

Standard 3.

Consumer and carer participation

Consumers and carers are actively involved in the development, planning, delivery and evaluation of services.

GUIDELINES

The intent of this Standard is to ensure that where appropriate and relevant in private office based mental health practices (MHS) there is an ongoing consultation with consumers, carers and others in its community regarding the planning, delivery, development, monitoring and evaluation of services.

Participation (Criteria 3.1, 3.2)

The MHS should use methods that suit an individual practice when engaging with and supporting consumers and carers in all areas of service planning, delivery, evaluation and quality assurance activities.

The consumer and carer participation needs to reflect the cultural and social diversity within which the MHS operates.

Examples of appropriate methods include:

- consumer and carer representation on service planning, delivery, evaluation and quality assurance committees
- use of consumer and carer feedback
- the terms of reference for the consumer and carer groups, and service planning, delivery, evaluation and quality assurance committees reflect the need for formal links and integration between them.

Support and training (Criterion 3.3)

Consumers and carers who are involved with the MHS must have access to training and support.

Advocacy (Criteria 3.4, 3.5)

Information on how to access advocacy services should be provided for example in the rights and responsibilities document and may include:

- a list of organisations such as Mental Health Carers ARAFMI Australia
- (information available at: ↗ <http://www.arafmiaustralia.asn.au>) and Children of Parents with a Mental Illness (COPMI) (information available at: ↗ <http://www.copmi.net.au>)
- other identified organisations in the state or territory, such as the Commonwealth Carer Resource Centre on 1800 242 636 (free call).

It is essential that consumer and carer advocates are provided with culturally appropriate information and support.

The MHS must explore alternative ways to ensure culturally appropriate advocacy. For example, it may be preferable to conduct periodic workshop sessions with a group of consumers or carers from different ethnic groups or from a particular remote community so a more representative and accurate 'voice' is heard.

Employment of consumers and carers (Criterion 3.6)

Consumers and carers can be employed in an MHS in these ways:

- as consumer/carer consultants on projects
- as peer workers
- in consumer/carer liaison with agencies
- in research.

Employed consumers and carers should be well informed about what processes are in place to protect, advise and support them. When consumers and carers are employed, the MHS should ensure they are mentored and supervised and have access to any training and support they may need.

Documentation of participation (Criterion 3.7)

Documentation of consumer and carer participation in the MHS should contain policies and procedures on:

- the process for choosing consumers, carers and other representatives
- payment (either direct or 'in kind') and reimbursement for expenses, in accordance with the preference of the consumer or carer
- how to identify the equipment, space and budget needed
- determining whether consumers or carers want collective or separate representation
- consultation with representatives from the MHS community as required.

SUGGESTED EVIDENCE

Evidence that may be provided for this standard includes:

- evidence of service participation activities such as planning decisions, meeting minutes, payment and expense reimbursement
- evidence on demographics of consumers and carer participation, which must include age, gender and ethnicity
- policies and procedures:
 - consumer and carer participation including training and support
 - advocacy including training and support, mentoring and supervision
 - representation on committees
 - terms of reference for consumer and carer committees
 - position descriptions for consumer and carer consultants.