oxygen

WE'RE IN THIS TOGETHER

FAMILY INCLUSIVE PRACTICE IN MENTAL HEALTH SERVICES FOR YOUNG PEOPLE

ABBREVIATIONS

AMHS	Adult Mental Health Services
ATAPS	Access to Allied Psychological Services
CYMHS	Child and Youth Mental Health Services
FPSW	Family peer support worker
GP	General Practitioner
hYEPP	headspace Youth Early Psychosis Program
MBS	Medicare Benefit Schedule
SSFC	Single Session Family Consultations

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EXECUTIVE SUMMARY

Implementing family inclusive practice in mental health services will improve the experience and outcomes for most young people. Recognition of the supportive role family can play in improving a young person's mental health has made family inclusive practice a focus of mental health strategies, practice and service guidelines and research. The *Fifth National Mental Health and Suicide Prevention Plan* emphasises the centrality of young people and their families in how services are planned, delivered and implemented. Implementation, however, has been slow. The Productivity Commission's draft report identified a need for more family-focused services. Transforming mental health services for young people to be more family inclusive requires system wide adoption of a new way of operating, that is informed by young people and families.

The requirements of family inclusive practice for young people and their families will differ. The level of illness, prior experience with a service and the service context, will all shape how family inclusive practice is delivered. While clinicians need to negotiate family inclusion with a young person, they should begin from the position that young people are generally open to family inclusion. The expectations of a family and their own need for support is also an important consideration in the delivery of family inclusive practice. Family inclusive practice needs to recognise that family does not simply mean parents but can include siblings, partners and other support people.

Service models, dedicated roles, and new approaches to family inclusive practice are available. These include:

- Single Session Family Consultations in which families are included to determine how they will be involved in a young person's care and to help family members identify and address their own needs.
- Family peer support workers whose role it is to support the family of a young person receiving mental health care.
- Online platforms which can provide information, psychoeducation, moderated online social therapy and support.

Implementation of family inclusive practice will require changes for many services and clinicians. What this change looks like and requires will differ between services, clinicians and across service contexts (i.e. a community youth mental health service compared with general practice). Successful implementation requires visible leadership and a commitment from clinicians and other staff to change how they work with families. Achieving the transformation to a family inclusive practice requires; collaboration (including with young people and families), more inclusive clinical practice, resourcing for system reforms, practice changes and incorporation of new roles.

There is an existing evidence-base for family inclusive practice service models and dedicated roles, including guidelines for making the change or designing a family inclusive practice. Governments too have recognised the importance of family inclusion in mental health service strategies. The main barrier to the transformation to family inclusive practice is a lack of specific, ongoing funding. Funding the transition to family inclusive practice and the provision of dedicated family peer support workers are the priority policy opportunities identified in this policy paper.

SOLUTION	MECHANISM
Funded transition to family inclusive practice There is instructive evidence for preparing an organisation, the role of management and workforce transition to family inclusive practice. The design, evaluation and implementation of family inclusive practice should be undertaken in collaboration with young people and families. Dedicated funding is required for transitioning to family inclusive practice. Transition funding should be: • linked to management performance • require structured and evaluated collaboration with young people and families • provide training and accreditation for clinical staff. Staged scaling up of a funding program for transition to family inclusive practice should include a continuous evaluation of transition strategies, collaboration with young people and families, workforce accreditation and service outcomes.	Council of Australian Governments Health Council

SOLUTION	MECHANISM
Funding for family peer support workers Resourcing is the primary barrier to implementing evidence-based family peer support worker roles in mental health services for young people. A three year incentive program to increase the family peer support workforce similar to the Mental Health Nurses Incentive Programme is warranted. Dedicated funding is required to ensure family peer support workers are located in primary health and specialist mental health services based on service need. Allocation of funding must be undertaken openly, transparently and in collaboration with local services.	Commonwealth Department of Health

INTRODUCTION

Family inclusive practice in mental health services will improve the experience and outcomes for most young people. Families can be the reason many young people seek help, yet they are often left out of the process once a young person accesses a service. The *Fifth National Mental Health and Suicide Prevention Plan* 'demands that consumers and carers' – young people and their families – 'are central to the way in which services are planned, delivered and implemented."[1] Transforming mental health services for young people to be family inclusive requires system wide reforms in operation and practice. This policy paper considers the perspectives of young people and families, service changes and workforce development, available models and dedicated roles, and the requirement for specific funding to achieve transformation.

Policy opportunities to remove barriers and enable the implementation of family inclusive practice in support of a young person's improved mental health are identified.

Recognition of the supportive role family can play in improving a young person's mental health has made family inclusive practice a focus of mental health strategies, service and practice guidelines, and research. Despite this emphasis, family inclusive practice remains low in mental health services for young people.[3] Engagement with a family also allows a service to provide a range of support for family members. This support can include psychoeducation, resources, psychological support, debriefing, collaborative case planning and family work. Changing from an individual based approach to one that also genuinely appreciates and works to engage with a young person's family is a fundamental reform.

Family inclusive practice is an approach to service design and treatment delivery that empowers a young person's family to take an active role in supporting a young person. Family inclusive practice begins from point of contact, intake, assessment, and through to service provision. Inclusion is an ongoing, dynamic process in which a therapeutic relationship is built.[4] The inclusion of family should be seen as part of the standard service a young person receives.

A FAMILY IS ...

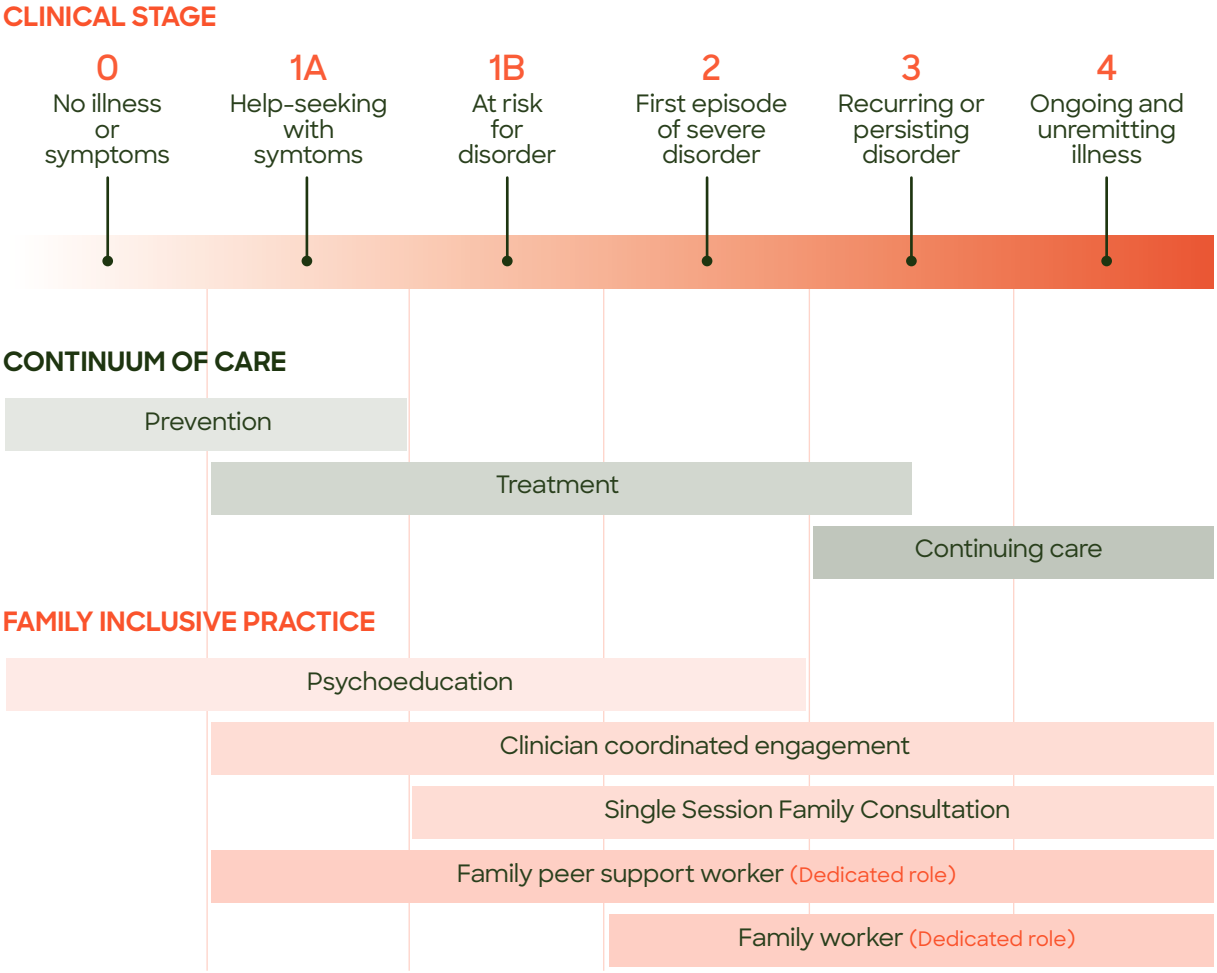
All families are different. A young person may live with: one or two parents (possibly including a step-parent or same sex parents or couples) or other members of their extended family, in out-of-home care, with a partner or in a share house. A young person will have their own family relationships that they deem important in their lives. These people may be: partners, parents, foster parents, grandparents, god-parents, adoptive parents, or siblings.[2] The term family is used throughout this policy paper with recognition of the diversity this represents.

The service context and stage of ill-health a young person is experiencing will inform how family engagement can be facilitated. Family inclusive practice in a primary health setting where a young person presents with mild or moderate symptoms will differ to the approach required when severe symptoms manifest or a young person is involuntarily hospitalised.

The experiences of families, including siblings and partners, in supporting a young person, needs to be considered within family inclusive practice and by clinicians at every stage of care.

To ensure that changes to improve family inclusive practice are on target, young people and families must be collaborators in the design, implementation and evaluation of family inclusive practice. What to consider and how to do this will be discussed in the following sections.

OPPORTUNITIES TO ENGAGE FAMILIES ARE AVAILABLE AT EVERY STAGE OF CARE



ENGAGING FAMILIES TO SUPPORT YOUNG PEOPLE

Young people undergo a major period of social and emotional development between the ages of 12 and 25 years. This period includes a process of individuation in which young people usually transition from identifying as part of a family to identifying primarily as an individual. The absence of a defined role after secondary school and into a young person's mid-twenties (identified as emergent adulthood) leaves young people free to explore their sense of identity.[5] During this process, young people typically become increasingly independent and less reliant upon their parents and other family members for emotional, social and economic support. While for some this transition may be a positive in their development of self and overall wellbeing, for others a lack of direction or support might be destabilising and may contribute to poorer mental health.

A young person's social and emotional development will influence how they see the role of family in their mental health care. This influence needs to be considered in the development of policies to implement family inclusive practice. For most young people their family will be a primary source of support. A family's experience of a mental health service may shape how they feel able to provide support. Frustration experienced by both clinicians and families in relation to communication and integration underlines the potential challenges of developing and implementing family inclusive practice. Research with parent caregivers and clinicians in Australia and the United States indicates that parents often experience a lack of support and at times feel ignored. Whereas, clinicians reported a perceived unwillingness from some families to participate but recognised that each case was different.[6, 7] To address this apparent contradiction a co-design project involving families and clinicians to explore their respective experiences is required to inform family inclusive practice.

The approach by a clinician to include family will differ if a family has had previous experience of mental health services or if it is their first time accessing a service. Similarly, the experience of a family of a young person receiving an early intervention will likely differ to that of families of a young person experiencing an enduring illness. For example, the experiences of supporting a 12-15 year old with a mild illness or emerging disorder will differ from a 20-24 year old who may have had an ongoing disorder or reoccurring symptoms for 10 years and who may also be in an Adult Mental Health Service with a family member in an established 'carer' role. Implementation of family inclusive practice needs to reflect these different contexts and experiences.

Orygen conducted an online survey of family members to understand their experiences of involvement in mental health services for young people.

OPENNESS TO FAMILY INCLUSIVE PRACTICE

For most young people including their family will support improved mental health outcomes. The level of family support a young person can access has been found to be a positive determinant of access to mental health services.[8] In many cases, young people are open to their family being included. A majority of young people accessing mental health services identified the value of family support[9] and reported being interested in family-centred care, open to their parents' involvement and to discussing their concerns.[6] Clinicians need to start from the assumption that young people are open to family inclusive practice.

For some young people, however, there may be resistance to including their family or limits on how they want them to be involved. A young person's willingness to involve their family can be shaped by a number of factors. These factors include a desire for privacy, concerns about how their family (or friends) will react (stigma), not wanting to burden them and conflict or misunderstanding within family relationships.[3]

The implementation of family inclusive practice supports young people to consider how including their family may be beneficial to their treatment and health outcomes. Respectfully negotiating partial consent to family involvement with a young person expressing reluctance can open the way to greater family engagement.[10] Respecting a young person's privacy and wishes needs to be balanced with the potential benefits of family support. Wherever possible, a clinician needs to facilitate a role for family as part of a young person's treatment.

CONFIDENTIALITY

Confidentiality provides an example of how family inclusive practice can enable engagement compared with existing approaches to service provision. A young person's privacy and confidentiality is often cited as a barrier to family inclusion and a key factor in family dissatisfaction with services.[11, 12] Legislation can also determine the amount or type of information a clinician can share with a family. Families report feeling particularly distressed when confidentiality is cited as the reason for not sharing information.[13] There may also be appropriate justification for not sharing information with a family. In instances where confidentiality poses a challenge to the practical implementation of family inclusive practice, agreeing on what can and cannot be shared with family is often a good starting place. A young person's initial concerns about confidentiality may also change over time and should be re-visited as part of an ongoing dialogue with a young person.

Understanding a young person's concerns will help a clinician identify potential avenues for family inclusion. The headspace *Family and friends inclusive practice handbook* highlights the possible complexity of negotiating confidentiality. The handbook states that fears around breaching confidentiality should not prevent staff from encouraging the involvement of family and friends where appropriate. A balance between young people's need to privacy and for support (and in some cases protection) from their family has to be considered.[3] The potential support a family can provide a young person and the general openness of young people to including them requires that a clinician starts with this expectation.

THE AGE OF A YOUNG PERSON

The age of a young person can be a determining factor in the sharing of information with their family. Young people aged 14 years are required to give consent for their parents to access their Medicare records and at 15 years of age a young person can apply for their own Medicare card. A young person is considered a mature minor and able to give informed consent if they have sufficient understanding and intelligence to enable full understanding of a proposed medical procedure. It is generally accepted that most young people aged over 16 years are capable of giving their own informed consent to medical treatment.[14] At 18 years of age a young person is considered an adult and in many cases any existing communication with family will likely change or may cease all together.

Legislation relating to communication with families differs between jurisdictions. Legislation can include that families, to the greatest extent practicable, are involved in decisions about treatment and care and that decisions are made in consultation with a young person and their family. Legislation can also permit the disclosure of information under specific circumstances. Potential influences on how legislation is applied can include: how it is interpreted, the culture and practice within a service and among clinicians, and workforce movement between jurisdictions.

Legislation can permit a young person undergoing mental health treatment to nominate a person (a Nominated Person) to be legally involved in their care.[15] For example: practice guidelines for engaging families in adult[A] mental health services from Western Australia outlines the special rights that nomination assigns to a Nominated Person.[16] For many young people a parent will likely fulfil the role of a Nominated Person if required.

A It is noted that the guidelines may be applicable to other programs and age groups subject to amendments and/or addenda.

SOLUTION	MECHANISM
Aligning legislation The alignment of legislation relating to mental health services, treatment and records between jurisdictions would ensure consistent application by clinicians moving between jurisdictions. This process would permit a review of legislation to identify barriers to family inclusive practice and necessary reforms to address issues and challenges across the youth age range (12-24 years).	Council of Australian Governments

NEGOTIATING A ROLE FOR FAMILY

A young person accessing mental health services should be consulted on the support their family provides in their lives and for their mental health. This support will be shaped by a young person's relationship with their family and a clinician's view on the benefits of including them. Resistance to family engagement from a young person and a family's desire to be involved can result in a degree of conflict between young people, families and clinicians or service providers. Family inclusive practice needs to recognise this potential conflict and have processes for facilitating a role for family while at the same time respecting a young person's position. A clinician needs to balance allowing a young person to remain independent, with establishing or maintaining family inclusive practice and a potential avenue of support for a young person.[17] Steps to improve or implement family inclusive practice need to recognise and accommodate the foundations and limitations of a youth focused service.

FAMILIES

The needs and experiences of the family of a young person accessing mental health services will vary. Some families will be aware of their young person's health needs, some will be prepared to engage with services and treatment, some will be immediately capable of communicating with intake staff, clinicians and other service workers. Others will not. Sometimes family members will have their own mental health challenges, which may complicate matters. While families and friends are a potential support for young people, they too need to be supported.[3] Family inclusive practice will be facilitated by helping families understand the experience of a young person in their care. A family inclusive practice; provides psychoeducation to help families understand the experience of a young person in their care, is designed and implemented to make families feel included, and ensures communication is open and clear. Recognition of the various forms families can take, and the members who may provide support to a young person, requires understanding the different perspectives parents, siblings or partners and others may have.

UNDERSTANDING THE SITUATION

A young person's experience of mental ill-health and their contact with a mental health service will present a steep learning curve for many families. Having a young person admitted as an inpatient or having to navigate community mental health services can be a stressful time for families, even those who have had contact with mental health services previously. This stress will likely affect their ability to take in information about an illness or disorder, therapeutic options, how services function and any available support.

Psychoeducation provides a family with information about symptoms, stress-vulnerability and treatment options. Learning about the experience of the young person in their care and the support options available to them can help reduce feelings of stigma and empower families in a situation where they may feel helpless. Improvements in family functioning following psychoeducation is relative to the level of parental psychological distress – higher distress levels can result in greater benefits.[18] Delivery of psychoeducation needs to be in an accessible and acceptable format for families and be part of an ongoing process. Psychoeducation builds a foundation of knowledge upon which further family inclusion can be built.

Not all family members will necessarily possess the same knowledge or 'process' the experience at the same rate. If a clinician assumes similar knowledge or shared perspectives there is the potential for distress or conflict that can undermine family inclusive practice.[4] For example, in a primary care setting a family's refusal to accept a diagnosis can be a barrier to a young person's access, despite the young person's willingness to participate.[8] Family agreement with a clinician's diagnosis and proposed therapeutic direction has been found to be positively related with a family's willingness to engage.[19]

FEELING INCLUDED

Feeling included will be important to most families. Families interviewed following discharge from a community youth mental health service in Australia reported that 'being actively included' was a prime determinant of their satisfaction with the service. Whereas, not being asked about their knowledge as parents and an unmet need for support and guidance resulted in lower satisfaction.[10] For families in which a young person is involuntary hospitalised, being seen, met, included and acknowledged is viewed as a basic level of involvement.[20]

Although there are legislative requirements regarding family involvement (and confidentiality), service and clinician practices will be a factor in how successfully these requirements are implemented. Including families in making decisions about the care of young people requires clinician facilitation. A less prescriptive approach would enable the voice of parents to be part of the therapeutic direction taken.[21] Being open and transparent about the limits of shared decision-making and the point at which unilateral decisions may begin[22] will help set reasonable expectations of inclusion for families.

The severity of disorder a young person experiences can be a factor in how families wish to be included. For example, in one study the families of young people involuntarily hospitalised indicated that involvement did not mean responsibility for treatment – they cited having too much responsibility already rather, they wanted to be 'just family members'.[20] This initial experience of involuntary admission can be intense for families but their experience often improves once a young person moves into a community service. Interviews with families using a community early intervention service for first-episode psychosis in England described feeling like the responsibility for the young person was shared once care was accessed.[11] The service context and stage of mental ill-health will inform what a family inclusive practice looks like and the approach taken to include families.

COMMUNICATION

Open and clear communication will increase the likelihood that families will feel included. For example, families using an Australian first-episode psychosis service for the first time reported contrasting experiences in which some families found clinicians to be approachable and supportive, but others felt their concerns were not listened to or taken seriously.[12] Communication was identified as a priority for service improvement in a co-design project including young people and families in the United Kingdom that examined ways to improve a youth psychosis service.[23] Better communication was also the most common suggestion for how mental health services could improve family involvement or participation by family members surveyed for this policy paper.

Suggestions from survey respondents on how communication could be improved varied. Regular discussions with families, communicating to them the potential outcomes and updates on what was happening for a young person, and being listened to were suggested improvements. The issue of confidentiality or privacy as a barrier to communication was also reported. The communication needs for families will differ. Potential differences will reflect the experiences of a young person and family members, the severity of illness and the service context a family is engaging.

> **"Receiving a phone call about what was happening could have helped me support her."**
>
> FAMILY MEMBER

Clinicians have a central role in facilitating family inclusive practice through communication with young people and families. Having an identified staff member or family worker can help with this process. There is a need to develop and enhance workforce capacity and practices around communication, including developing clinician confidence to engage families (addressed below). Communication is central to delivering family inclusive practice and is an underlying factor in many of the themes discussed in this policy paper and a foundation of family inclusive policies and practice.

More creative channels of communication have the potential to increase family inclusive practice. These channels include email, phone, skype and extended opening hours or communication after hours. A clear preference among family members for personal communication (in person or via phone[B]) was identified in survey responses. Different service contexts may make the utilisation of such channels easier, for example a private practitioner who has discretion over their practice approaches compared with a more structured community mental health service. Providing multiple communication options would allow a clinician to offer family members a preferred channel.

B Skype was not an identified option in the survey. Further research is required to understand preferences for this option.

SOLUTION	MECHANISM
Clinician communication with families Family inclusive practice requires developing communication skills within the existing clinical workforce beyond traditional one-on-one practices. The development of professional development modules and ongoing supervision, together with coordinated promotion by professional bodies and publicly funded services, would maximise take-up.	Professional bodies, Commonwealth and state and territory health departments.
Collaboration between universities and professional bodies is required to incorporate communication with families as an integral component of practice in training and education curriculum for the future workforce.	Universities and professional bodies.

PARENT'S PERSPECTIVES

Understanding the perspectives and experiences of parents and other caregivers will help design and develop policies and practices to include them. A survey of parents in the United Kingdom found that while parents want to provide support they are often sidelined, with 41 per cent of respondents saying they felt excluded.[24] The capacity of parents to provide support will be determined by their own experience of a young person's mental ill-health, service access and any personal need for support.

Parents of young people experiencing mental ill-health can struggle with: the mental health system and a need for information, their own emotional response, psychological and physical exhaustion and concerns about the rest of the family.[25, 26] In response to these struggles, parents may benefit from identifying forms of personal support they will need to prepare them to be available to support a young person. Supports identified by parents include: support groups, access to mentors, advocates or liaison staff and acknowledgment that they are important partners in supporting a young person.[24] After communication, the second most frequent theme identified by family members surveyed for this policy paper was the need for more family support. Forms of support included; understanding a young person's experience, how to care for them, and family member's own health needs, including coping and self-care strategies. Various forms of peer support were identified by family members as a helpful form of support. One respondent identified the need for specific support for siblings.

If mental health support is required by family members, a family inclusive practice would ideally provide this service alongside services for young people. Specific roles have been developed to provide support to parents (family peer support workers) and facilitate their inclusion in a young person's treatment (family workers).[C]

FAMILY PEER SUPPORT WORKER

The role of a family peer support worker (FPSW) is to support the family of a young person receiving mental health care. The authentic experience of people in a FPSW role gives this support credibility. Although the definition and emphasis of the role can vary between services and countries,[C] the support provided can be informational, instructional, emotional (including hope), instrumental and advocacy.[27]

FAMILY WORKER

The role of a family worker includes helping to create a caring, nonblaming and respectful environment, and providing time-limited intervention to the family in supporting the recovery of the young person.[28] A family worker can be integrated as part of the treating team, attending clinical reviews and working to directly support and up-skill clinicians.[29]

C There is also variation in the name given to this role in the literature (which can reflect the particular focus in a given context). To ensure clarity a single term has been used in this paper that is already used in Australia.

> **"Expect that parents will need ongoing individual support to manage their own health when they have a child with mental illness. Be proactive in offering this."**
>
> FAMILY MEMBER

RECOGNISING SIBLINGS

Despite regularly providing support for a young person experiencing mental ill-health, siblings are often only mentioned briefly in guidelines to family inclusive practice and are largely absent from existing policies and programs. Siblings are often 'ignored' due to a focus on parents in family inclusive practice.[30] While siblings may be recognised as part of a family, specific references to how they might be engaged, the potential role in supporting a young person, or the particular needs for their own support, is often missing.

Siblings can play a critical role in supporting a young person receiving treatment. In some instances, a sibling may be the middle person facilitating communication between a young person and their parents. In such cases, they could be an enabler of family engagement with a service and clinician. Siblings can also play a key role in providing companionship and social contact for a young person.

A practice guide from Anglicare Victoria on family involvement for alcohol and other drug workers who work with young people, provides an example of how siblings can be engaged.[31] The guide includes a focus on the value of strengthening sibling relationships and considering a sibling's own support needs.

The support siblings need will be shaped by their experiences. Siblings aged 11–16 years reported: mixed emotions of resentment and guilt by keeping their sibling's mental ill-health hidden from friends and school, coping by keeping a low profile, and feeling lonely from a reduced parental focus. Siblings also described the feeling that they had 'lost' their sibling.[32] Where suicide attempts have been made or there is a history of violence the burden experienced by siblings increases, especially for younger sisters.[33] The younger the person is who is receiving treatment, the greater parental involvement. This can mean siblings receive less attention and have to be more self-reliant.[34] In addition to emotional responses, siblings may take on parental duties or overcompensate for the stress being experienced by parents by appearing to be the 'perfect' child. Siblings also report feeling it was inappropriate to talk about their own needs.[32]

Potential forms of sibling support include targeted psychoeducation, respite, education support; and diversion activities.[30] Support groups for siblings are 'hit and miss' and do not always reach those who need support. Support may not be provided in a timely manner and many will worry about talking about their sibling when they are not present in the room. Clinician awareness of factors effecting the burden experienced by siblings (i.e. suicide attempts or age and gender of siblings) should be used to provide support to siblings.[33] The Space4Us program and facilitator training is a peer support program for young people aged 13–18 years who live with or have significant contact with a parent and/or family member who has a mental illness. The program gives young people an opportunity to share their experiences and receive support from other young people in similar situations.

PARTNERS

Partners of young people accessing mental health services can sometimes find they are sidelined as service support people prioritise engagement with a young person's family of origin. The limited recognition (or absence) of the presence and role of partners in a young person's life, and as a support for their improved mental health, may be attributable to the historical demarcation between Child and Youth Mental Health Services (CYMHS) and Adult Mental Health Services (AMHS). Irrespective of the reason; services, clinicians and researchers need to expand their conception of family for young people to more explicitly recognise and engage partners.

SOLUTION	MECHANISM
Engaging siblings and partners Best practice guidelines for engaging and supporting siblings and partners as important family members need to be developed. Guidelines should be developed in collaboration with young people and their siblings and partners. Guidelines should be incorporated into broader service and clinical guidelines and published as a specific guide.	National Mental Health Commission

SUMMARY

Family engagement needs to be built into service design on a foundation of clear and open communication.

Family inclusion should be negotiated with a young person.

Clinicians need to recognise and understand the experience and perceptions of family members.

The support role for siblings and partners needs to be specifically referenced in best practice guidelines.

“Families and young people should be included in the co-design of family inclusive practice.”

SERVICE MODELS TO IMPROVE FAMILY INCLUSIVE PRACTICE

Service models that locate young people within a support network of family and friends improve the potential for family inclusive practice. The service context will inform how family inclusive practice is delivered. Young people can access mental health services through a range of community-based services. These services include CYMHS, AMHS (for those aged 18 years and over) and private practice, including general practice, psychiatry and psychology. The size of a service or practice will be a factor in the type and scale of resources (i.e. staff, time) and flexibility available to implement and deliver family inclusive practice.

There is variation in interpretations of concepts and application of family inclusive practice. A distinction is made between family inclusive practice and family-focused approaches. While a family-focus acknowledges the role of family in a young person's life and their treatment, the clinician remains the expert and determines how families are involved. Whereas, a family inclusive practice approach empowers and supports families to be part of the process from the beginning.[35] A meaningful experience requires consideration of (1) how engagement is set-up, (2) the structure of the meeting and (3) continued inclusion. The Ontario Centre of Excellence in Child and Youth Mental Health provides *Tips on engaging youth and families*.[36] Within the three aspects identified, tips include:

SET THE STAGE

- Engage young people and families in the planning process
- Be clear and transparent about why you are engaging them
- Ask people how they want to be engaged and if there are any barriers to participation that could be addressed.

STRUCTURE THE MEETING

- Create a safe and welcoming space
- Take time to build relationships
- Be flexible and use accessible language
- Create a shared vision and a sense of mutual responsibility.

STAY CONNECTED

- Report back and evaluate the experience
- Build ongoing partnerships with young people and families.

There are a number of options available for improving family inclusivity in mental health services for young people. Some options are well established while other options are still developing. Families and young people should be included in the co-design of family inclusive practice.

SINGLE SESSION FAMILY CONSULTATION

Single Session Family Consultation (SSFC) is a brief process for engaging and meeting with families which aims to clarify how the family will be involved and to help family members identify and address their own needs, particularly as these relate to their own supportive role for a young person.[37] A consultation is convened early in a young person's contact with a mental health service and is not restricted to one session where there is a need for further consultation. In addition to identifying a young person's needs, consultation facilitates family inclusive practice to determine how family members might inform and support the therapeutic course to be taken. The consultation is also a chance for family members to consider their own need for support.[38]

The SSFC model has been trialled in headspace centres.[39, 40] These trials have found the model to be successful in facilitating family inclusive practice. Returning families reported being positively surprised when clinicians did not assume the position of 'expert'.[39] The model was established at a headspace Youth Early Psychosis Program (hYepp) in south-eastern Melbourne in 2017. While evaluation data is not yet available, anecdotal evidence indicates that families place a high value on the approach. Another trial of SSFC across four distinct mental health services in Victoria, including a youth mental health service and a combined child and adult service, found a strong therapeutic alliance was established between clinicians and families. Clients (young people and adults) and their families, were highly satisfied with the SSFC approach, with more than 80 per cent of participants reporting that they felt heard and talked about what they wanted to discuss.[41]

> **"Perhaps some sort of "family consultation" every six months or so could become part of treatment."**
>
> FAMILY MEMBER

Barriers to negotiating a SSFC arise when one or more individuals or parties do not want to participate. Evidence shows that sometimes it is a young person who refuses an offer of a SSFC and other times it is the family. An evaluation across four headspace services found that young people accounted for a majority (86 per cent) of the declined invitations (39.5 per cent) to hold a SSFC.[40] Inexperience with SSFC among clinicians and the sequence of invitations were given as reasons for the rate of declines. In another study, however, young people were found to be more open to SSFC, wanting to improve or repair their relationship with their family.[41]

While 'fractured' family relationships was a common reason given by families for not wanting to participate in a SSFC, not wishing to participate in additional treatment was another reason given by families.[41] Families who have previously been involved in mental health services may have had negative past experiences. Efforts to engage these families will need to recognise this barrier and will require a different approach to that suited to first time families.

There is sufficient evidence to support an extended multi-year trial of SSFC in mental health services for young people.

SOLUTION	MECHANISM
Single Session Family Consultation Model documentation and training programs exist for the Single Session Family Consultation model to support implementation in primary and specialist mental health services. The Department of Health should provide funded support to Primary Health Networks for trialling Single Session Family Consultation within mental health services for young people.	Commonwealth Department of Health
A national three year model fidelity and program evaluation would determine the potential of Single Session Family Consultation in youth mental health services.	Mental health research organisation

OPEN DIALOGUE

Open dialogue is an emerging approach to providing mental health services in which all participants (young person, clinician, family members and possibly others) participate in treatment together. Open dialogue is focused on the development and learning of everyone to improve a young person's mental ill-health. Structured meetings with at least two open dialogue practitioners bring together anyone who might have a useful perspective on what is happening for a young person. Psychotherapeutic discussions focus on the experienced needs and difficulties with the aim of increasing the capacity of a young person and their family and extended network to take action in their own lives.[42]

Peer-supported open dialogue has been trialled in adult mental health services in England. The trial involved forming a support network within the first 24 hours of a crisis, having the same clinicians involved throughout the delivery of care, and the involvement of peer support workers. A clinical lead on the trial reported that people with previous involvement with the mental health system can find the reflective practice disconcerting.[43]

As an emerging model of care, the available evidence-base is limited.[43] The Cochrane Schizophrenia Group has published an evaluation protocol 'Open dialogue for psychosis or severe mental illness' but no evidence reviews.[44]
A three year open dialogue training program commenced at St. Vincent's Hospital Sydney in November 2017.[45] St. Vincent's Hospital Sydney acknowledges that there is currently no formal manual for open dialogue.[42]
More research is needed to evaluate the application of open dialogue with young people in an Australian context.

WRAPAROUND SERVICES

The wraparound model integrates multiple services accessed by a young person that go beyond the multidisciplinary team approach used within health services. A principle of the model is an emphasis on the central role of families in making decisions. The individualised focus of the wraparound model prioritises the preferences and perspectives of a young person and their family throughout the design and implementation of a care plan.[46] The inclusion of family workers in wraparound teams has been suggested as a way to build more effective family inclusive services.[47, 48]

The evidence-base for the wraparound model is mixed. A review of the available evidence suggested that outcomes for young people are better than those achieved through conventional services.[49] There are contradictory conclusions within the literature, for example: the conclusion that wraparound models of service have 'evolved into a well-described process'[48] compared with a finding that there is a continuing lack of definition[49]. Rather than a documented approach, wraparound services are inherently flexible which hinders the ability to define the model and measure fidelity.[49] Manualised evidence-based therapies, and the need for specific protocols, can be a barrier to inclusion in wraparound services that are focused on acceptance of a therapeutic strategy, rather than the appropriateness to a young person's mental health care needs. Facilitation by those not trained in providing mental health treatment means the use of evidence-based treatments is not consistently incorporated.[46]

FAMILY PEER SUPPORT WORKERS

The role of a Family peer support worker (FPSW) is to support the family of a young person receiving mental health care. In some instances, a move to family-centred practice has opened the way for FPSWs[50] and in others, the emergence of peer support for families has improved the family centredness of care.[51] The form of support FPSWs provide will vary depending on the role identified by an organisation. The role can include informational, instructional, emotional, instrumental and advocacy support.[27]

Available evidence indicates that parent satisfaction with existing FPSW services or interventions tends to be high.[27] The genuine authenticity of people who have lived through the experience as family of young people experiencing mental ill-health, gives the role credibility with families. The role has also been identified as an enabler of access to information and services for kinship carers.[52] Although intended as a support for families, the burden of having an additional person to deal with may add to the potentially overwhelming experience faced by families.[50] The role of FPSWs needs to be promoted and explained to families as part of a service wide approach to family inclusive practice.

The evidence-base for FPSWs includes recognition of the role they play in meeting the needs of families, the barriers organisational culture can present to implementation, and the need for support and training. A personal experience with youth mental health services is generally a prerequisite for a FPSW role. Although personal experience lends credibility to the role for parents,[27, 53] qualification by experience often means a lack of formal training for the role.[54] There is a need for training to equip FPSWs to provide support to families. Analysis of a training program for FPSWs found that while knowledge did not increase, collaborative skills and self-efficacy did[55] (workforce training is addressed in the next section). Interviews with FPSWs revealed a demand for support needs, such as manuals, supervision and administration assistance, similar to those provided to clinicians.[53] FPSWs need to be equipped to work with family members and their response to a stressful experience, potentially including their own mental ill-health, anger or aggression and family conflict. The *Fifth National Mental Health and Suicide Prevention Plan* identifies the need to update mental health workforce data to include the role of 'consumers and carers' in the mental health peer workforce.

ONLINE ENGAGEMENT

Online platforms provide new opportunities to include families. These platforms have the potential to overcome barriers related to work-hours, travel, distance and other family and life commitments. Psychoeducation, tips for families in engaging with young people, and links to support resources are examples of existing online services, such as those provided by ReachOut.While these are valuable resources, families need to be directed to these sites because finding them through a search engine is not guaranteed.

Moderated online social therapy is an emerging field that enables a more interactive engagement with families. These online platforms integrate treatment, social networking, peer and expert support, and social problem-solving for families. An Australian trial for carers of young people diagnosed with depression and anxiety found the delivery of moderated online social therapy to be safe, acceptable, and a feasible approach to family inclusive practice.[56]

Online platforms to communicate with families and deliver therapeutic and social support services are initiatives that have the potential to reduce barriers and improve family inclusive practice. This potential, however, may also generate additional barriers. Individuals who are not confident accessing or using online platforms will be unlikely to benefit from these new avenues to engagement and support. Unpublished research undertaken by Orygen has found that parents aged over 50 years are less engaged with technology, with those aged 30-50 years being more likely to engage with services and clinicians through online platforms.

Thirteen survey respondents provided suggestions on how online or electronic technologies could be used to improve engagement or service delivery.
Four respondents saw the potential for alternative access points to clinicians, support staff or peer support. Although two respondents saw ecounselling as an alternative to face-to-face therapy, one respondent stated that face-to-face was necessary. Another respondent noted the need for online or electronic technologies to be fit for purpose (numeracy, literacy levels and culture) and identified the need for an app or component for families.

SUMMARY

Models of family inclusive practice in youth mental health exist with varying levels of evidence.

Single Session Family Consultation is a tested model for family inclusive practice in youth mental health services.

FPSWs provide support to the family members of young people accessing mental health services.

Online options are available for providing information and support.

“A change to family inclusive practice means including families and other support people is a default process – not an additional option.”

MOVING TO FAMILY INCLUSIVE PRACTICE

Moving to a family inclusive practice will in most cases require an all-encompassing change to how mental health services have previously been delivered. Reform requires commitment from management and staff, the provision of training and support and sufficient resourcing. Family inclusive practice will be further enabled through the provision of dedicated staff. Implementation is more likely to be successful if applied at multiple levels, as part of service, system and organisational change.[35] A change to family inclusive practice means including families and other support people is a default process – not an additional option – undertaken alongside intake and assessment with a young person. The *Fifth National Mental Health and Suicide Prevention Plan* emphasises the role for young people and families in the design, implementation and evaluation of mental health care and services.[1] Collaborating with young people and families in the co-design and implementation of inclusive practices is a natural fit with the principles of family inclusive practice.

The Ontario Centre of Excellence for Child and Youth Mental Health has developed a five step guide to developing a family inclusive practice model based on the available literature.[57] The five steps are:

1. organisational commitment
2. collaborating with families
3. capacity growth
4. implementation
5. evaluate and sustaining family engagement.

The challenge of realising family inclusive practice in mental health services for young people will differ on the service context. These different contexts include CYMHS, AMHS, general practice and private practice. Existing practices will inform the design and implementation requirements for family inclusive practice in these contexts. For example:

- AMHS have established service models of including carers in a person's treatment
- individual clinicians in private practice potentially have more flexibility in communication
- Community mental health services operate at a larger scale that may make funding of service reforms and the employment of dedicated staff more feasible.

Mind Australia and Helping Minds have developed six partnership standards to guide organisations towards better engagement with families.[64] These standards provide a framework applicable at an organisational, service and individual clinician and staff level.

ORGANISATIONAL CHANGE

To ensure family inclusive practice is implemented, the approach needs to be visibly adopted at all levels of a service from management down. Alongside leadership by management, champions in different areas of an organisation are required to drive implementation. Reflecting the importance of organisational support, The Bouverie Centre[D] has changed its approach to service implementation of SSFC from a focus on individual training to practice change, and being involved from the beginning in the development of new systems and services.

D The Bouverie Centre: Victoria's Family Institute combines clinical family therapy, academic teaching, qualitative and quantitative research, workforce development and community education.

COMMITMENT FROM MANAGEMENT

Commitment from management is integral to implementing family inclusive practice that will enable the inclusion of families. For example, an evaluation of SSFC across four headspace centres found clinicians had perceived sustained positive changes at an organisational level. [40] At headspace Hobart, support from the centre manager and clinical lead for a demonstration project for Mind Australia and Helping Minds' partnership standards was identified as a key factor in the success of the project.[58] Similar evidence is available internationally. A determining factor in the success of an open dialogue trial in England was the support of the chief executive and medical director of the organisation.[43] A review of best practices in wraparound services found that implementation required organisation and system level support for the model. [47]
There is strong evidence for providing FPSWs, but successful incorporation of this role within a service requires leadership.

The culture of an organisation has been identified as a key factor in whether the role of FPSWs can be successfully implemented in a mental health service.[59] The study of FPSW programs in the United States of America has found that organisational culture and program quality were correlated.[60] Training, organisational leadership and endorsement for the role, a clear role definition[61] and clear practice parameters[62] will support FPSW programs to provide a high standard of quality service. Changes in management approaches and program design, together with professional development for staff, moved the focus of change beyond individual behaviour to include the demonstrated values by the staff across the organisation.[51] Where low quality measures for FPSW practices were identified, a corresponding workplace culture of resistance was evident.[63]

Partnership standards developed to enable improved engagement with families were implemented in headspace Hobart as part of a demonstration project. Implementation of the guidelines enabled headspace Hobart to identify service gaps in family inclusive practice processes and avenues to improve inclusion in everyday practice. Challenges in implementing the partnership standards included time and cost pressures, engaging private practitioners, the tension between a young person's need for confidentiality and independence and the potential benefits of involving family in their recovery.[58]

SOLUTION	MECHANISM
Family inclusion guidelines The six partnership standards developed by Mind Australia and Helping Minds provide a guide to family inclusive practice. The standards should be implemented across mental health services for young people.	Commonwealth Department of Health
The Department of Health should stipulate that implementation of the partnership standards are a requirement of youth mental health services commissioned by Primary Health Networks.	
State and territory governments should work with specialist mental health services to plan time frames for implementing the partnership standards.	State and territory health departments

CHANGE NEEDS A CHAMPION

Individual staff championing change to family inclusive practice is required alongside leadership from management. The Mental Health Beacon (Beacon) project trialled SSFC in four different family interventions at six sites across Victoria. The project included 'champion' roles and management sponsors within an organisation.[41] The importance of a 'champion' role in facilitating organisation change was highlighted in discussion of the scaling up of a SSFC trial in a headspace setting.[40] At headspace Hobart the role of champion for a demonstration project of the Mind Australia and Helping Minds' six partnership standards was taken on by a full-time reception staff member. This role enabled family engagement to be initiated early in a family's contact with the centre. The sustainability of a 'champion' role is dependent upon a visible commitment and support from management.

DIFFICULTY CHANGING

The potential challenges and difficulties of implementing system reform need to be acknowledged. Implementing change requires time as well as leadership. For example, it has been found that implementation of SSFC in a time frame of less than 12 months was 'difficult'.[41] The experience of clinicians participating in the implementation of SSFC as part of the Beacon project found levels of support received from co-workers increased in the 12 months following training but that in contrast there was a decline in organisational support.[41]

An audit of early intervention mental health services in the United Kingdom that participated in a co-designed reform process found that at nine months many plans remained at baseline or had only progressed minimally. Attendance at the steering group was centred on a small group of committed staff who were frustrated by a lack of time and organisational support to implement plans.[23]

A study of quality indicators for multidisciplinary team functioning in community-based children's mental health services identified the role of structural and procedural barriers and the need for further evidence to facilitate teamwork.[61] A need for more rigorous evaluation of changes to improve family engagement was identified.[65]

While these examples illustrate the challenges of changing to family inclusive practice, anecdotal evidence indicates that at four headspace centres where SSFC was implemented, it was still being used two years later.[40] Misgivings towards practice change in a hospital-based service was overcome through a combination of training and supervision, shared goals, open communication and clearly defined roles among team members.[21] Alongside organisational leadership, staff development and support are integral to the move to family inclusive practice.

CHANGE NEEDS TO BE COLLABORATIVE

Improved inclusion of families will be optimised by engaging them and young people in making the changes required to achieve family inclusive practice. The experiences of everyone (young people, families, staff and management) involved in a service will bring insights that will help build a family inclusive practice. The 'co' in co-design is a partnership of different groups working together.[66] A collaboration or co-design process will include many of the aspects that a family inclusive practice will include. Collaboration begins with design but should continue to include families (and young people) during implementation and evaluation.

Evidence shows that although co-design processes can be an effective mechanism for service improvement there can be particular issues in the context of mental health services. Some of these challenges are similar to the issues identified in negotiating family inclusion earlier in this paper. The importance of high-level support within an organisation for the process is another common issue. Other challenges relate to the vulnerabilities of service users and their consent. In the past, co-design in the health sector has not always ensured the impact of their involvement was communicated to services users and their carers. When co-designed improvements are not implemented participants can be left feeling disappointed and dissatisfied.[23]

A co-design project to improve the delivery of a youth psychosis services in the United Kingdom[23] provides lessons for how collaborative processes can be undertaken in Australia to improve family inclusive practice in mental health services for young people. Collaborative design processes are reliant on good will, commitment, and trust between all parties. Without the support of management, the process is at risk of being over reliant on collaborators and 'champions'. To optimise the process of co-design a project should include: an evidence-based approach, feedback groups prior to the main co-design event providing good preparation and improved process for participants, and reflecting on each stage before moving forward (including recognising the time this requires).

There is an Experience-based co-design toolkit available from The Point of Care Foundation (UK).[67] The toolkit, however, only includes the design stage of a collaborative process, not implementation or evaluation.

DEVELOPING CLINICIAN PRACTICES TO ENGAGE FAMILIES

Developing clinician practices to engage families will facilitate implementation of family inclusive practice. Guidelines exist for family inclusive practice but they rely on implementation by clinicians. Communication with families is central to family inclusion. Barriers to changing clinician practices around communication include: a lack of confidence, not feeling skilful enough, time restraints and not seeing it as their role. Younger or early career clinicians could benefit from additional professional support from more experienced colleagues in overcoming some of these barriers. A study of clinician perceptions of barriers and enablers to adherence to (and participation in) psychosocial therapy found a bias towards their role as enablers. They primarily located barriers in adolescent and family domains. While not measured, this perception may not match that of young people or their families. An awareness of clinician bias will be required as part of any practice and system move to family inclusive practice.[19] The increased demands of family inclusive practice on top of existing workloads also needs to be recognised. Clinicians need to be given the time resources to proactively engage and support families at times of non-crisis.

Employing a family worker, as part of the therapeutic team is an enabler of family inclusion in a young person's treatment. The role of a family worker can help ensure that services and clinicians are guided by families on what they need and the pace they need it. Clinicians also need to be trained in supporting FPSWs. Checking in with families regarding their support needs during treatment can support FPSWs in their role. Providing training and support to develop clinician skills and confidence and resourcing dedicated staff roles (family workers and FPSW) would demonstrate organisational commitment to family inclusive practice. A corresponding commitment is required from clinicians to implement practice changes to facilitate family inclusion.

TRAINING AND SUPPORT

Previous training and experience informs the practice and therapeutic approaches clinicians will be confident delivering. To implement a new approach or practice in order to improve family inclusive practice may require training to develop requisite skills. In addition to training, clinicians may need ongoing support and consultation to assist them in implementing what they learn following training and further on, should a challenging situation arise at a later stage. Lessons from the evaluation of established or trial family inclusive practice provides direction for clinician support to enable the roll out of family inclusive practice in mental health services for young people.

Available evidence includes:

- A co-design project to improve the delivery of a youth psychosis service in the United Kingdom identified the importance of support for staff.[23]
- Champions and managers implementing SSFC have observed that when work demands pressed clinicians, there was a tendency to revert to their core role and withdraw the new family consultation practice.[41]
- Training and practice development sessions for clinicians moving to SSFC resulted in significant changes in clinicians' family related attitudes and behaviours.[41]
- Implementation of SSFC resulted in improved support for supervision in the workplace and clarity about workplace policies and procedures for working with families at six months post-training.[40]
- Sustained improvements in clinician practice of SSFC across four socio-geographically diverse headspace centres included familiarity with approaches and confidence in working with families.[40]
- An interest from clinicians in a family's need for support and demonstrated partnering with FPSWs (i.e. following up with a FPSW once connecting them with a family[50]) will help ensure the right form of support is delivered and affirm the role of FPSWs.[25]
- The value of support from senior clinicians for FPSWs[54] points to the need for organisation wide support for the role.

RESOURCING

The time allocated to fostering family inclusion is often described as additional work. Having to fit working with families into afterhours work or between sessions demonstrate the undervalued and unrecognised importance of family inclusive practice within mental health services. Implementation of family inclusive practice is a medium-term project and is dependent upon organisation wide participation. Initial training and service design changes need to be reinforced with continuing support and evaluation. Investment in family inclusive practice, therefore, needs to consider upfront and ongoing costs.

MEDICARE BENEFITS SCHEDULE

The Medicare Benefits Schedule (MBS) provides publicly funded subsidy for the private provision of health services. The headspace model for example, is based on private providers delivering services which are funded by MBS receipts. Reliance on this funding model can result in the perverse practice of suggesting a family member access time with a clinician through a mental health plan of their own. While this ensures that a clinician is paid for the time required to include the family member in a young person's treatment; it potentially undermines the framing of a family member's role in supporting a young person and, if later needed, available access to mental health support of their own.

Expanding the scope of existing MBS items provides an opportunity to provide additional or extended funding of sessions with a young person's family or inclusion in one of their sessions. The Productivity Commission has recommended (draft recommendation 13.3) the Australian Government should amend the MBS so that psychologists and other allied health professionals are subsidised to provide family therapy. This recommendation would enable the inclusion of a SSFC as part of a young person's treatment.

ACCESS TO ALLIED PSYCHOLOGICAL SERVICES

The Access to Allied Psychological Services (ATAPS) program permits family participation in any or all sessions for children aged under 12 years. There is also scope for ATAPS sessions to be with families without the presence of a child. Clinicians determine the allocation of sessions, however, the child receiving a service and their treatment is to be the focus. Extending this program to young people aged up to 25 years would facilitate family inclusive practice. Negotiation with a young person rather than clinician discretion would be required in determining how family members were included.

PACKAGES OF CARE FOR YOUNG PEOPLE AND THEIR FAMILIES

An alternative to expanding the scope of existing MBS items or introducing new items would be to develop a targeted primary mental health care funding package for young people that can include their family. Such a package of care could include sessions with a young person and their family (i.e. SSFC) and provide support for families (i.e. psychoeducation, counselling and peer support). This approach would also facilitate the coordinated provision of services suited to a young person's particular health needs.

Although care planning exists through the GP Mental Health Care Plan (within Better Access) and Team Care Arrangements (under a Chronic Disease Management Plan) these plans are built around access to allied health care and, therefore, existing barriers to family inclusion will persist. A broader care packaging approach is required that provides funding for services rather than an allocation of MBS funded sessions. This approach would enable access to services designed to include families.

FUNDING TRANSITION TO FAMILY INCLUSIVE PRACTICE

Specific funding is required to transition to family inclusive practice. Trimming other aspects of a block funded service or funding models largely based on session funding cannot adequately fund the training, additional resources and dedicated roles that enable family inclusive practice.

Service models based on MBS receipts require additional funding to implement a move to family inclusive practice. This funding, for example, would be required to pay private providers to attend training in a new family inclusive practice model. Continuing costs can include extra time associated with system changes, professional support and time, and consolidating new ways of working together in and outside of treatment. An economic evaluation of the implementation of wraparound services found that additional activities associated with the new model add to a clinician's workload and that they were unable to predict at intake the likely extra resource load.[68]

SOLUTION	MECHANISM
Funded transition to family inclusive practice There is instructive evidence for preparing an organisation, the role of management and workforce transition to family inclusive practice. The design, evaluation and implementation of family inclusive practice should be undertaken in collaboration with young people and families. Dedicated funding is required for transitioning to family inclusive practice. Transition funding should be: • linked to management performance • require structured and evaluated collaboration with young people and families • provide training and accreditation for clinical staff. Staged scaling up of a funding program for transition to family inclusive practice should include a continuous evaluation of transition strategies, collaboration with young people and families, workforce accreditation and service outcomes.	Commonwealth Department of Health State and territory health departments

The potential benefits of FPSWs within a family inclusive practice provides another example of the funding constraints to improving family inclusive practice in mental health services. The Productivity Commission has identified a need to broaden the mix of skills available in the mental health workforce. Family peer support, however, fits in this category. Family peer support is not a therapeutic service for a young person and, therefore, funding of this position needs to come from core funding rather than existing therapeutic services or session funding. There is suggestive evidence that family peer support in child and adolescent mental health services was 'likely' to be cost-effective.[27] This evidence, together with the evidence-base for both the benefits of providing family peer support and the implementation of this role within mental health services, warrants the allocation of specific funding.

SOLUTION	MECHANISM
Funding for Family peer support workers Resourcing is the primary barrier to implementing evidence-based family peer support worker roles in mental health services for young people. A three year incentive program to increase the family peer support workforce similar to the Mental Health Nurses Incentive Programme is warranted. Dedicate funding is required to ensure family peer support workers are located in primary health and specialist mental health services based on service need. Allocation of funding must be undertaken openly, transparently and in collaboration with local services.	Commonwealth Department of Health

SUMMARY

Implementation of family inclusive practice requires visible leadership and support from management.

Staff require training and support to implement family inclusive practice changes.

Dedicated roles to facilitate participation in treatment where appropriate and provide support to families when needed will prepare families for inclusion.

Family inclusion needs to be funded in addition to providing mental health services.

“The primary impediment to implementation is a lack of funding.”

POLICY SOLUTIONS

An evidence-base, guidelines, practice models and dedicated roles exist to enable the implementation of family inclusive practice in mental health services for young people. The primary impediment to implementation is a lack of funding. The need for funding is identified in the two key policy solutions identified at the beginning of this policy paper.

Additional opportunities exist to support the implementation of family inclusive practice. These policy opportunities address specific aspects of family inclusive practice, such as the implementation of Single Session Family Consultations, the role of siblings and partners and communication skills for clinicians and dedicated roles.

SOLUTION	MECHANISM
POLICY	
Aligning legislation The alignment of legislation relating to mental health services, treatment and records between jurisdictions would ensure consistent application by clinicians moving between jurisdictions. This process would permit a review of legislation to identify barriers to family inclusive practice and necessary reforms to address issues and challenges across the youth age range (12-24 years).	Council of Australian Governments
SERVICE	
Engaging siblings and partners Best practice guidelines for engaging and supporting siblings and partners as important family members need to be developed. Guidelines should be developed in collaboration with young people and their siblings and partners. Guidelines should be incorporated into broader service and clinical guidelines and published as a specific guide.	National Mental Health Commission
Single Session Family Consultation Model documentation and training programs exist for the Single Session Family Consultation model to support implementation in primary and specialist mental health services. The Department of Health should provide funded support to Primary Health Networks for trialling Single Session Family Consultation within mental health services for young people.	Commonwealth Department of Health
A national three year model fidelity and program evaluation would determine the potential of Single Session Family Consultation in youth mental health services.	Mental health research organisation

SOLUTION	MECHANISM
Family inclusion guidelines	
The six partnership standards developed by Mind Australia and Helping Minds provide a guide to family inclusive practice. The standards should be implemented across mental health services for young people.	Commonwealth Department of Health
The Department of Health should stipulate that implementation of the partnership standards are a requirement of youth mental health services commissioned by Primary Health Networks.	
State and territory governments should work with specialist mental health services to plan time frames for implementing the partnership standards.	State and territory health departments
Funded transition to family inclusive practice	
There is instructive evidence for preparing an organisation, the role of management and workforce transition to family inclusive practice. The design, evaluation and implementation of family inclusive practice should be undertaken in collaboration with young people and families.	Council of Australian Governments Health Council
Dedicated funding is required for transitioning to family inclusive practice.	
Transition funding should be: • linked to management performance • require structured and evaluated collaboration with young people and families • provide training and accreditation for clinical staff.	
Staged scaling up of a funding program for transition to family inclusive practice should include a continuous evaluation of transition strategies, collaboration with young people and families, workforce accreditation and service outcomes.	
WORKFORCE	
Clinician communication with families	
Family inclusive practice requires developing communication skills within the existing clinical workforce beyond traditional one-on-one practices. The development of professional development modules and ongoing supervision together with coordinated promotion by professional bodies and publicly funded services would maximise take-up.	Professional bodies, Commonwealth and state and territory health departments.
Collaboration between universities and professional bodies is required to incorporate communication with families as an integral component of practice in training and education curriculum for the future workforce.	Universities and professional bodies.
Funding for family peer support workers	
Resourcing is the primary barrier to implementing evidence-based family peer support worker roles in mental health services for young people.	Commonwealth Department of Health
A three year incentive program to increase the family peer support workforce similar to the Mental Health Nurses Incentive Programme is warranted.	
Dedicate funding is required to ensure family peer support workers are located in primary health and specialist mental health services based on service need. Allocation of funding must be undertaken openly, transparently and in collaboration with local services.	

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