2.10 Provide supported referral pathways to non-government and government organisations that can provide advocacy and additional support for consumers, carers and/or families. Facilitate links to ensure continuity and coordination of care. <b>NSMHS (2010)<sup>1</sup> —1.10/1.12/10.1.1</b></p>
Superior achievement	<p>2.11 Promote the significance of active involvement of consumers, carers and families in recovery planning processes to consumers, carers, families and other stakeholders. <b>NSMHS (2010)<sup>1</sup> —1.2/1.10/1.12/8.4/8.9</b></p>

### Examples of practice

‘When I am working on intake and a carer calls I may not know if consent has been given by the consumer to share personal information. In one intake call I received a question from the carer asking “What medication is my son taking?” As a mental health clinician you pick up the emotion and the potential worry from the carer. On this call, I explored what was happening in the current situation that the carer needed to know information about her son’s medication. By opening up the conversation like this the carer was able to explain her concern about her son’s mental health seeming to deteriorate. I was able to respond to this concern by speaking to the case manager involved and organising a doctor’s appointment to review her son’s medication. In calls with carers on intake, it is about listening to their concern, providing support and reassurance about how you will respond to their concern, without providing any personal confidential information if consent has not been given.’ **(mental health clinician)**

‘In my previous work with a consumer and his family, whenever he got unwell, he would argue with his family. He would forbid me to talk with his mother and other family



members. At the same time the mum would ring me upset and concerned about her son. I would listen to her concerns. I explained how I was not able to share any confidential information. But I would reassure her that I would continue supporting her son. She could rely on me to follow things up. I would continue speaking with her, asking her how she was going, asking her what was happening for her as carer. When the consumer became well again I would ask him “Is it OK that I talk to your mum again?” And he would be open to this. My work with carers is about building a therapeutic relationship, to build trust over time.’ (mental health clinician)

‘I work to engage the consumer and family/carer (if consent given) in developing a holistic recovery plan that engages everyone involved in the treating team (the “treating team” refers to the consumer and family/carer, as well as the mental health practitioners). I encourage all to identify personal strengths and limitations along with providing opportunities/strategies for family/carers to access respite. I assure the treating team that recovery plans are individualised and flexible to change, but that the intended purpose/theme is one of hope.’ (mental health clinician)

‘I have been a presenter for family support program for over the last two years. These programs run over seven weeks for two hours at each session, specifically for carers of consumers with schizophrenia. We provide information and education about how professionals come to diagnosis decisions, treatment options, problem-solving strategies, dual diagnosis issues, and carer resource options. In this forum carers also have the opportunity to swap important stories and personal experience. This forum provides a chance (often for the first time) for carers to develop a real connection to other carers. Carers have come to the group initially hoping to gather knowledge but come away with much more. Carers have stated that they have come to some terms with their circumstances and find some sort of meaning. Carers have expressed they feel supported by not only other carers but also come away feeling that there is someone in the mental health service system that believes in supporting and listening to carers. This program has become so important to our service and it has created so much passion that we have gone to great lengths to recently run a two-day train-the-trainer workshop for other local mental health services to use this invaluable tool.’ (consumer and carer support worker)

**Priority area 3**  
**Enhanced consumer, carer and family participation within service development and evaluation activities**

**Desired outcomes**

- Staff appreciate that consumer, carer and family participation is inherent in everyone’s role.
- Consumers, carers and families are valued contributors to service development and evaluation activities.
- Feedback from consumers, carers and families is meaningfully considered and responded to by the mental health service.

**Priority area 3**

Enhanced consumer, carer and family participation within service development and evaluation activities

Level of achievement	Implementation strategy
Minimal achievement	<p>3.1 Enhance mental health service staff understanding of the importance of consumer, carer and family participation in service development and evaluation activities. Prepare the service for consumer, carer and family involvement, to create a ‘consumer, carer and family-friendly culture’.<sup>4</sup> <b>NSMHS (2010)<sup>1</sup>—3.1/3.2/3.7/10.1.8</b></p>
	<p>3.2 Create a strategic plan that supports consumer, carer and family participation within service development and evaluation activities within local mental health services. <b>NSMHS (2010)<sup>1</sup>—8.3/10.1.8</b></p>
	<p>3.3 Develop a local mental health service consumer, carer and family participation plan (developed as a partnership between the executive, clinicians, and consumer and carer workers/representatives). Ensure the plan outlines a range of local consumer and carer participation strategies. Identify timeframes for implementation, outcome measures and review processes. Identify available resources to financially support the implementation of participation strategies identified in the plan. This could mean the service being resourced to employ a consumer and/or carer worker(s) to work in collaboration with staff to develop, implement, coordinate and evaluate consumer and carer participation at all levels of service delivery, development and evaluation, and for the consumer and carer workers’ roles to be supported by all staff. <b>NSMHS (2010)<sup>1</sup>—8.9/8.11</b></p>
	<p>3.4 Develop a range of service policies and procedures that formalise and support consumer, carer and family participation at all levels of service planning, development, delivery and evaluation. A key document includes, but is not limited to, Guidelines for the Remuneration for Consumer and Carer Representatives in Mental Health.<sup>5</sup> <b>NSMHS (2010)<sup>1</sup>—8.2</b></p>





► **Priority area 3**

Enhanced consumer, carer and family participation within service development and evaluation activities

Level of achievement	Implementation strategy
<p><b>Minimal achievement</b></p>	<p>3.5 Recruit a range of consumer and carer representatives to participate in service planning, development, evaluation and quality improvement activities. Match consumer and carer skills, experience and interests to the representation roles available. <b>NSMHS (2010)<sup>1</sup>—3.1/3.2/3.4/6.17/8.11</b></p> <hr/> <p>3.6 Support and resource the development of an independent consumer, carer and family advisory mechanism, for example Consumer Advisory Group, that gives feedback to the mental health service on key issues impacting on consumer, carer and family participation and key strategies to further support participation. <b>NSMHS (2010)<sup>1</sup>—3.1/3.2/3.4/6.17/8.11</b></p>
<p><b>Comprehensive achievement</b></p>	<p>3.7 Consult relevant workers and community leaders about the diverse participation considerations and interests of the local community, in terms of Aboriginal and Torres Strait Islander persons, culturally and linguistically diverse persons, religious beliefs, gender, sexual preferences, physical and intellectual disability, age profile and socio-economic status. Incorporate identified diverse participation considerations into local mental health plans. <b>NSMHS (2010)<sup>1</sup>—3.8/3.9/4.1/8.3</b></p> <hr/> <p>3.8 Create a variety of options for consumers, carers and families to offer feedback about the service. This could include, but is not limited to, word-of-mouth, a compliments and complaints procedure, de-identified service evaluation surveys during and at closure of service delivery, and suggestion boxes. Provide a verbal and/or written response to all feedback received by the mental health service. <b>NSMHS (2010)<sup>1</sup>—3.1/3.2/8.11</b></p> <hr/> <p>3.9 Provide comprehensive orientation and ongoing training, support and supervision for consumer and carer representatives. Create peer support options for consumer and carer representatives. Ensure that training and support is age-appropriate. <b>NSMHS (2010)<sup>1</sup>—3.3/6.18/7.15/7.17</b></p>
<p><b>Superior achievement</b></p>	<p>3.10 Facilitate consumer, carer and family forums that focus on specific issues and areas (separate or combined for consumers and carers depending on local consumer and carer preferences). Collate consumer, carer and family feedback to inform service planning, development, delivery and evaluation processes. Follow up and respond to feedback from forums. Provide updates to forum participants about how the feedback is being progressed. <b>NSMHS (2010)<sup>1</sup>—3.1/3.2/3.4/6.17/8.11</b></p> <hr/> <p>3.11 Conduct qualitative and quantitative research initiatives at a local level. <b>NSMHS (2010)<sup>1</sup>—8.9/8.11</b></p>



## Part B

### Implementation framework

#### Examples of practice

'Our child and youth mental health service created a culture of readiness for consumer/ carer participation by forming a group of interested staff, for example director, manager and senior staff, to oversee the development of the consumer participation plan. A working group worked with team leaders from the community clinics to identify interested parents or carers. These parents worked for a short time at the local clinic in a consumer group on local issues. The team leader then invited these parents/carers to participate at a higher level meeting at the hospital. This meeting was more about service and strategic issues and was chaired by the manager and attended by team leaders, senior staff and parent/carer representatives.

'Other factors that created a culture of readiness included:

- a genuine belief in the value of consumer/carer participation which flowed down from the director and manager
- staff were made aware of the consumer participation plan
- staff were encouraged to address their fears and concerns about involving consumers and carers
- staff were encouraged to have a voice in the implementation of the consumer participation plan
- consumer issues were discussed at various key service meetings
- parents and carers were invited and supported to attend the annual service conference
- parents and carers were supported to present their stories at the annual service conference
- some parents and carers were supported to attend major state and national conferences
- the service leaders demonstrated a genuine respect for consumer/carer experiences
- parents and carers were invited to speak at staff training sessions.

'Factors that supported consumer and carer participation in service development included:

- Parent/carer members of the parent advisory group were given administrative, personal and emotional support to enable their participation
- Ideas from parent/carer members were always given respect and consideration which often led to changes in service documentation, brochures and policies
- Parents and carers were asked to review service documentation to make it more consumer-friendly
- Morning tea was provided, parking costs were met
- Meetings were conducted in a structured but informal way and were always attended by the same senior staff, which gave some credibility and continuity to what was being developed
- Gradually, parent/carer representatives were invited to attend the peak service program development meeting



- Parents and carers were involved in the service accreditation process. From the service accreditation report, a process was initiated to employ two consumer consultants
- The value of consumers and carers has now been confirmed by reimbursement of parent advisory group members for their time and expertise.’ <sup>6</sup> (consumer worker)

‘In a previous role, I established a consumer advisory group. The membership of the group included some stand-out consumers and carers who were very knowledgeable, articulate and passionate about improving the healthcare experience of others. Of course, these people were the ones who healthcare professionals wanted to engage on everything from input into the hospital menus to implementing highly technical databases.

‘Caught up in the hype of having this new consumer and carer resource, the organisation went about picking and choosing who were thought to be the most appropriate consumers and carers to involve in various activities, and based these choices on their level of functioning, their attitude and how they expressed themselves—which are all key elements to consider when engaging consumers and carers—but what the organisation failed to do was to consider their interests, past experiences and strengths.

‘One lady on the group had a particular interest in children’s health. Her terminally ill son had recently passed away. Her son had spent more years in hospitals than out of them, so she got to know ‘the system’ and, more importantly, she had some great ideas about how to improve it. Her contribution and input into children’s health was extremely valuable, and it was also a great healing experience for her, but because she was so valuable in children’s health, we assumed she would be able to provide carer input on other facets of health care also. We asked her to be on the steering committee for the implementation of a new database. She hesitated as this was far from her area of expertise, but with a lot of encouragement, she agreed to be part of the steering committee. The first meeting consisted of representatives from IT, finance and senior medical staff.

‘After the meeting, I asked the carer representative how it went. She said she felt out of her depth, intimidated and just plain stupid. It was then that I thought about what we had done. We had put someone in a situation that they:

- really did not want to be in
- knew very little about
- were unsupported.

‘We simply based our decision to include her on the fact that she did such a great job at providing carer input previously (in her area of expertise). This was tokenistic, inconsiderate and ultimately inappropriate—how would I feel if I were an eye surgeon and asked to contribute to planning for an acute mental health unit? Probably out of my depth. This is something the organisation wouldn’t do because an eye surgeon does not have the mental health expertise to contribute meaningfully to building a psychiatric unit, yet we expect consumers and carers to provide generic input without considering their skills and expertise.

‘We then developed brief biographies for each member of the consumer advisory group and shared them across the district. This allowed consumers and carers to ‘market’ their interests, skills and expertise and also gave staff an idea of who would be most appropriate for them to engage—based on their interests, skills and expertise.’

(mental health service development worker)



### Priority area 4

#### Strengthened partnerships

#### Desired outcomes

- Strengthened partnerships between mental health services, government and non-government agencies.
- Improved inter-sectoral consumer, carer and family participation planning and implementation processes across agencies.

#### Priority area 4

##### Strengthened partnerships

Level of achievement	Implementation strategy
Minimal achievement	<p>4.1 Develop a local partnership agreement with relevant government and non-government agencies which explicitly states how sectors work together to enhance consumer, carer and family participation. Share this local partnership agreement with all relevant staff to inform day-to-day practice. <b>NSMHS (2010)<sup>1</sup>—5.3/5.4</b></p>
	<p>4.2 Mental health service staff play a lead role in improving service integration across government and non-government sectors. <b>NSMHS (2010)<sup>1</sup>—5.3/5.4</b></p>
	<p>4.3 Develop and maintain an up-to-date intranet-based resource list outlining all key consumer, carer and family support agencies in the local district. Offer links to pre-existing relevant web-based service directories. The resource list is accessible to all staff. <b>NSMHS (2010)<sup>1</sup>—10.1.9</b></p>
	<p>4.4 Mental health service representatives attend relevant non-government meetings and support relevant events. Where appropriate share local mental health service information with non-government organisations. <b>NSMHS (2010)<sup>1</sup>—8.3/9.5</b></p>
	<p>4.5 Invite non-government representatives from consumer, carer and family support agencies to share service information with local mental health service staff. <b>NSMHS (2010)<sup>1</sup>—8.3</b></p>
Comprehensive achievement	<p>4.6 Invite relevant non-government representatives to attend consumer, carer and family participation planning meetings. Include relevant non-government representatives in prioritising, planning and developing local consumer, carer and family participation strategies that are responsive to the diverse needs of the community. Provide this information to the local mental health service executive management meetings. <b>NSMHS (2010)<sup>1</sup>—9.5</b></p>



<b>Priority area 4</b> Strengthened partnerships	
Level of achievement	Implementation strategy
Comprehensive achievement	4.7 Create joint opportunities to reflect on the effectiveness of current partnerships with key stakeholders to improve ways of working together. <b>NSMHS (2010)<sup>1</sup>—9.3</b>
Superior achievement	4.8 Support local agencies in applying for funding for advocacy, support and training for consumers, carers and families to meaningfully participate in individual, service, organisational and policy levels of mental health services.
	4.9 Collaboratively develop an in-service education package to support workers across agencies in relation to consumer, carer and family participation skills and knowledge. <b>NSMHS (2010)<sup>1</sup>—8.7</b>
	4.10 Resource and attend relevant joint training opportunities with non-government and other government agencies. <b>NSMHS (2010)<sup>1</sup>—9.5</b>
	4.11 Provide community education to all key stakeholders about the benefits of consumer, carer and family participation and ways consumers, carers and families can become involved. <b>NSMHS (2010)<sup>1</sup>—3.3/9.3</b>

### Examples of practice

‘The key purpose of this position is to work closely with the director of social work services, program and services advisor, consumer consultant, and other government and non-government agencies in the development of strategic directions and building community capacity and linkages to ensure our mental health service meets the needs of the consumers and carers. I am working to develop a sustainable and open forum for continued involvement of consumers/carers and non-government agencies regarding future directions of the mental health services.’

‘This position provides strategic guidance and leadership to the mental health service consumer and carer participation team. This assists in the continuing maintenance, development and growth of the collaborative relationship between the mental health services and other government and non-government services, supporting consumers and the consumer advisory group.’

‘I have been meeting with mental health service and non-government staff to gain a better understanding of the current status of the working relationships between the services. I have done this through conducting a survey filled out by both the mental health service and the non-government sector. The survey has provided an opportunity to explore what contributes and strengthens and what inhibits working relationships. Together, this information will guide the priorities for future focus and development.’  
 (community capacity coordinator)

**Priority area 5**  
**Enhanced consumer and carer workforce recruitment and development**

**Desired outcomes**

- Career pathway options are developed for consumers and carers who are interested in (re)entering the workforce.
- Consumers and carers fulfil valued roles within mental health services. These roles are seen as integral to the service.
- A supported, skilled and trained workforce of consumers and carers exists.
- Additional consumer and carer positions are created within the mental health workforce.

**Priority area 5**

Enhanced consumer and carer workforce recruitment and development

**Level of achievement**

**Implementation strategy**

Minimal achievement

- 5.1 Enhance the understanding of mental health service staff about the relevance and importance of consumer and carer workers within the service.  
**NSMHS (2010)<sup>1</sup>—3.7**

---

- 5.2 Become familiar with The Mental Health Consumer and Carer Workforce Pathway that outlines standardised consumer and carer position classification structures.

---

- 5.3 Identify key local mental health service consumer and carer worker roles to enhance consumer, carer and family participation and what support structures are needed.  
**NSMHS (2010)<sup>1</sup>—6.18**

---

- 5.4 Clarify and incorporate core competencies into consumer and carer worker role descriptions that include but are not limited to, high-level communication skills (written and verbal), consultation skills, systemic advocacy and teamwork skills.  
**NSMHS (2010)<sup>1</sup>—8.6**

---

- 5.5 Recruit a range of consumers and carers with the appropriate experience and skills to fulfil consumer and carer worker roles within mental health services.  
**NSMHS (2010)<sup>1</sup>—3.6/3.7/8.6**

---

- 5.6 Provide local mental health service orientation activities for new consumer and carer workers.  
**NSMHS (2010)<sup>1</sup>—3.3/6.1.8/8.7**

---

- 5.7 Resource and support regular professional, operational and peer supervision opportunities for consumer and carer employees.  
**NSMHS (2010)<sup>1</sup>—3.6/8.7/8.8**





► **Priority area 5**

Enhanced consumer and carer workforce recruitment and development

Level of achievement	Implementation strategy
Comprehensive achievement	5.8 Use existing performance appraisal and development structures to identify and build on the strengths of consumer and carer workers. Support consumer and carer workers to identify key learning goals. <b>NSMHS (2010)<sup>1</sup>—3.3/6.18/7.15</b>
	5.9 Ensure access to training opportunities relevant to the role. This could include but is not limited to Certificate IV in Mental Health (non-clinical), Mental Health First Aid training, non-clinical supervision training, and Certificate IV in Workplace, Assessment and Training. <b>NSMHS (2010)<sup>1</sup>—3.3/6.18/7.15</b>
	5.10 Support consumer and carer workers to participate in relevant consumer and carer worker network meetings and other networks. <b>NSMHS (2010)<sup>1</sup>—3.6</b>
Superior achievement	5.11 Support consumer and carer workers to attend relevant statewide conferences and the annual Consumer and Carer Workers Network Workshop. <b>NSMHS (2010)<sup>1</sup>—3.5/3.6/3.7</b>
	5.12 Support consumer and carer workers to participate in statewide skills and knowledge audits, and continue to offer professional training and development opportunities that are responsive to their needs. <b>NSMHS (2010)<sup>1</sup>—3.5/3.7</b>
	5.13 Encourage and support consumer and carer workers to prepare and deliver conference presentations with other service staff about key consumer, carer and family participation initiatives. <b>NSMHS (2010)<sup>1</sup>—3.5/3.7</b>
	5.14 Support consumer and carer workers to facilitate and present internal and external staff training. <b>NSMHS (2010)<sup>1</sup>—3.5/3.7</b>
	5.15 Support and implement succession planning activities to ensure more experienced workers have opportunities to mentor and/or share their knowledge and expertise with other consumer and carer workers. <b>NSMHS (2010)<sup>1</sup>—3.7</b>

**Examples of practice**

‘Our mental health service context is within remote and Indigenous communities, across multiple sites. There are no existing models of mental health consumer and carer consultation informed by a specific Indigenous cultural context. This presents a unique opportunity for our health service district to resource community participation in developing an appropriate model. While engaging a consumer and/or carer coordinator role has been the adopted model for most services, a single position was seen to have limited capacity in providing coordination and engagement across 12 sites within our

## Part B

### Implementation framework

district, and would face challenges of equity, logistics and cultural considerations in providing appropriate consultation to the service. Instead we have been considering employing a range of consumer and carer workers on a casual basis. These consumer and carer workers could form a network, supported by existing networks with the mental health service and the community. Recruitment strategies, position and support structures will require further consultation within pre-existing forums and more broadly within the community to identify a sustainable and effective model. The Integrated Mental Health Alcohol, Tobacco and Other Drugs program includes staff with collaborative roles in community engagement and capacity building. These positions are seen as well placed to provide support to consumer and carer consultants in each community, and identify sustainability issues with the support of the program management and teams.’ (service director)

‘The service employed two consumer consultants after recommendations from the accreditation process. These consultants had provided input into service planning, development and evaluation over the past six years in a voluntary role, which included:

- attending the peak service program development meeting (a quarterly meeting attended by peak service personnel, including the director, manager, senior professionals and team leaders)
- presenting their stories at the annual service conference
- being supported to attend state and national level conferences
- reviewing service documentation
- operating as chair of the parent advisory group
- spending time at local community clinics in consumer groups.

‘Time spent undertaking these activities was seen as an ‘apprenticeship’ in the lead-up to their paid roles as consumer consultants. They had been given the opportunity to meet and work with key service people on a range of activities, during which time they were able to demonstrate their own skill set and knowledge.

‘Once employed, the consumer consultants participated in the service-wide performance appraisal and development process, where they were asked to identify additional skills and knowledge that they saw would enhance their roles. They identified:

- additional IT skills
- further education around mental health disorders
- project management training
- education to enhance facilitation of staff and parent/carer training (for example Certificate IV in Workplace, Assessment and Training).

This process was facilitated by the service manager and senior psychotherapist.’ (consumer worker)

‘It was decided by service management that the role of the consumer consultant would be shared between two people. This enabled them to share ideas, provide support to each other and offer two perspectives. This has proven to be a valuable and worthwhile experience, one which the consumer consultants state has been beneficial to themselves



and the service. This peer support provided to each other, was in addition to the supervision provided by a senior professional of the service.’ (consumer worker)

‘Two years ago a number of clinical service delivery and knowledge management challenges were identified by our mental health service. Among a range of identified needs, our service recognised the need to more closely integrate support positions such as the service’s consumer and carer consultants with clinical teams as a means of decreasing their isolation and increasing their value to clinical service delivery. Recommendations were drawn from a literature review and consultation with consumers, carers, clinicians and the community sector. This led to the development and implementation of the resource team.

‘A number of specialty clinical and support positions were relocated from clinical units to the resource team. These included the consumer consultants. Under the guidance of the resource team manager each position provides consultation and liaison services to clinicians across the mental health service, links consumer and carer services to the clinical teams and provides consumer and family psycho-education, advocacy and representation. The resource team actively supports consumer and carer participation in the planning, delivery and evaluation of all mental health services.

‘Consumer and carer services have been developed and expanded as a direct result of their relocation to the resource team. Consumer and carer representation at an organisational level has been enhanced while improved linkages and information-sharing with clinical teams reinforce the recovery approach to service delivery. The consumer and carer consultants are directly involved in the implementation of the strengths-based model of recovery within the service and provide education to clinical staff. They provide peer support and education to consumers and carers within the district and to local non-government and community agencies via monthly consumer/carers meetings and quarterly education forums. They have been successful in negotiating payment for consumers and carers who provide education, lectures or training sessions to the service. The consultants are a conduit for consumer and family feedback. They sit on all new program steering committees and are routinely invited to participate in working parties. Since the inception of the resource team, the consumer consultants have had direct access to regular operational and role support. Having consolidated the role of the consumer and carer consultants and benchmarking their positions from AO3 to AO5 level, we are now in a position to consider the expansion of consumer and carer services. With support from their manager, the consultants have visited other local services with a view to developing a proposal for additional positions. It is envisaged that these additional positions will provide career pathway options and include recovery support workers and volunteer workers.’ (team leader)



**Priority area 6**  
**Enhanced mental health workforce recruitment and development**

**Desired outcomes**

- A skilled mental health workforce who can meaningfully engage with consumers, carers, families and key stakeholders to develop collaborative partnerships at all levels of service delivery, planning and evaluation.
- A mental health workforce who can identify, understand and respond to barriers that affect consumer, carer and family participation.

Priority area 6 Enhanced mental health workforce recruitment and development	
Level of achievement	Implementation strategy
Minimal achievement	6.1 Develop and implement a service guideline that formalises consumer and carer participation in recruitment and selection processes of mental health staff. <b>NSMHS (2010)<sup>1</sup>—8.6/8.7</b>
	6.2 Provide consumer and carer representative selection panel and recruitment training. <b>NSMHS (2010)<sup>1</sup>—3.5/3.7/8.6</b>
	6.3 Ensure mental health staff position descriptions include key skill requirements/competencies/attributes about supporting and facilitating consumer, carer and family participation. Recruitment processes to include questions on knowledge and attitudes about consumer, carer and family participation. <b>NSMHS (2010)<sup>1</sup>—8.7</b>
	6.4 Orientate new mental health service staff to: <ul style="list-style-type: none"> <li>• statewide consumer, carer and family participation orientation resources</li> <li>• local mental health service policies that relate to consumer, carer and family participation</li> <li>• local consumer, carer and family support organisations</li> <li>• practical local information on how to meaningfully engage with consumers, carers and families at all levels of service planning, development, delivery and evaluation.</li> </ul> <b>NSMHS (2010)<sup>1</sup>—8.7</b>
Comprehensive achievement	6.5 Provide ongoing supervision, mentoring and training opportunities for relevant staff to enhance their skills and knowledge of: <ul style="list-style-type: none"> <li>• consumer, carer and family participation</li> <li>• strengths-based practice</li> <li>• consumer-directed recovery planning</li> <li>• Part 7 (Confidentiality) of the <i>Health Services Act 1991</i> to develop a clear understanding of the information that can be conveyed to carers and families and under what circumstances</li> </ul>



► **Priority area 6**

Enhanced mental health workforce recruitment and development

**Comprehensive achievement**

**Implementation strategy**

- working with carers and families
- the facilitation of consumer, carer and family participation within committee meetings.

**Note:** Consumer and carer workers/representatives must be involved in training initiatives, particularly through co-presenting with mental health service staff.

**NSMHS (2010)<sup>1</sup>—4.3/8.6/8.7**

6.6 Use performance appraisal and development processes to identify consumer, carer and family participation performance outcomes. Support staff to outline their learning goals for effective consumer, carer and family participation.

**NSMHS (2010)<sup>1</sup>—4.3/8.7**

6.7 Connect rural and remote services to larger regional or metropolitan mental health services which can provide supervision, support and training around consumer, carer and family participation.

**NSMHS (2010)<sup>1</sup>—4.3/8.7**

**Superior achievement**

6.8 Support staff to undertake higher-level education that enhances their skills and knowledge of consumer, carer and family participation.

**NSMHS (2010)<sup>1</sup>—4.3/8.7**

6.9 Liaise with tertiary sector training providers in medical, social work, nursing, psychology and occupational therapy to enhance course curriculum to facilitate an understanding of consumer, carer and family participation within a mental health context.

**Examples of practice**

‘The current service policy makes provision for consumer and carer representation on recruitment and selection panels. Before participation, the consumer or carer is to attend recruitment and selection training provided by our human resource staff. In a recent example, the chairperson of a local consumer and carer advisory group was a member of the recruitment and selection panel for the position of consumer and carer representative, which enabled positive consumer input in a crucial area of responsibility within the mental health service.

‘All clinical role descriptions refer to contemporary mental health service delivery. This service model is underpinned by recovery principles. Questions that elicit consumer-focused responses are included in clinical scenarios put to applicants as part of the selection process.

‘The mental health service orientation program now includes a presentation on consumer and carer participation, facilitated by the consumer and carer consultants. This training provides an overview of the structure and roles of consumer and carer services, including

## Part B

### Implementation framework

the consumer companion program, and underpinning policies. Staff members are advised of mechanisms for consumer consultation within the service. For example consumer and carer advisory groups, consultation forums conducted by the recovery and rehabilitation service, inpatient unit consultations and the mental health interagency network. Also the orientation program incorporates a section on recovery practice, which describes the overarching Sharing responsibility for recovery policy document<sup>8</sup>, to ensure staff members are aware of their responsibility to engage with consumers and carers in meaningful ways across the spectrum of service implementation.

‘Our mental health service has recognised the need to create a service structure that can provide leadership for the implementation of consumer and carer participation and recovery-based practice. The service has developed a service-wide recovery and rehabilitation service, which facilitates a recovery committee consisting of representatives from clinical areas, consumer and carer services, and senior allied health staff. The workgroups established by this committee have provided on-site training to clinical teams and units in consumer-directed recovery-based practice, including strengths-based approaches and collaborative goal-setting. These training programs have been co-facilitated by a recovery support worker, providing a key lived experience component. Where co-facilitation is not possible, we have used consumer stories as recorded on DVD to provide this perspective.

‘Additionally, the Transition to Mental Health Program for staff moving into mental health now incorporates a session on recovery practice, and a five-hour training program on recovery and rehabilitation, co-facilitated by the recovery support worker, has been included within the education program for all mental health service staff.’

[\(mental health service director\)](#)





## Priority area 7 Enhanced mental health organisational culture and leadership

### Desired outcomes

- The ongoing development of a mental health organisational culture that values and supports consumer, carer and family participation.
- Mental health service management and medical staff work alongside consumers, carers, families and other staff to co-create a culture within the service that values and supports consumer, carer and family participation.

### Priority area 7

#### Enhanced mental health organisational culture and leadership

Level of achievement	Implementation strategy
Minimal achievement	7.1 Develop an organisation mission statement in consultation with consumers, carers, families and staff. Within the statement, identify key principles and values that support consumer, carer and family participation. <b>NSMHS (2010)<sup>1</sup>—10.1</b>
	7.2 Develop mental health service policies and procedures that reflect recovery-orientated values and principles. <b>NSMHS (2010)<sup>1</sup>—10.1.1/10.1.8</b>
	7.3 All staff use respectful language when discussing consumers, carers and families. <b>NSMHS (2010)<sup>1</sup>—4.4</b>
	7.4 Provide ongoing training for staff about: <ul style="list-style-type: none"> <li>• the relevance and importance of consumer, carer and family participation at all levels of service delivery</li> <li>• the organisation’s mission statement</li> <li>• service policies and procedures that reflect recovery-orientated values.</li> </ul> <b>NSMHS (2010)<sup>1</sup>—4.3</b>
Comprehensive achievement	7.5 Initiate regular informal events with consumer and carer workers, representatives and staff. <b>NSMHS (2010)<sup>1</sup>—10.1.8</b>
	7.6 Support mental health staff to play a lead role in facilitating consumer, carer and family participation. <b>NSMHS (2010)<sup>1</sup>—4.3/8.7</b>
	7.7 Develop and implement a service guideline that formalises consumer, carer and family participation in recruitment and selection processes of local mental health service managers and medical staff. <b>NSMHS (2010)<sup>1</sup>—8.6</b>



## Part B Implementation framework

<b>Priority area 7</b> Enhanced mental health organisational culture and leadership	
Level of achievement	Implementation strategy
Comprehensive achievement	7.8 Involve consumer and carer representatives in orientation processes for all staff. <b>NSMHS (2010)<sup>1</sup>—3.5/3.7/8.6</b>
	7.9 Mental health service management consult directly with consumer and carer representatives. Managers acknowledge the contribution of consumers, carers and families to service improvement activities. <b>NSMHS (2010)<sup>1</sup>—10.1.8</b>
Superior achievement	7.10 Incorporate consumer, carer and family participation as a core competency within leadership and medical staff training programs. <b>NSMHS (2010)<sup>1</sup>—4.3/8.7</b>
	7.11 Identify local mental health service management and senior medical staff who have demonstrated knowledge and skills in implementing consumer, carer and family participation. Coordinate these service leaders to provide peer supervision and training to other local mental health service staff. <b>NSMHS (2010)<sup>1</sup>—8.7/10.1.8</b>

### Examples of practice

‘Our child and youth mental health service has been actively working to build a working relationship with consumers since 1995. We started by talking with team leaders to identify consumers who would be willing to meet with us. Some brave people did and as we talked together we found that we all benefited.’

‘The leadership of the service, the director, the manager and a senior clinician have met with consumers regularly over this whole period. The consumers have had ongoing regular access to senior management. They have been given training and opportunities to develop skills in public speaking, actively participating in conferences in Queensland and interstate, meeting organisation, research and writing for publication. Their involvement in key service meetings has been essential to help all staff see them as valued and influential players in our service. We have great consumer consultants.’

‘We hope our consumers have enjoyed and learnt from their participation, but we know that our service has been the major beneficiary.’ **(senior clinician)**



## Priority area 8 Consumer and carer leadership

### Desired outcomes

- A respected body of diverse consumer and carer leaders across the Queensland Health mental health service sector.
- A body of consumer and carer leaders with a working knowledge of the mental health service system and the key issues affecting consumers, carers and families statewide, who are actively involved in informing the strategic direction of Queensland Health mental health services.
- Effective systemic advocacy structures established to ensure active involvement of consumer and carer leaders.
- A strengthened collective voice of consumers, carers and families.

### Priority area 8 Consumer and carer leadership

Level of achievement	Implementation strategy
Minimal achievement	8.1 Recruit a range of consumer and carer leaders to participate in statewide mental health networks and advisory groups. Recruit both independent consumer and carer representatives and consumer and carer workers employed by Queensland Health. <b>NSMHS (2010)<sup>1</sup>—3.1</b>
	8.2 Provide mental health service system orientation for consumer and carer leaders. <b>NSMHS (2010)<sup>1</sup>—3.5</b>
	8.3 Involve consumer and carer leaders in reviewing national and state policies and plans. <b>NSMHS (2010)<sup>1</sup>—3.1</b>
	8.4 Support and resource a statewide network of consumer and carer workers to provide strategic direction to Queensland Health mental health services, regarding the needs of consumers, carers and families. This network will complement local consumer and carer networks, both independent consumer and carer representatives and consumer and carer workers employed by Queensland Health. Support the network to create feedback mechanisms to inform local consumer and carer leaders about statewide initiatives. <b>NSMHS (2010)<sup>1</sup>—3.1</b>
Comprehensive achievement	8.5 Market statewide participation and advocacy opportunities for consumer and carer leaders. <b>NSMHS (2010)<sup>1</sup>—3.1</b>





# Part B

## Implementation framework

Priority area 8 Consumer and carer leadership	
Level of achievement	Implementation strategy
Comprehensive achievement	8.6 Resource ongoing training and support for consumers and carer leaders to participate in leadership roles. Recognise the previous work experiences and knowledge of consumer and carer representatives. Tailor training opportunities that are responsive to their training needs. Resource ongoing consumer and carer peer support processes. <b>NSMHS (2010)<sup>1</sup>—3.5/3.6</b>
Superior achievement	8.7 Support consumer and carer leaders to present at relevant conferences to share key learning and knowledge on specific areas of consumer, carer and family participation. <sup>7</sup> <b>NSMHS (2010)<sup>1</sup>—3.5</b>

### Examples of practice

‘I am a consumer representative on a clinical sub network. I have been linked to a monthly facilitated peer support teleconference. Each month we explore a different topic of relevance. The peer support sessions have been an opportunity to be linked in friendship, to keep in touch with others throughout Queensland who are in similar roles and circumstances. The peer support has been a chance to listen and share our issues. This has enabled me to make the most of every topic and piece of information, to realise the ongoing challenges and responses needed within the community. It has been a chance to play a supportive and, at times, encouraging role with my peers at a level not widely offered within my professional development, offering hope that we can “stay afloat” and look after ourselves!’ (consumer leader)

‘I have really enjoyed being a carer representative at the statewide level over the last year. It has given me a whole set of new perspectives; there are so many issues, some of which I have never even considered, and there are also so many different points of view.

‘The statewide network comprises clinicians and non-clinicians from every facet of mental health, both government and non-government, as well as across age groups, geographical areas and cultures. It is not only interesting to learn about the various issues and perspectives, it is also very rewarding to be part of a team resolving challenges and gaining consensus.

‘I have generally had very good support. The practical issues like receiving the notes in time to read them thoroughly before the meetings are important—although there have been a few hiccups, usually there is a reason, and besides, we are all human! I have also had great support personally. The other members of the network are friendly and treat me respectfully, even though there are times when I think I have challenged them quite seriously. There was also a time when I felt I needed some extra support with dealing with some distressing issues and the person I spoke to organised it immediately.

‘I would like to think my participation has made a difference. What I do know, unequivocally, is that the reality of consumer and carer participation has already made an enormous improvement to the outcomes for consumers, and carers are also being recognised as having the ability to add value to the recovery process. We are not there yet, but at least we are on the way.



‘I have met quite a few carers who are equally passionate about becoming involved and it has been good to have some of them come on board as carer representatives. The more the merrier, I think! That way there is not too much of a burden on any one of us and the knowledge is more effectively shared among our networks of contacts, and this means more carers can provide better support for their family members, which is what it is all about.’ (carer leader)



## Priority area 9

### Enhanced consumer and carer participation in research, policy and legislation development activities

#### Desired outcomes

- Prioritising of a range of research initiatives that further explore consumer and carer participation models.
- Consumers and carers to be valued contributors to the development of these research activities.
- Consumers and carers actively involved in prioritising policy initiatives.
- A respected diverse group of consumer and carer leaders with relevant skills contributing to policy development.

#### Priority area 9

Enhanced consumer and carer participation in research, policy and legislation development activities

#### Level of achievement

#### Implementation strategy

#### Minimal achievement

- 9.1 Identify, monitor and record emerging trends and issues that will further inform consumer and carer participation models and initiatives.  
**NSMHS (2010)<sup>1</sup>—8.9**
- 9.2 Conduct research projects that explore a range of consumer and carer participation models, identifying which models are more sustainable and maximise diverse consumer and carer participation strategies.  
**NSMHS (2010)<sup>1</sup>—3.1**
- 9.3 Develop transparent and standardised recruitment processes congruent with Queensland Health recruitment procedures for the selection of consumer and carer representatives. To enhance these representatives include other consumer and carer leaders on these selection panels.  
**NSMHS (2010)<sup>1</sup>—3.1/10.1.8**
- 9.4 Recruit and engage consumer and carer leaders to participate in research, policy and legislation development activities. Recruit consumers and carers with appropriate skills. Engage selected consumer and carer leaders to be key members on Queensland mental health policy, research and legislation networks, subgroups, reference groups and committees.  
**NSMHS (2010)<sup>1</sup>—3.5**
- 9.5 Provide relevant orientation for selected consumers and carers.  
**NSMHS (2010)<sup>1</sup>—3.7**





► **Priority area 9**

Enhanced consumer and carer participation in research, policy and legislation development activities

Level of achievement	Implementation strategy
Minimal achievement	9.6 Use a standardised remuneration guideline for reimbursing consumer and care representatives for their time, travel, accommodation and other additional expenses. <b>NSMHS (2010)<sup>1</sup>—3.5</b>
	9.7 Send briefing documents to the selected consumer and carer in a timely fashion prior to a policy development meeting.
Comprehensive achievement	9.8 Devise and implement marketing strategies to promote and make publicly available information about consumer and carer participation opportunities in research, policy and legislation development. <b>NSMHS (2010)<sup>1</sup>—3.1</b>
	9.9 Support consumer and carer workers and leaders to initiate research projects. Support consumers and carers to further develop surveying and other research skills, to document and publish key research findings and recommendations for future consumer, carer and family participation initiatives. <b>NSMHS (2010)<sup>1</sup>—3.6</b>
	9.10 Develop clear protocol that maximises consumer and carer leaders' inclusion in research, policy and legislation development discussions. <b>NSMHS (2010)<sup>1</sup>—3.7</b>
	9.11 If desired, a nominated peer support person from the same committee to give support before and after meeting, to ensure the consumer and carer have ample opportunity to ask any questions about committee content and processes. <b>NSMHS (2010)<sup>1</sup>—3.7</b>
Superior achievement	9.12 Fund scholarships for consumers and carers to initiate research relating to consumer and carer participation. <b>NSMHS (2010)<sup>1</sup>—3.5</b>

**Examples of practice**

‘For three years, the consumer consultants met with parents and carers who had a child or young person admitted to the inpatient unit. During these meetings parents often discussed the emotional and practical burden they face themselves and as a family. During these informal meetings, tea, coffee and sandwiches were provided. It was not uncommon for the families to express their gratitude for being able to have refreshments, as well as having someone to talk to who understands what they are going through and how they feel. This information was recorded in a de-identified and informal way and thus provided information to present to the team, management and for a research article for publication.

‘The service has a dedicated research department. Consumers and their carers have been involved in many projects. As consumer consultants, we have been involved in writing policy, as well as writing, delivering and analysing consumer-driven and consumer-

## Part B

### Implementation framework

focused surveys. This has been a change of direction for the service, where past surveys were written and developed by clinicians. This now allows the service to see first-hand what consumers and carers identify as practical concerns around access, information, treatment and services. Analysis has then led to recommendations by the consumer consultants to inform service delivery.’ (consumer worker)

‘The service now remunerates consumers and carers for their expertise, effort and time under the Guidelines for the remuneration of consumers and carers in Queensland mental health services<sup>5</sup>, developed by Queensland Health. Before this taking place, consumers and carers were reimbursed for costs associated with their participation. They were also offered administrative and personal support, and refreshments were always made available. Occasionally, parents or carers of the parent advisory group raise our attention to related conferences, seminars or workshops they wish to attend. The consumer consultants advocate for their attendance in writing and the service is often able to fund their costs.’ (consumer worker)

‘The consumer consultants developed and initiated the parent/carer survey in 2004. A pilot survey was first conducted in one community clinic with a further survey the following year in the remaining two community clinics. At this time, the consumer consultants had little knowledge around databases or analysis of findings. The research centre provided staff to assist with the entering of data, analysing the data and writing a final report of the findings. The survey was run again in 2007 at all clinics. At this time, the research centre was unable to provide staff to undertake the data entry and analysis but provided some basic training in these processes. The consumer consultants had a quick lesson by trial and error. They were able to complete the process themselves and reported the findings and recommendations for the future back to the team leaders, management and consumers and carers in their local community.’ (consumer worker)

‘I was thrilled to be asked, together with one of the consumer representatives, to participate in the recent forum on the Fourth National Mental Health Plan. It is quite sobering knowing just how important it is that you truly represent other carers, but also exciting when you see that it can make a positive difference.’ (carer leader)



## References

---

1. Commonwealth of Australia, National Standards for Mental Health Services, Department of Health and Family Services, Canberra, 2010.
2. Queensland *Health Services Act 1991*, Queensland Government, 1991.
3. Meagher J, *Partnership or Pretence*, Psychiatric Rehabilitation Association, 1995.
4. Queensland Health, Towards Consumer Centred Services: Queensland Health Action Plan for Consumer and Carer Participation in Queensland Mental Health Services, Mental Health Directorate, Queensland Government, 2003.
5. Queensland Health, Guidelines for the Remuneration of Consumer and Carer Representatives in Mental Health, v9, 2007.
6. MacDonald E, Lee E, Geraghty K, McCann K, Mohay H, O'Brien T, Towards a developmental framework of consumer and carer participation in child and adolescent mental health services, *Australasian Psychiatry*, 2007, 15:504–8.
7. Queensland Health, The Mental Health Consumer and Carer Workforce Pathway, (DRAFT) Mental Health Directorate, Queensland Government, v8, 2010.
8. Queensland Health, Sharing Responsibility for Recovery: creating and sustaining recovery-oriented systems of care for mental health, Queensland Government, 2005.