Mental Health Carers Tasmania
in Partnership with
headspace Hobart

A Practical Guide for Working for Carers of People with a Mental Illness Implementation Demonstration Project

Final Report

January 2018

The purpose of the report is to document the implementation and evaluation of the Mind Australia and Helping Minds Demonstration Project: 'A Practical Guide for Working with Carers of People with a Mental Illness'. The project was provided via a partnersip between Mental Health Carers Tasmania and headspace Hobart, with the aim of addressing inclusiveness of Family/Friends/Carers when supporting young people in their recovery journey.

1. Summary

This report outlines the implementation and evaluation of the resource: *A Practical Guide for Working with Carers of People with Mental Illness*, *(*the *Guide).* As a demonstration project, the *Guide* was explored through engaging with staff in supportive, shared learning within a community mental health service, towards ensuring a service model that values and includes family and carers in a client's mental health recovery journey.

Implementation involved self-assessment data collections using the pro-forme within the *Guide.* Exploration of how the organisation performed against the *Guide's* six Standards used a values-based action research model, culminating in the shared development of six overarching policies that reflect the messages within it.

Self-assessments were completed at the beginning and end of the demonstration project. This enabled a comparison that revealed learnings and improvements that can be directly attributed to the *Guide's* intervention.

The results showed that intervention via the *Guide* enabled headspace Hobart were able to clearly identify through a number of tools of analysis the gaps in service. These could be considered towards improving the inclusion of Family/Friends/Carers in everyday practice. The key areas of focus were training staff, allocating roles for carer champions, carer rights and responsibilities and confidentiality.

2. Introduction

2.1 Background

Mental Health Carers Tasmania (MHCTas) is a Statewide service that supports carers, family and friends of people with a mental illness. headspace Hobart is a free community service for young people aged between 12 and 25 with mild to moderate mental ill health. The service operates with The Link Youth Health Service (The Link) as lead agency. Both are branches of national peak organisations: Mental Health Carers Australia and headspace National.

MHCTas is well placed to understand that the national demonstration project has the potential to positively address carer concerns, including that they their role is unrecognized, that they often don't receive information due to lack of clarity around confidentiality and are often unable to fully support the person they care for to access appropriate services.

As well the MHCTas role of advocating for positive systemic change provides a pathway that brings the project findings to levels of influence that would normally be difficult to access for both individual carers and demonstrably stretched mental health service providers.

At the same time the project was fortuitously able to respond to concerns recently raised by headspace Hobart management around carer engagement within its culture and practice. Although the headspace service model includes commitment to engaging with family and friends, the concerns were that the service was not including them to their full potential as valuable partners in the recovery journey, nor were the support needs of carers fully known. Management consequently sought advice and support from MHCTas.

The project fits within current Tasmanian Government policy as outlined in its Rethink Mental Health Plan (2015-2025). The 10-year Plan recognizes the 'significant contribution' and vital role played by family and carers of a person with a mental illness (in economic terms $60.3 billion annually across Australia); it also states the need to value, support and include them in service design and delivery. The Plan offers direction from the current 'complex, disjointed and confusing' service system to a new approach that includes improving inclusiveness for family and carers, reducing stigma and recognizing the lived experience of carers by engaging with them as peers within the mental health workforce.

On a successful funding application, a partnership was formed between MHCTas and headspace Hobart, supported by a Memorandum of Understanding. The project was required to introduce collaborative, strengths-based systems for exploring and managing discussion around any changes that would flow from the Guide's learnings, primarily:

- Detailed analysis of the data from the Self Assessments as they related to each Standard within it, which were conducted at the beginning and end of the implementation phase
- Action Research
- Program Logic as an evaluation tool.

The project employed two project officers in a shared role capacity, who each worked eight hours per week. The CEO of MHCTas (the lead organization) provided primary management, advice and direction. Regular meetings, at least fortnightly, and also as-needed phone and email communication between the project officers and the manager of headspace Hobart were readily available. These provided guidance, support, relevance, understanding of headspace culture and access to staff and resources.

The project's budget included specific opportunities to access University of Tasmania (Utas)-based expert advice on all aspects of the project.

Ethics Approval at the required level was sought and obtained from the Utas Ethics Committee.

A project reference group was formed, with members from key mental health services, carers with lived experience and representatives from headspace Hobart's young people's reference group. Its terms of reference aimed to provide access to:

- Specific and specialized experience and knowledge
- A forum for discussion including around the planning, delivery and evaluation of the project
- Identifying opportunities for exploring how learnings from the *Guide* could help towards resourcing more support for carers.

2.2 Primary Aim of the Project

The demonstration project's primary aim was to implement and evaluate the application of *A Practical Guide for Working with Carers of People with A Mental Illness* into service practice at headspace Hobart.

2.3 The Project Objectives

- Inform staff of the 'Triangle of Care' Model for practice as presented in the *Guide*
- Understand the current context for staff at headspace Hobart regarding family/friends/carer involvement
- Obtain quantitative and qualitative data from headspace staff to create a picture of the culture regarding family/friends/carers inclusive practice
- Engage headspace Hobart staff in conversations regarding family/friends/carers involvement and the potential barriers to engagement that may present from current practises
- Educate and inform headspace Hobart staff on the *Guide* and its evidence-based framework for supporting family/friends/carers
- Obtain a shared understanding with headspace Hobart staff regarding the interpretation of the *Guide* and its six Partnership Standards
- Introduce and inform staff of legislative requirements, as highlighted in the *Guide,* that impact on the rights and responsibilities of family/friends/carers in a mental health service client's recovery journey
- Discuss a model of inclusion for a wholistic recovery journey with a view to changing culture and practice.

It endeavoured to achieve this within an interactive framework to enable shared learnings that would result in improved outcomes for young people with mental ill health and their carers. This was to be achieved by applying the learnings towards influencing workplace culture and practice within headspace Hobart. As already stated, a number of strategies were used to support change (please see below) to encourage open, informed communication across all levels, including within The Link as its lead agency. Information and training were provided to ensure that the tools were easily understood so that they can be used in an ongoing way.

2.4 Further Strategies

Communication systems offered opportunities to share in the design, implementation and evaluation of the work. This was achieved through interactive presentations and discussions with each as below:

- The Board and management (ie that of both headspace Hobart and its lead agency The Link)
- The project's reference group
- Young people (with contact limited to The Link's youth reference group)
- headspace Hobart's staff
- To maximize reach, staff were also encouraged to disseminate the project's aims, objectives and ongoing progress via local sector networks.

A commitment to learning and change: headspace Hobart management ensured that staff were informed via presentations provided by the project officers, staff meeting agendas and intranet emails about the project and that as many as possible were able to attend weekly lunchtime meetings during the implementation stage of the project

Offering accurate understanding of key factors within the Guide by broadened the project's perspectives:

- Integrating the background information to each Standard offered within the *Guide* to give informed depth to interactions with headspace Hobart.
- Linking the process with headspace National web resources relating to carers.
- Conducting and disseminating a literature search specifically around young people and mental health, MHCTas-sourced literature and data relating to carer lived experience, Action Research and Program Logic.

Staff participated in a preliminary self assessment against the six Standards within the *Guide*, followed by a detailed analysis and comparison of the data obtained including via a spreadsheet that organized the data into an Action Research format, which was presented to staff as a proposed working document. Action Research was used as an approach to facilitating shared active, systematic enquiry towards improving workplace practices in an open, fluid and responsive way. With headspace management support, the project facilitated staff to take primary responsibility for developing resources that flowed from perceived gaps in meeting the Standards. Staff and project officers then collaborated in developing and refining a set of six headspace Hobart-specific Policies that will support the organization towards meeting the Standards within the *Guide*. A second self-assessment by staff against the Standards within the *Guide* enabled analysing the results and presenting them back to management and staff for discussion towards change. The Program Logic model was useful as an evaluation tool.

2.5 Project Barriers

The level of ethics approval obtained did not allow direct contact with headspace Hobart's young people, or with their family, friends and carers. This meant that no qualitative or quantitative data could be sourced from carers or consumers currently involved in headspace Hobart. However, the data and stories-rich resources available at MHCTas offered some compensation. Further compensation was provided by studying the headspace National website, which offers clear direction and numerous resources that support the inclusion of carers in headspace service delivery. The project co-ordinated a small reference group for consultation, however there was limited participation, which was evidenced through a lack of attendance for a variety of reasons.

Staffing is stretched: the headspace Hobart service agreement includes a mix of nine permanent 'core' workers, most of whom work part-time. They include 1.5 full time equivalent clinical staff. As well there are seven professionals with clinical expertise who are employed on a contract basis, and who also work as private practitioners outside their headspace commitments. Some funding was provided within the project for them to attend meetings, however staffing allocations placed strain on the abilities of contract staff to participate in the project:

- Not all staff were able to engage in the self-assessments or were able to provide feedback on the process, or to be involved in the weekly sessions.
- Not all staff were able to complete both the pre and post self-assessments.

2.6 Unforseen Events

The project began in late April 2017 and sessions with headspace Hobart began in June 2017 onwards. The Hobart community experienced a serious flu during the 2017 winter, resulting in decreased participation in the project from time to time: some staff were absent for extended periods.

During the implementation phase a tragic event with direct impact on staff and young people affected operations. This had an indirect impact on the project and resulted in around 2-3 weeks during which it was not possible to engage with headspace staff.

3. Methods

The methods used followed the scope of the Demonstration Project set up by MHCTas in the initial Project Proposal. Each method enabled open and supportive communication, which was strengthened and encouraged by both project partners (MHCTas and headspace Hobart).

All policies and procedures of headspace Hobart and/or headspace national were adhered to as part of the partnership agreement/MOU.

Primarily, three research methods were required within the project's proposal around its delivery:

- To implement the *Guide* including its data collection, analysis and extrapolation
- Action Research
- Program Logic

3.1 Data Collection, Analysis & Extrapolation

The self-assessment tool within the *Guide* provided the starting point towards individual headspace Hobart staff reflecting on both the organisation's culture, and their own practice, against the six Partnership Standards. The project officers conducted this exercise early in the work and then repeated the procedure towards the end of the project. This enabled evidence of any change due to the project's intervention to be brought back to staff for discussion and proposed action.

The *Guide* organised the self-assessments by using a 'traffic light system' through which individuals could assess current performance against a comprehensive range of quality and safety activities as either:

- Red: significantly under-performing and an urgent need for action towards improvement
- Orange: Some achievement of sometimes meeting an element towards a Standard but that improvement is necessary
- Green: A positive achievement, most of the time.

A further column was added to this project to enable capturing responses that were unsure or unclear:

- Grey: Unsure, for instance not fully completed, vague or non-applicable.

Data findings were collected and collated in the following ways (please see attachments for pro-formes):

- Using the format provided in the *Guide's* six Standards-based self-assessment pro-formes to produce a single page document that summarised criteria (the elements recommended to successfully meet each Standard), staff responses, and findings
- Pie charts that summarised responses to the data in terms of percentages
- A single page document that grouped all findings into three sets of responses, colour coded in red, orange and green:
    - Majority of responses in 'positive achievement'
    - Majority of responses in 'needs improvement'
    - Majority of responses in 'under-performance': as the number of participants was relatively small (12), this group included the 'unsure' group, explained above. Language used from this point on changed the wording from 'under-performance' to 'opportunities'.

The data was presented back to staff by systematically examining the results for each of the six Standards through in the following ways:

- Strengths identified towards meeting each Standard
- Opportunities for improvement for each Standard.

The weekly sessions that followed via the Action Research model started by focusing on Partnerships Standards that were highlighted in the self-assessments as having the majority of responses in the RED section. There were three Partnerships Standards (PS) with majority of responses in the RED: PS 4, PS 5 and PS 6. These sessions with staff provided time for reflection and clarification around meanings of any wording within the *Guide* and helped to unpack any values and beliefs that may be impacting on the understanding of any elements in a particular Partnership Standard.

While data was analysed by headspace Hobart management and staff and discussed with the project officers at this early stage in the project, a number of suggestions were quickly identified towards implementing change, please see Results and Discussion below.

A second data collection and analysis was conducted in the final weeks of the project's implementation. This enabled a comparison to determine the extent of change in service culture and practice as a result of the Project's activities.

Results obtained through the data was at this point logically grouped into two parts:

- Where the majority of responses showed positive achievement
- Where the majority of responses showed randomness and inconsistency.

This data was presented back to staff in a single page, colour coded format.

3.2 Action Research

Action Research, a method that encourages open and responsive, collaborative and systematic enquiry to help improve practices within a workplace, was introduced after the first data collection. The method requires an exploration of values and how they relate to practice, which fits well with the *Guide's* Standards. Action Research-based triangulation of evidence enabled results from the data to be explored within the context of other sources, including professional knowledge, expertise and experience, the text available within the *Guide* and resources relating to family/friends/carer inclusion, such as publications from MHCTas. This prepared the ground for weekly lunchtime sessions that were conducted throughout the remainder of the project.

The weekly sessions were most successful when the discussions were clear and shared by all and a level of direction from either the Centre Manager or the Clinical Lead was available. From time to time the project officers struggled with maintaining flow, mainly due to the inability of all staff to consistently attend the meetings, however no alternative ways to proceed within the timeframe and resources of the project were identified.

Action Research was a catalyst for the decision to develop six overarching Standards-based policies to embed carer inclusion in headspace Hobart culture and practice.

3.3 Program Logic

The Program Logic method has been utilised throughout this project and it encompasses four main elements. Firstly, the collection of data = initial self-assessment, data evaluation = putting all the responses together into a format suitable for analysis, data analysis = understanding the story to data is portraying and any variables that need to be considered and then data prioritisation for headspace action.

All the weekly sessions and conversations were based on the resources and suggestions given from the *Guide*. The process of triangulation started after the completion of the first self-assessment this gave direction for areas of discussion at the weekly sessions.

Project Officers offered the development of Policies in line with each of the Partnership Standards. During the weekly sessions and with further understanding and triangulation, it was agreed that the development of six policies in line with the *Guide* would support an inclusive process for family/friend/carer engagement at headspace Hobart. The policies were developed from the *Guide* and discussed and scrutinised by staff until an agreement was found regarding the policy wording.

The Project Reference Group was established and similar training was undertaken regarding the *Guide* and the intent to create a shared understanding of its elements.

To understand the data and the rationale of the 'Data Analysis Framework' see table below.

Data Analysis Framework for Self-Assessment (1) n=12

Dominant Positive Achievement (DPA)	*10 responses and above in Positive Achievement*
Partial Achievement & Growing (PA&G)	*10 responses and above in Needs Improvement*
Partial Achievement (PA)	*11 responses in Positive Ach & Needs Improving*
Randomness & Inconsistency (R&I)	*Responses do not fit any other criteria*
Underperforming and Learning (UP&L)	*11 responses in Underperforming & N/A*
Significance Underperforming (SU)	*10 responses and above in Underperforming*

Data Analysis Framework for Self-Assessment (2) n=16

Dominant Positive Achievement (DPA)	*12 responses and above in Positive Achievement*
Partial Achievement & Growing (PA&G)	*12 responses and above in Needs Improvement*
Partial Achievement (PA)	*13 responses in Positive Ach & Needs Improving*
Randomness & Inconsistency (R&I)	*Responses do not fit any other criteria*
Underperforming and Learning (UP&L)	*13 responses in Underperforming & N/A*
Significance Underperforming (SU)	*12 responses and above in Underperforming*

4. Results

The self-assessment data collection was completed twice within this Demonstration Project; once during July/August to obtain a baseline regarding staff's perspectives of their performance against the core elements within each Partnership Standard (PS) and again in Nov/Dec to capture any change in this perspective as a result of a more thorough understanding of the Guide and the implementations.

First round of data obtained in July/August 2017 showed the following results:

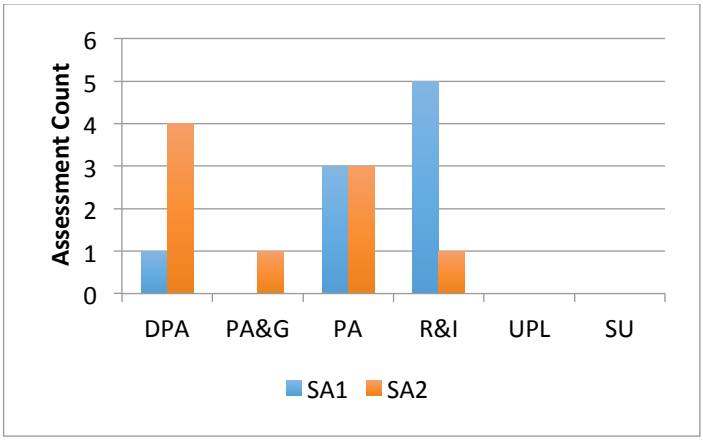
- Majority of responses in Positive Achievement in PS 2 and PS 3.
- Majority of responses in Needs Improvement in PS 1.
- Majority of responses in Under Performance in PS 4, PS 5 and PS 6.

Second round of data obtained in Nov/Dec 2017 showed the following results:

- Majority of responses in Positive Achievement in PS 1, 2, 5 & 6.
- Majority of responses in Needs Improvement PS 3 & 4.

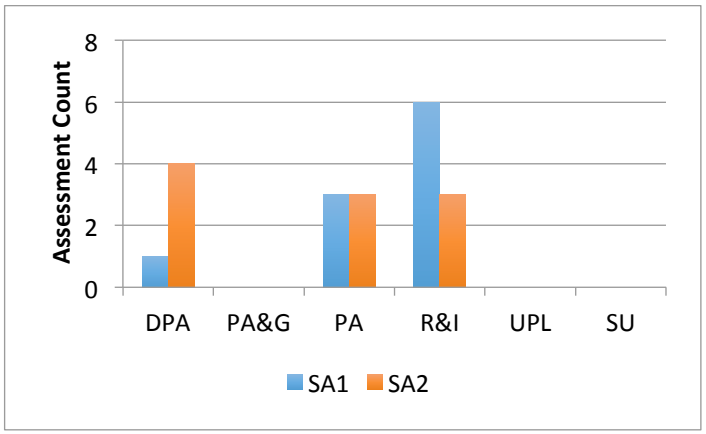
The data above did not give a complete picture of the responses and required further analysis. The *'Data Analysis Framework'* detailed in the 'Methods' section was developed and produced further insights into the raw data. Below are column graphs used to compare the responses from the first and second self-assessment and show change in the specific elements within *The Guide*.

Figure 1 – PS 1 Carers and the essential role they play are identified as first contact, or as soon as possible there after.



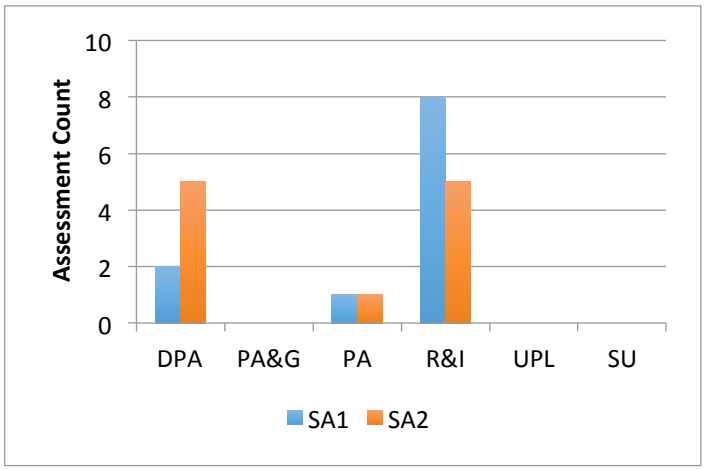
Differences in responses between the first and second self-assessments show a marked increase in positive responses on activities towards meeting the elements of partnership standard 1.

Figure 2 – PS 2 Staff are carer aware and trained in carer engagement strategies.



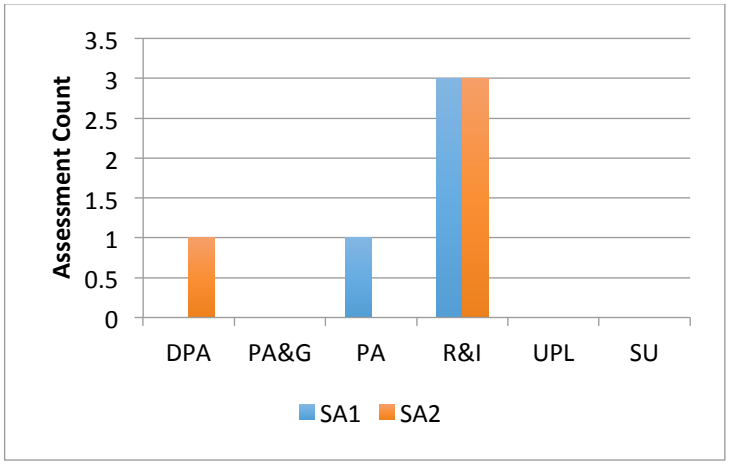
Differences in responses between the first and second self-assessments show a marked decrease in random and inconsistent responses on activities towards meeting the elements of partnership standard 2.

Figure 3 - Policy and practice protocols regarding confidentiality and sharing of information are in place.



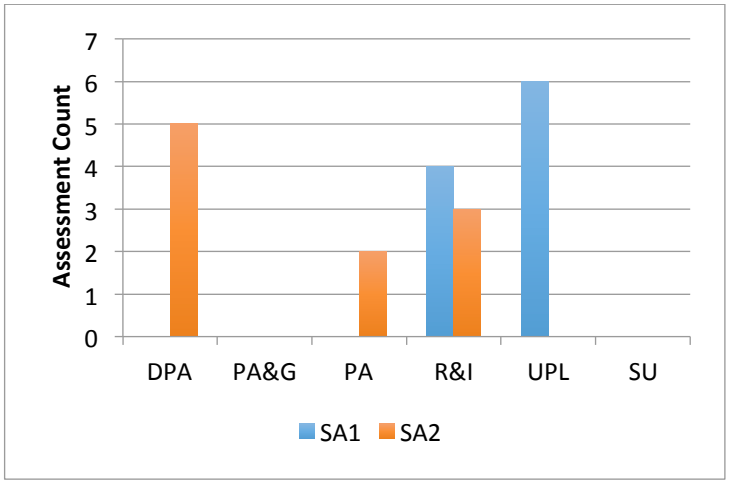
Differences in responses between the first and second self-assessments show a significant movement from random and inconsistent to a positive response on activities towards meeting the elements of partnership standard 3.

Figure 4 - Defined staff positions are allocated for carers in all service settings.



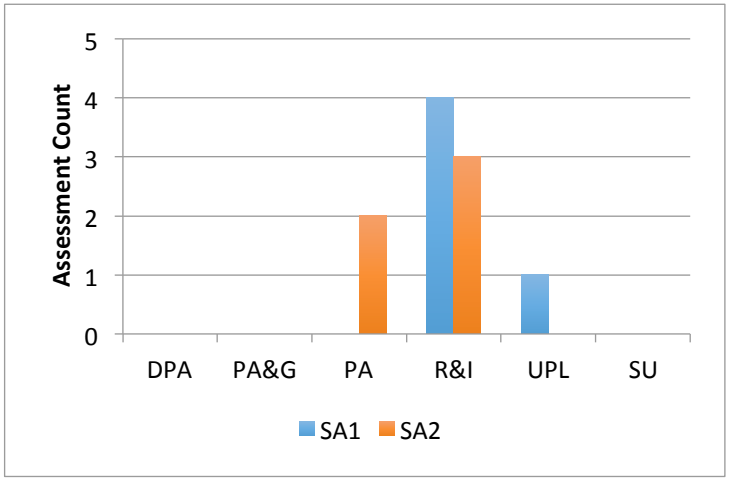
Positive responses increased on one element in this standard, however three elements remain random and inconsistent.

Figure 5 - A carer introduction to the service and staff is available, with a relevant range of information across the care settings.



Differences in results between the self-assessments show consistent improvement in responses towards meeting this standard.

Figure 6 - A range of carer support services is available.



Self-assessments show improvement, however there is still some randomness and inconsistency.

Further insights became evident through using an Action Research method to explore key findings from the data. As stated above, the method culminated in the shared development of six overarching Partnership Standards.

5. Discussion

5.1 General Discussion

This project, the implementation and evaluation of the *Guide*, came about through headspace Hobart, with primary direction from the Centre Manager, identifying a need to partner with MHCTas and investigate:

- Staff self-perception of how successfully headspace Hobart includes family and friends in service design and delivery
- Develop shared understanding of how to address any gaps in including family and friends.

A major factor that contributed to the project's success was that headspace Hobart's management initiated enquiry into how to address gaps in inclusion. This was supported by its lead organisation The Link, its Board of Management and the headspace youth reference group. The manager also proactively sought guidance and assistance from MHCTas.

The two self-assessment activities within the *Guide* gave staff the opportunity to explore in detail headspace Hobart's culture and practice in regard to family and friends inclusiveness. The fact that clients of the service are aged between 12 and 25 provides an additional layer of variables that tested the *Guide's* relevance: as stated by a member of the project's reference group, young people undergo developmental and emotional milestones that are different to adults. These impact on, for example:

- The tension between a young person's developmental need to seek independence
- Confidentiality concerns, particularly when the young person is under age and may not be able to fully process legal and family obligations
- The greater impact of family dynamics
- The potential for increased anxiety among family and friends.

The weekly meetings provided a way for staff to link in with the comprehensive background information, explanatory notes, recommendations and resources within each chapter in the *Guide*. These were invaluable towards informing all activities including:

- Meeting agendas
- Development of resources
- Guiding discussion and direction
- The *Guide* alludes to current rollouts of National standards appraisals in the mental health service arena: although not a primary focus of the project, its significance as a preparatory resource was noted.

Even though the service is relatively small and staff were unable to attend all sessions including both the data collections, the data revealed a mine of useful results, please see attached for more in-depth explanations. Below are some highlights from the data analysis.

5.2 Partnership Standard 1

A marked improvement was evident between the two self-assessments, for instance an increase from one to 13 respondents agreed that 'There is a documented procedure for welcoming carers', as well as increased confidence that carers and their particular circumstances are consistently

identified during assessments. Again, the obtaining and recording of consumer consent to include carers reached a high achievement in the second assessment.

The data reveals that although there is a positive shift in performance perceptions between the two collections, some staff remained unsure in some elements, for instance around carer access to support, and involvement in discharge planning and medication management. Even so, the weekly discussions with staff show the shift from early concerns raised around the risk of harm that could result from providing information to carers, towards that of improved achievement in the majority of the second assessment's elements.

5.3 Partnership Standard 2

The data reveals an overall marked improvement, such as from 'random and inconsistent' to 'dominant positive' in staff awareness that there is a policy that requires working with carers (75% in second self-assessment). This increase could be linked back to the contribution from staff towards the six Policies relating to the Standards, referred to above.

There is improvement in awareness of how a carer's capacity to provide support can change over time, and how this needs to be incorporated into care planning. A slight improvement is also evident in carer inclusion in assessment, ongoing care, and the treatment and recovery of the consumer.

Both assessments confirm some uncertainity around how to develop carer awareness by including carers in training delivery. However, headspace Hobart management has already initiated access to this training by planning future collaborations with MHCTas.

5.4 Partnership Standard 3

By the second self-assessment there was 100% agreement that:

- The consumer's consent to share information
- Staff perception around level of information that could be shared with family/friends/carers was fully achieved (67% and 75% in the first self-assessment). Even so, there was no change to an unsure response in both assessments around the *Guide's* recommendation that carers share information relating to the assessment, treatment and support with staff.

Discussion during the weekly meetings showed a tension between the crucial need to develop and maintain trust between staff and a young person, whose age indicates a critical developmental stage, and the *Guide's* directives to work within changing legislative and other boundaries that support the rights of carers to be recognised as partners in recovery. The *Guide* provided clear advice for exploring and understanding the boundaries. The discussion strongly influenced the structure of the third overarching Policy. Discussion focused on whether carers could be offered confidentiality, and one result of this, for example, was that the administration team realised their communication procedures need to be tightened around disclosures made by carers when they contact reception.

5.5 Partnership Standard 4

The data across both collections shows that staff responded with confidence to responsibility for identifying, working with and supporting carers, moving from 'positive' to 'dominant positive'. Even so, they remained unsure across the remaining three elements of the self-assessment, with the majority of responses random or inconsistent. Discussions during meetings suggest that rather than having negative views around identifying and supporting a carer champion, or employing carer consultants within the organisation, these strategies towards inclusion were new solutions and need further exploration and orientation. A similar response was evident around embedding carer peer roles, either by employing specialised workers or by expanding the role of relevant current workers. An interesting insight was made during one meeting that:

> *'Given the prevalence of mental illness it is pretty well sure that there are already staff here who are also carers of a person with a mental illness'.*

5.6 Partnership Standard 5

The staff self-assessed their performance against Standard 5 as very low in the first assessment, and therefore it became the first focus of discussions with staff. As noted by one participant,

> *'It should be simple to address, it's simply that lots of staff are unaware of what's in place.'*

And again:

> *' It's (a carer introduction to the service) offered, but staff may not be aware of it.'*

The second self-assessment showed a marked improvement, to that of 'dominant positive'. This was a consequence of a number of resources and processes being improved, please see below, with the administration team taking a lead role, collaboratively working through drafts during the lunchtime meetings.

Staff access to cultural awareness training moved forward with some staff undertaking the training soon after the first self-assessment process.

Conversations during meetings also addressed a carer's right to bringing an advocate to meetings should they wish to do so.

5.7 Partnership Standard 6

Positive change was evident in regard to carers accessing local support and advocacy services, shown by shifts from 'random and inconsistent' to 'positive achievement' in data. Again, results improved around carers accessing support from specialist services if required: an increase to 69%, even though the results still register a level of randomness and inconsistency. The weekly meetings revealed staff concerns around funding availability to meet carer support needs, when in fact there is a need to link in with existing community-based carer support services.

Similarly, the data shows a level of randomness around whether carer needs and plans are regularly reviewed. The inconsistency highlights that not all staff feel the same.

Overall, the responses to Standard 6 suggest that some staff are unsure of their responsibilities in offering support to carers and are unaware of parameters around local services already available.

Several improvements resulted from using the Action Research process when investigating the data, as stated above. Indeed, these changes began even before the process, and started to flow immediately after shared analysis of the first data collection. Briefly, they relate to the Standards as below:

5.8 Other Key Observations

- Staff uptake of diversity training
- Changes made to the case review process
- Exploration and discussion towards developing a shared understanding of consent
- A commitment to review current legislation relating to consent
- Introduction of a Welcome Pack
- Systematic use of a localised headspace '*How we can help'* resource
- Production of a Welcome Letter
- Review of first point of contact reception procedures
- Planned regular open day events

The above two sets of results show some inconsistencies between the two. For example, the Action Research method achieved a willingness to explore confidentiality, however confidentiality achieved a random and inconsistent result in the second data collection. This is most likely due to the inability of staff to attend all meetings. It may also be influenced by the fact that the current funding model includes very limited direct funds for carer inclusion and support through family conferencing. It is also possibly because the data collection model within the *Guide* was unable to support the depth of analysis required to refine results.

As stated above, the Action Research-driven method culminated in staff and project officers working together to develop six headspace-Hobart-specific overarching policies that directly relate to the Standards, please see attached.

6. Conclusion

There is clear evidence that application of the *Guide* resulted in overall positive outcomes across all six Standards within in a mental health service for young people with mild to moderate mental ill health. The self-assessments for data collection and analysis, combined with an action research methodology, provided insight into key themes for future exploration:

- Staff training
- Carer roles within the organisation
- Carer rights and responsibilities
- Confidentiality

It successfully captured staff self perceptions regarding inclusiveness of family/friends/carers within its service model as it relates to organisational culture and practice.

The design of the *Guide* enabled the project to capture specific information across a broad range of elements. The explanatory text relating to each Standard enabled informed, unprejudiced collaboration, which culminated in the development of six overarching policies to support the Standards within the *Guide.* At all times the final content of these policies was directed by participating staff. These policies support and strengthen existing policies within the organisation.

It also directly contributed to the organisation's strategic planning as it relates to family/friends/carer inclusion. It has also strengthened pathways for more specific future collaborations with other organisations that directly relate to family/friends/carer support.

7. Recommendations

7.1 The Guide

The *Guide* was successful in provided a lens in which an organisation could benchmark their practice around the needs of family/friends/carers. It is recommended that the *Guide* be considered for dissemination throughout the national mental health sector.

The *Guide* supports the current service provision environment that is shaped with a move towards national standards of practice. It is well placed to provide organisations with a tool to capture awareness and inclusiveness of family/friends/carers within their culture and practice. Given its relevance to standard based practice it is recommended as a preparatory tool for this purpose across the sector.

A future consideration for further development of the *Guide* would be to strengthen the self-assessment tool by elaborating on ways in which an organisation can seek carer feedback and service evaluation processes.

7.2 Organisational

1. The Board of Management maintains a focus on family/friends/carer inclusion, in particular through it's strategic planning processes. This could include maintaining awareness of any legislative changes that directly relates to the area of governance.
2. Develop an organisational strategy for recruitment, selection and orientation that includes family/friends/carer awareness.
3. Expand the operational strategy to continually consider the family/friend/carer lens, for example as a standing agenda item for meetings, staff training and performance reviews.

7.3 Systemic

- headspace Hobart advocate for funding for a staff contact point for Family/Friends/Carers.
- Advocate for family/friends/carer inclusion in mental health service models.

8. Bibliography

8.1 Resources headspace Specific

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Summary of Online Survey and Face to Face Feedback On Our Questions of 'How Can MHCTAS Improve Its Communication and Engagement with Carers Across the State', June 2017.

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MacDonald, C. (2012). Understanding Participatory Action Research: A Qualitative Research Methodology Option. Canadian Journal of Action Research, Volume 13, Issue 2, 2012, pp. 34-50.

National Statement on Ethical Conduct in Human Research, 2007 (updated May 2015), Section 3: Ethical Considerations Specific to Research Methods of Fields.

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9. Appendix

9.1 First Stage Self – Assessment Responses

Responses from First Self-assessment

Criteria	Unsure N/A	Red	Orange	Green	Total Responses	STRENGTH (7UP) / OPPORTUNITY	DOMINANT / UNDERPERFORMING
Partnership Standard 1: Carers and the essential role they play are identified at first contact, or as soon as possible thereafter							**Partnership Standard 1**
Carers are routinely identified when carrying out an assessment	1	1	3	7		**STRENGTH**	Partial Achievement
Special circumstances of the carers are recorded, for example: -parent of young family -single parent -caring for parents -young carer -carer with mental illness -friend -partner -relative		1	4	7	12	**STRENGTH**	Partial Achievement
Carers views and knowledge are sought throughout the assessment and ongoing support process	1	1	9	1	12	**STRENGTH**	Partial Achievement
Consent of consumer is routinely obtained and recorded re: carers involvement	1		1	10	12	**STRENGTH**	Dominant Postive Achievement
Carers are regularly updated and involved re: care plans	2	3	6	1	12	**STRENGTH**	Randomness & Inconsistency
Strategies for medication management are explained to the carers	6	2	4		12	**OPPORTUNITY**	Randomness & Inconsistency
Carers have access to advice re: advocacy, rights, information and support	3	4	2	3	12	**OPPORTUNITY**	Randomness & Inconsistency
There is a documented procedure for welcoming carers	4	2	3	3	12	**OPPORTUNITY**	Randomness & Inconsistency
Carers are involved in the discharge process	6	2	3	1	12	**OPPORTUNITY**	Randomness & Inconsistency
	24	16	35	33	108		
Partnership Standard 2: Staff are carer aware and trained in carer engagement strategies					0		**Partnership Standard 2**
Your organisation has a policy that requires you to work with carers	3		7	2	12	**STRENGTH**	Randomness & Inconsistency
All staff have received carer awareness training	3	5	2	2	12	**OPPORTUNITY**	Randomness & Inconsistency
The training includes: -awareness of carer needs -carer expectations re: 1. assessment, care and support 2. dealing with carer queries and concerns 3. advising on sources of help 4. advising on treaments, strategies and medication management 5. how to involve and engage with carers and consumers	3	6	3		12	**OPPORTUNITY**	Randomness & Inconsistency
Training is delivered by carer trainers or carers as part of the training delivery team	4	5	2	1	12	**OPPORTUNITY**	Randomness & Inconsistency
Opportunities are offered to carers to participate in all aspects of assessment and the ongoing care, treatment and recovery of the consumer	2	3	4	3	12	**STRENGTH**	Randomness & Inconsistency
The level of support carers are able, or need, to provide is taken into account in the ongoing planning for the consumer	1	1	4	6	12	**STRENGTH**	Partial Achievement
Information is provided to carers regarding services and strategies available if a crisis occurs or the consumer becomes unwell	3	1	3	5	12	**STRENGTH**	Partial Achievement
You work in a way that supports relationships within families	1	1	4	6	12	**STRENGTH**	Partial Achievement
Carers are provided with opportunities to enhance their abilities in the caring role	4	2	3	3	12	**OPPORTUNITY**	Randomness & Inconsistency
You convey hope for recovery when working with carers	1		2	9	12	**STRENGTH**	Dominant Postive Achievement
	25	24	34	37	120		
Partnership Standard 3: Policy and practice protocols regarding confidentiality and sharing of information are in place.					0		**Partnership Standard 3**
Consumer consent to share information with the carer is sought	2		2	8	12	**STRENGTH**	Partial Achievement
Agreement is reached with consumer about the level of information to be shared with the carer	2		1	9	12	**STRENGTH**	Dominant Postive Achievement
If the consumer requests no disclosure, staff regularly revisit this decision with them	2	2	5	3	12	**STRENGTH**	Randomness & Inconsistency
Opportunities are provided to carers to discuss the care, treatment, recovery and support of the consumer (even if, for reasons of confidentiality, you cannot provide specific personal information)	3	2	5	2	12	**STRENGTH**	Randomness & Inconsistency
Carers are encouraged to share information re: consumer to inform assessment, treatment and support	3	2	3	4	12	**STRENGTH**	Randomness & Inconsistency
Carer notes and letters are kept in a separate section of the consumers' case notes/on IT systems	6	3		3	12	**OPPORTUNITY**	Randomness & Inconsistency
Wellness Plans/Advance Directives are routinely used	5	4	2	1	12	**OPPORTUNITY**	Randomness & Inconsistency
A Recovery Plan is in place	5	1	3	3	12	**OPPORTUNITY**	Randomness & Inconsistency
Practice guidelines re: information sharing with carers are in place	4		1	7	12	**STRENGTH**	Randomness & Inconsistency
A policy is in place to support practice re: confidentiality	1		1	10	12	**STRENGTH**	Dominant Postive Achievement
Staff training is available and includes carer best practice for information sharing and confidentiality	3	3	3	3	12	**OPPORTUNITY**	Randomness & Inconsistency
	36	17	26	53	132		
Partnership Standard 4: Defined staff positions are allocated for carers in all service settings					0		**Partnership Standard 4**
A carer champion is identified within the service, or there are carer consultants employed	3	6	2	1	12	**OPPORTUNITY**	Randomness & Inconsistency
All staff are responsible for identifying, involving and supporting carers	2		4	6	12	**STRENGTH**	Partial Achievement
A network is in place to support carer champions, carer consultants and carer peers	4	5	1	2	12	**OPPORTUNITY**	Randomness & Inconsistency
Carer peer roles are in place	4	5	2	1	12	**OPPORTUNITY**	Randomness & Inconsistency
	13	16	9	10	48		
Partnership Standard 5: A carer introduction to the service and staff is available, with a relevant range of information across the care settings.					0		**Partnership Standard 5**
Upon first contact, across all service settings, provide the carer with: -an introductory letter that explains the service and points of contact (for example, CMO staff names and contact numbers) -carer rights and responsibilities information -the partnership policy of the service -information regarding carer support services (for example, local groups, carer champions, carer consultants, carer peer workers) -a number to call for after-hours service	4	6	1	1	12	**OPPORTUNITY**	Underperformance & Learning
Offer an early appointment to the carer to hear their story/history and to address their concerns	3	7	1	1	12	**OPPORTUNITY**	Underperformance & Learning
Ensure that the service has meeting and greeting protocols in place to minimise carer distress and address any concerns they may have	3	2	5	2	12	**STRENGTH**	Randomness & Inconsistency
Discuss with the carer whether they wish to bring a support person with them to meetings	3	4	4	1	12	**OPPORTUNITY**	Randomness & Inconsistency
Provide locally developed carer information packs to new carers at first meeting	3	8		1	12	**OPPORTUNITY**	Underperformance & Learning
Ensure that the cultural and language needs of carers have been addressed during the preparation of this pack	4	6	1	1	12	**OPPORTUNITY**	Underperformance & Learning
Ensure that the format of the information pack is flexible and regularly updated	4	6	1	1	12	**OPPORTUNITY**	Underperformance & Learning
Make a member of staff responsible for developing, storing and issuing the packs	4	6	1	1	12	**OPPORTUNITY**	Underperformance & Learning
Ensure that the carer is involved in discharge planning and is clear about what to do and who to contact in the organisation in a crisis	3	4	2	3	12	**OPPORTUNITY**	Randomness & Inconsistency
Ensure that the carer is asked for feedback regarding the service provided as part of quality improvement activities	4	4	3	1	12	**OPPORTUNITY**	Randomness & Inconsistency
	35	53	19	13	120		
Partnership Standard 6: A range of carer support services is available.					0	**Partnership Standard 6**	
A carer support service is in place locally	4	1	3	4	12	**STRENGTH**	Randomness & Inconsistency
Carers have access to local carer advocacy services	3	2	3	4	12	**STRENGTH**	Randomness & Inconsistency
Carers have access to a range of support services if required	3	2	4	3	12	**STRENGTH**	Randomness & Inconsistency
Carers' needs and plans are regularly re-assessed	2	8	1	1	12	**OPPORTUNITY**	Underperformance & Learning
More specialised services such as family therapy are offered to carers and family if required	1	6	2	3	12	**OPPORTUNITY**	Randomness & Inconsistency
	13	19	13	15	60		

9.2 Second Stage Self – Assessment Responses

Responses from Second Self-Assessment

CRITERIA	UNSURE	RED	ORANGE	GREEN	TOTAL RESPONSES	STRENGTH (7UP) / OPPORTUNITY (BELOW 7)	DOMINANT / UNDERPERFORMING	PRIORITY
Partnership Standard 1: Carers and the essential role they play are identified at first contact, or as soon as possible thereafter							**Partnership Standard 1**	
Carers are routinely identified when carrying out an assessment	1		1	14	16	STRENGTH	Dominant Positive Achievement	6
Special circumstances of the carers are recorded, for example: -parent of young family -single parent -caring for parents -young carer -carer with mental illness -friend -partner -relative		1	3	12	16	STRENGTH	Dominant Positive Achievement	6
Carers views and knowledge are sought throughout the assessment and ongoing support process	1	1	9	5	16	STRENGTH	Partial Achievement	4
Consent of consumer is routinely obtained and recorded re: carers involvement	1		3	12	16	STRENGTH	Dominant Positive Achievement	6
Carers are regularly updated and involved re: care plans	1	1	10	4	16	STRENGTH	Partial Achievement & Growing	5
Strategies for medication management are explained to the carers	5	1	6	4	16	STRENGTH	Randomness & Inconsistency	3
Carers have access to advice re: advocacy, rights, information and support	2	1	5	8	16	STRENGTH	Partial Achievement	4
There is a documented procedure for welcoming carers	1	1	1	13	16	STRENGTH	Dominant Positive Achievement	6
Carers are involved in the discharge process	3		8	5	16	STRENGTH	Partial Achievement	4
	15	6	46	77				
Partnership Standard 2: Staff are carer aware and trained in carer engagement strategies							**Partnership Standard 2**	
Your organisation has a policy that requires you to work with carers		3	1	12	16	STRENGTH	Dominant Positive Achievement	6
All staff have received carer awareness training	2	3	6	5	16	STRENGTH	Randomness & Inconsistency	3
The training includes: -awareness of carer needs -carer expectations re: 1. assessment, care and support 2. dealing with carer queries and concerns 3. advising on sources of help 4. advising on treaments, strategies and medication management 5. how to involve and engage with carers and consumers	5	1	6	4	16	STRENGTH	Randomness & Inconsistency	3
Training is delivered by carer trainers or carers as part of the training delivery team	6	3	5	2	16	STRENGTH	Randomness & Inconsistency	3
Opportunities are offered to carers to participate in all aspects of assessment and the ongoing care, treatment and recovery of the consumer	1	1	10	4	16	STRENGTH	Partial Achievement	5
The level of support carers are able, or need, to provide is taken into account in the ongoing planning for the consumer	1	2	5	8	16	STRENGTH	Partial Achievement	4
Information is provided to carers regarding services and strategies available if a crisis occurs or the consumer becomes unwell	2		2	12	16	STRENGTH	Dominant Positive Achievement	6
You work in a way that supports relationships within families			3	13	16	STRENGTH	Dominant Positive Achievement	6
Carers are provided with opportunities to enhance their abilities in the caring role	2		8	6	16	STRENGTH	Partial Achievement	4
You convey hope for recovery when working with carers	1		2	13	16	STRENGTH	Dominant Positive Achievement	6
	20	13	48	79				
Partnership Standard 3: Policy and practice protocols regarding confidentiality and sharing of information are in place.							**Partnership Standard 3**	
Consumer consent to share information with the carer is sought				16	16	STRENGTH	Dominant Positive Achievement	6
Agreement is reached with consumer about the level of information to be shared with the carer				16	16	STRENGTH	Dominant Positive Achievement	6
If the consumer requests no disclosure, staff regularly revisit this decision with them			3	13	16	STRENGTH	Dominant Positive Achievement	6
Opportunities are provided to carers to discuss the care, treatment, recovery and support of the consumer (even if, for reasons of confidentiality, you cannot provide specific personal information)	1		6	9	16	STRENGTH	Partial Achievement	4
Carers are encouraged to share information re: consumer to inform assessment, treatment and support	5		2	9	16	STRENGTH	Randomness & Inconsistency	3
Carer notes and letters are kept in a separate section of the consumers' case notes/on IT systems	5	2	5	4	16	STRENGTH	Randomness & Inconsistency	3
Wellness Plans/Advance Directives are routinely used	3	4	5	4	16	STRENGTH	Randomness & Inconsistency	3
A Recovery Plan is in place	4	5	5	2	16	OPPORTUNITY	Randomness & Inconsistency	3
Practice guidelines re: information sharing with carers are in place	1		2	13	16	STRENGTH	Dominant Positive Achievement	6
A policy is in place to support practice re: confidentiality			1	15	16	STRENGTH	Dominant Positive Achievement	6
Staff training is available and includes carer best practice for information sharing and confidentiality	4	1	6	5	16	STRENGTH	Randomness & Inconsistency	3
	23	12	35	106				
Partnership Standard 4: Defined staff positions are allocated for carers in all service settings.							**Partnership Standard 4**	
A carer champion is identified within the service, or there are carer consultants employed	4	4	3	5	16	STRENGTH	Randomness & Inconsistency	3
All staff are responsible for identifying, involving and supporting carers	1		3	12	16	STRENGTH	Dominant Positive Achievement	6
A network is in place to support carer champions, carer consultants and carer peers	5	1	7	3	16	STRENGTH	Randomness & Inconsistency	3
Carer peer roles are in place	5	6	2	3	16	OPPORTUNITY	Randomness & Inconsistency	3
	15	11	15	23				
Partnership Standard 5: A carer introduction to the service and staff is available, with a relevant range of information across the care settings.							**Partnership Standard 5**	
Upon first contact, across all service settings, provide the carer with: -an introductory letter that explains the service and points of contact (for example, CMO staff names and contact numbers) -carer rights and responsibilities information -the partnership policy of the service -information regarding carer support services (for example, local groups, carer champions, carer consultants, carer peer workers) -a number to call for after-hours service	2		3	11	16	STRENGTH	Dominant Positive Achievement	6
Offer an early appointment to the carer to hear their story/history and to address their concerns	1	2	10	3	16	STRENGTH	Partial Achievement	4
Ensure that the service has meeting and greeting protocols in place to minimise carer distress and address any concerns they may have		1	2	13	16	STRENGTH	Dominant Positive Achievement	6
Discuss with the carer whether they wish to bring a support person with them to meetings	2	4	3	7	16	STRENGTH	Randomness & Inconsistency	3
Provide locally developed carer information packs to new carers at first meeting	1	1	2	12	16	STRENGTH	Dominant Positive Achievement	6
Ensure that the cultural and language needs of carers have been addressed during the preparation of this pack	2	3	7	4	16	STRENGTH	Randomness & Inconsistency	3
Ensure that the format of the information pack is flexible and regularly updated	2	1	2	11	16	STRENGTH	Dominant Positive Achievement	6
Make a member of staff responsible for developing, storing and issuing the packs	1	1	2	12	16	STRENGTH	Dominant Positive Achievement	6
Ensure that the carer is involved in discharge planning and is clear about what to do and who to contact in the organisation in a crisis	2	1	5	8	16	STRENGTH	Partial Achievement	4
Ensure that the carer is asked for feedback regarding the service provided as part of quality improvement activities	3	2	6	5	16	STRENGTH	Randomness & Inconsistency	4
	16	16	42	86				
Partnership Standard 6: A range of carer support services is available.							**Partnership Standard 6**	
A carer support service is in place locally.	2	2	2	10	16	STRENGTH	Partial Achievement	6
Carers have access to local carer advocacy services.	2	2	2	10	16	STRENGTH	Partial Achievement	6
Carers have access to a range of support services if required.	1	3	1	11	16	STRENGTH	Randomness & Inconsistency	6
Carers needs and plans are regularly re-assessed.	1	6	6	3	16	STRENGTH	Randomness & Inconsistency	3
More specialised services such as family therapy are offered to carers and family if required.	1	4	3	8	16	STRENGTH	Randomness & Inconsistency	4
		17	14	42				

	Responses
Please tick this box if you completed the first self-assessment in July 2017.	11
Please tick this box if you been involved in any of the weekly sessions.	11
Please tick this box if you are salaried staff member of headspace.	13