Foreword

I believe it is important that the people who use our services have a say in how and where they are delivered.

The Department of Health and Human Services is developing a consumer and community engagement strategy that will actively involve people in decisions about their own health and wellbeing, and that of their communities.

Consumer and community engagement is not an end in itself but an important step towards creating more effective health and human care services for all Tasmanians.

It is widely recognised that individuals and communities benefit when people actively engage in service planning and delivery.

Consumer and community engagement is a two-way process that involves all parties listening and responding. It also involves joint learning and discussion.

For it to be meaningful, consumer and community engagement must be based on principles we all understand and believe. While getting it right will take time, I am keen we move quickly to establish the appropriate approach and framework, and then refine this as we move forward.

Different situations will demand different approaches, but I am committed to developing a strategy that meets the needs of all those who use human and health services.

We are keen to work together with you in shaping the services we deliver.

I encourage you to read this consultation paper and to feed back your comments and ideas. As you read through the document, please consider the following:

• Consumer engagement is important for the people who use our services and for services to better meet their needs.
• There are significant benefits for everyone if consumers and communities are engaged with decisions about their own care and the performance of health and human services
• There are common principles we can all share in our approaches to engagement
• There are a range of levels and approaches that suit different situations
• That as practitioners and service providers we can help improve our engagement with one another and our communities.

Improving consumer and community engagement will not mean everyone will get everything they want all of the time, but it will mean that the reasons behind decisions are better understood and that individuals and communities have a real chance to influence the shape of decisions.

Consumer and community engagement is a vital part of the great transition that health and human services are undergoing in Tasmania. I hope you will join us in creating services of which we can all be truly proud.

David Roberts
Secretary
Department of Health and Human Services

Please let us know your thoughts by Tuesday 12 May 2009.

You can use the questions at the end of this paper to guide your response.

Please send your comments and ideas by email to susan.stipcevic-webb@dhhs.tas.gov.au or post them to:

Susan Stipcevic-Webb
Consumer and Community Engagement Manager
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Hobart, Tasmania 7001
1. Introduction

The Department of Health and Human Services (DHHS) engages with consumers, carers and communities in many ways. These interactions range from individual care consultations through to formal whole-of-community consultation processes. They occur at service and site level as well as in service delivery programs based on client empowerment such as chronic disease self management and aligning child protection and disability services to best meet client needs. Many community sector organisations also advocate for and represent consumer and community views to DHHS.

Consumer and community engagement is particularly important in times of change. However, there is no consistent, systematic approach to this engagement in Tasmania. Tasmania’s Health Plan identified the need to develop a whole-of-department consumer and community engagement strategy, and DHHS has now begun this process.

Nationally and internationally more is now understood about person-centred approaches and what that means for individual consumers and carers. These new approaches accept that the health and social care of the individual is based on a partnership between the service provider and service user that involves sharing power and responsibility. This results in better health and wellbeing for the consumer and a heightened sense of purpose for the service provider. Research shows significant benefits for all when governments actively involve consumers and communities in decision making. Countries such as the United Kingdom and Canada, as well as other Australian states and territories, are now implementing strategies that involve communities and consumers in health planning, policy development, service design and in decisions about their own care and support. DHHS recognises that it must listen more closely and better respond to the people who use and fund its services.

However, there is no one right way to engage people. Therefore, DHHS will develop an approach and framework that is easy to implement, affordable and has long term meaning for the services and the public. Through its consumer and community engagement strategy DHHS aims for:

• Active participation in decision-making in individual care and support leading to improved individual and population outcomes
• Effective program and strategy development and implementation that integrates consumer and community views
• Delivery of more accessible, safe and effective health and human services informed by an understanding of consumer needs.

Consumer and community engagement requires flexibility and commitment and this will demand the establishment of evaluation mechanisms. It will also pose some challenges including spanning health and human services within the same framework, however, this is important because there are many shared issues across these consumer groups. DHHS will also consider how this approach may impact on community sector organisations.

Despite the challenges, DHHS will make consumer and community engagement part of its everyday work. It will also develop the strategy in an inclusive and respectful way by engaging with and involving consumers, carers, communities and staff at every stage.
2. The meaning of ‘consumer’ and ‘engagement’

“Consumer” refers to anyone using or who may use DHHS services. It includes people using hospitals, health centres, housing, mental health, disability, children and family services as well as services run by community sector organisations funded by DHHS.

“Consumer” is now in wide use in health and human services in Australia. In the health context, the Australian Institute of Health Policy Studies (AIHPS) defines a consumer as:

...someone who makes either direct or indirect use of health services - that is, a current or potential user of the health system. This definition makes no assumption about the consumer's knowledge of an issue or their involvement in a consumers' organisation. The definition also makes no assumptions about whether consumers are engaged as individuals or as a collective group. The definition is broad, encompassing both consumers with specific health needs, and broader community members who have a general interest in the health system and health funding.³

This definition applies equally to the human services sector.

AIHPS defines engagement as:

... a broad way to cover the range of activities used by governments, organisations and individuals to generate consumer input in or discussion about policy ... the term ‘engagement’ is used to discuss the full range of engagement activities – including those that some authors may describe as ‘consultation’ or ‘information provision’.⁴

The engagement strategy also includes engaging with the broader community including organisations that represent the views of specific groups of consumers, local government and other stakeholders such as service providers.

Health Canada has produced a set of definitions (see Attachment B) to help its staff cut through the jargon and develop a common language.⁵

In its Doing it with us not for us, the Victorian Department of Human Services states that consumers, carers and other community members may participate as individuals or as representatives on advisory or reference committees. Doing it with us not for us defines a representative as a consumer, carer or community member nominated by and accountable to an organisation of consumers, carers or community members.

While it is sometimes hard to reach agreement about whether someone is engaged as an individual or as a representative, this should not impact on who is involved in consumer and community engagement processes. The purpose and context of these processes should determine whether engagement is with consumers, and/or their carers, and/or community groups or community members.

Consumer and community engagement is an ongoing process, not a one-off event. It assumes that working in partnership with consumers and the community will lead to better decisions and outcomes.⁶
3. Why consumer and community engagement is important

Consumer engagement is valued because it:
- improves outcomes for the individual and the quality of care that they receive
- is an important democratic right
- is a mechanism to ensure accountability.\(^7\)

Organisations that fully involve their communities and respond to their needs can make better decisions and develop better services.\(^8\)

Consumer and community engagement provides policy makers and service providers with a richer view of their environment.

It is important to note that not all consumers are the same: their interests, reasons for participating, views and opinions will vary depending on their life experiences. This may pose challenges for policy development, which tends to focus on common elements or experiences when developing solutions.

Stronger involvement by individuals in their own health and social care improves their satisfaction levels, pain management, compliance with recommendations, management of chronic disease and reduces use of follow-up services.\(^9\) The process can lead to greater community acceptance and support.\(^10\)

There is also growing evidence of the positive contribution that consumers, carers and community members can make for the development of services and effective consumer and community engagement strategies.\(^11\)

The actual process of participation can inherently empower individuals and communities through the better understanding of their own situations and through greater control over factors affecting their lives. This process can, in turn, improve the sense of wellbeing and quality of life.

Consumer and community engagement also leads to a more holistic and integrated approach to care because consumers and carers tend to have a broader perspective on the needs of the whole person than do medical professionals dealing with specific conditions. For example, a consumer’s transport need may not be considered when an appointment is being made.

Community participation can harness and mobilise a wealth of untapped resources and energy by using a range of practical techniques to engage people.
4. Principles

DHHS, consumers and the community must build a shared commitment to the values that underpin effective consumer and community engagement. To support this it is suggested that a set of guiding principles be adopted. The following principles of engagement (based on those operating in Victoria) are proposed:

1: **Trust:** There is mutual agreement of the processes and assessment of the issues under consideration as developed through productive working relationships.

2: **Respect:** All participants need to show consideration and value each other as equal contributors.

3: **Openness:** All participants are open to considering the ideas of consumers, carers and the community, and are willing to accept change.

4: **Equal opportunity:** Involve all those affected by the decisions at an early stage, inform them of the decision-making process and give them the information and means to participate.

5: **Advocacy and support:** Consumer and community engagement is supported from the top and resourced so participation is meaningful for all.

6: **Responsiveness:** Consumer and community engagement needs a flexible approach and benefits from multiple strategies that reflect the needs of all stakeholders. No "one size fits all" solutions.

7: **Shared ownership and accountability:** All involved share ownership of the process and decisions, and are responsible for monitoring and evaluating the impact and outcomes.

8: **Dissemination:** Inform everyone affected or involved of decisions that are made, explain how consumers, carers or community members’ participation influenced those decisions.

9: **Evaluation:** There is ongoing learning and improvement with the engagement processes. Lessons learned are identified and communicated widely.
5. Levels of engagement

All organisations that want to systematically engage with consumers and the community need to determine how to structure this and where the main areas of activity will occur. Most jurisdictions use a mix of individual, place, service and whole-of-agency approaches. The United Kingdom and other jurisdictions have done important work in engaging with groups that have not always participated in consultation processes. This includes children, young people, people with disabilities, homeless people and people of diverse cultural backgrounds.

DHHS is very keen to learn from these experiences and to build this into its consumer and community engagement strategy to make sure the strategy reaches “hard-to-reach” people.

In Tasmania, where human and health services are incorporated within the one department, there is the chance to develop a responsive strategy that meets the needs of all consumers and the broader community. It is therefore proposed that consumer and community engagement should operate across four levels in Tasmania:

1: At the individual level: This is about the consumer and, if appropriate, their carer(s) being actively involved (and supported to be involved) in their own care, support and treatment.

2: At the local level: Here the focus is on the area, town or municipality (for example Glenorchy City Council), which will help DHHS design flexible, locally determined approaches that best meet local needs and preferences. This will allow for flexible, locally determined approaches that better meet local needs and preferences, and will help create capacity for an independent local voice in planning health and human services, monitoring performance and assessing service quality.

3: At the service level: This is at either a statewide or an individual service unit level. Examples of statewide services could include housing, mental health, disability, child and family and oral health services. Examples of individual service delivery units could include Ashley, Cancer Screening Services, Launceston General Hospital and the Campbelltown Multi Purpose Service.

This will make sure staff engage with consumers, carers and community members to plan and develop policy as well as monitor performance and assess service quality. The direct involvement of consumers and the community in service quality assessment, service processes and the review of adverse incidents has been shown to improve service standards.  

4: At the whole-of-system level: This is about DHHS receiving advice (to the head of DHHS) and engaging consumers and the community in the development of its policies and plans. It will also help DHHS set its priorities and assess the performance of the health and human services system.

Within each level, all stakeholders must work together to create an environment, based on the principles outlined in section 4, that encourages consumer and community engagement.

A summary of the key elements of the four levels of consumer engagement is included in Table 1.
<table>
<thead>
<tr>
<th>Level of Engagement</th>
<th>Features</th>
<th>Parties involved</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INDIVIDUALS</strong>&lt;br&gt;Care and support</td>
<td>Between: (a) individuals (b) service providers Individual actively involved in their own care and support. Staff actively promote client choice, empowerment and self determination</td>
<td>CONSUMER/COMMUNITY • Individual who is a current or potential user of services • Carer/s of current or potential user of services • Families and advocates DHHS • Individual service provider</td>
</tr>
<tr>
<td><strong>LOCALITY BASED</strong>&lt;br&gt;Planning and development of services for defined geographical areas</td>
<td>Between: (a) local communities including individual consumers, consumer groups, local government and consumer representation on government advisory groups (a) services Consistent engagement in service planning and priority setting, but especially when changes may be necessary to service configuration or priorities</td>
<td>CONSUMER/COMMUNITY • Individual consumers or carers • A group or groups representing specific local consumer interests • Local Government • Various local, area and statewide communities • Community sector organisations DHHS • Service managers and their teams • Program directors and their staff</td>
</tr>
<tr>
<td><strong>OUR SERVICES</strong>&lt;br&gt;Improvement, planning and development</td>
<td>Between: (a) consumers and consumer groups (b) services May be reactive (e.g. to complaints) or proactive (e.g. engagement in quality assurance and planning processes)</td>
<td>CONSUMER/COMMUNITY • Individual consumers or carers • A group or groups representing specific consumer interests • Community sector organisations DHHS • CEOs, service managers and their teams • Program directors and their staff</td>
</tr>
<tr>
<td><strong>OUR SYSTEM</strong>&lt;br&gt;Policy development and decision-making</td>
<td>Between: (a) individual consumers, consumer groups and consumer representation on government advisory groups (b) department staff and government officers Usually strategic and proactive (e.g. policy direction, resource allocation) May occasionally be reactive in response to political contingencies May include legislation</td>
<td>CONSUMER/COMMUNITY • Individual consumers or carers • A group or groups representing specific consumer interests • Community sector organisations • Various communities at local, area and statewide levels DHHS • Secretary and Departmental Executive • Government ministers</td>
</tr>
</tbody>
</table>
6. Types of consumer and community engagement

There are several types of consumer and community engagement (outlined in the DHHS background paper that considered engagement in other jurisdictions \(^{13}\)) differentiated by the levels of engagement and opportunities for active participation.

The Australian Institute of Health Policy Studies in *Conceptualising Consumer Engagement* points out:

Consumer engagement is often represented as a ladder or hierarchy, ranging from low levels of engagement that offer little opportunity for consumer input, through to high levels that offer elements of consumer control or partnership.

… approaches placed higher on the engagement ladder – such as partnership approaches or joint management – may allow for extensive involvement by consumers, but the trade-offs are that only a very small number of consumers can be involved, the process can be time consuming and it is likely to be costly. Approaches from the lower levels – such as advising or gathering information – allow for large numbers of consumers to contribute, but with less active involvement.

The Victorian DHS identified five types of consumer engagement, which DHHS is interested in adopting to guide effective consumer and community engagement in Tasmania. The types of engagement are: \(^{14}\)

- information
- consultation
- partnership
- delegation
- control

**Information**: Information is often used to support or invite participation, for example, information about how to access a service and what is involved in care or support.

However, giving information is not engagement because the information flow is one-way. Giving information does not change how services, policy, research, treatment or support are made or provided. For this reason, information is usually identified as supporting engagement. Giving information is usually to:

- support participation
- convey facts
- educate.

**Consultation**: Consultation is used to find out what consumers, carers and community members think about a proposal. However, the government agency remains in control of the process. Consultation is only considered true engagement when the information gathered from consumers, carers or community members is used to make or change policy, planning, research, care or treatment.

Consultation can improve services or treatment and increase acceptance. Consultation can take several forms, including focus groups, public meetings, family meetings and individual health consultations. The objectives of consultation are to:

- find out people's views and ideas
- use people's views and ideas to improve services or policies
- increase acceptance.

**Partnership**: Partnerships move towards joint decision-making. Consumers, carers, community members and the government agency jointly own the process and outcomes.

Partnerships are often achieved through advisory boards or committees that provide input over time, usually years. The partners agree to work together to decide a policy direction, research, plan, treatment or support.
Positive relationships between service providers and individual consumers lead to partnerships where responsibility for care and treatment is shared and where all are clear about their rights and responsibilities. The objectives of partnerships are to:

- make joint decisions
- agree on process
- collectively own the outcomes.

Delegation: Delegation means giving control to consumers, carers and community members to make decisions within specified guidelines. The government may set out guidelines for the decision-making roles of particular groups in legislation or through a government department. Examples include the operation of boards of health and human services, delegation of responsibility to ethics committees to ensure research adheres to ethics principles and the delegation of power to consumer and community representatives and clinicians via quality and safety committees. The objectives of delegation are to:

- hand control to a committee, board or to community representatives within a specified framework
- ensure policy options are made at arms length from party politics.

Control: Decision-making power is given directly to the community, consumer or carer by the health professional, service or government department. The objectives of control are to:

- hand control of an issue to the community
- hand control to the consumer or, where appropriate, their carer.

Choosing the right type of engagement

Each type of engagement is valuable and suits a particular situation. Using a variety of methods, starting early in the decision-making process, usually provides the best results. Discussions with stakeholders will help decide what type of participation gives the best result in each situation. Attachment A has more information about the Victorian framework.

It is important that consumers, carers and community members feel their input is valued and that they understand how their contribution can influence the final decision.

For example, consumers need to know whether they are contributing to the development of possible solutions, helping to choose between a set of options, providing their opinions for a research process or simply making minor changes around the edges of a pre-defined approach. Consumers and community members need to understand the constraints of the issue and the limits of their input.

Table 2 (overleaf) is based on Victorian DHS work combined with the International Association of Public Participation thinking to illustrate the various types of participation.

This is one way of thinking about the various engagement types.
Table 2: Participation types, their aims and commitments

This is one way of thinking about the various engagement types.

<table>
<thead>
<tr>
<th>Participation Type</th>
<th>Public engagement goal</th>
<th>We aim to</th>
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</thead>
<tbody>
<tr>
<td>Inform</td>
<td>To provide the public with balanced and objective information to help them understand the problem, alternatives, opportunities and/or solutions</td>
<td>Keep you informed about the things that are important to you</td>
</tr>
<tr>
<td>Consult</td>
<td>To work directly with the public throughout to ensure their concerns and aspirations are understood and considered</td>
<td>Work with you to ensure your concerns and aspirations are directly reflected in the alternatives developed and provide feedback on how public input influenced the decision</td>
</tr>
<tr>
<td>Partnership</td>
<td>To partner with the public in each aspect of the decision including developing alternatives and identifying the preferred solution</td>
<td>Look to you for direct advice and innovation in formulating solutions and incorporate your advice and recommendations into the decisions as far as possible</td>
</tr>
<tr>
<td>Delegation</td>
<td>To give the public control for making decisions within specific guidelines</td>
<td>Authorise you to make decisions in specific situations, which we will then implement</td>
</tr>
<tr>
<td>Control</td>
<td>To place final decision-making in the hands of the public</td>
<td>Implement what you decide</td>
</tr>
</tbody>
</table>
Effective engagement with consumers, carers and community members demands the following:

- Clear values and beliefs that underpin consumer engagement
- Clear purpose of specific engagement activities
- Clear engagement processes. Make sure everyone is aware of these, understands them and has realistic expectations of them
- Doing it skilfully. Training staff, consumers and community members in general principles and processes, and use of people with specialist expertise where necessary
- Being open to everyone learning through the process.

Very good resources are available on the wide range of techniques for different engagement activities. Regardless of which technique(s) are chosen, it is important that staff have the chance to familiarise themselves with the techniques and receive appropriate training.  

DHHS will develop engagement methods that support those who have previously found it difficult to fully participate in consultation processes. Victoria has developed a guide, *Inclusive Consultation and Communication with People With a Disability* (www.dhs.vic.gov.au/ds/communicate), that provides practical help with communication style and the organisation of consultation processes.

The following represents some options for methods and techniques that support consumer and community engagement at the broader level:

- Questionnaires administered by independent bodies
- Focus groups
- Informal/formal interviews (through active outreach or at gathering places)
- Informal interviews in the context of other activities (e.g. meals)
- Activities aimed at overcoming literacy and language difficulties
- Culturally appropriate activities that allow people to participate in informal feedback opportunities where they already gather
- Ongoing reference, working or action groups
- Feedback mechanisms, e.g. postcards, surveys
- Consultation meetings with existing consumer and community groups
- Citizen juries, deliberative councils
- Consumers and community membership of quality or clinical governance committees
- Training consumers and community members to provide orientation sessions for new DHHS staff
- Peer leader training.

DHHS recognises that many consumers of health and human services experience specific disadvantages and often do not engage in more common consultation and participation activities.

These groups include the elderly and the young, Indigenous communities, people from CALD backgrounds, homeless people and people with disabilities. Other barriers to involvement are literacy and access to transport or childcare.

Some groups experience many causes of disadvantage and are, therefore, particularly difficult to reach.

The Queensland Council of Social Service identified homeless people as one such group. Significant barriers to consultation and participation may exist and are influenced by the following:

- Few, if any, prior experiences of encouragement or support to participate
- Mental health, addiction and disability issues (sometimes combined)
- Few dedicated resources for consultation
- Feedback and consultation mechanisms that do not consider access issues, culture and confidence levels
The extent to which staff are encouraging and receptive.

The Victorian Local Government Association has begun research on techniques for councils to access hard-to-reach groups. The report says:

To recognise particular groups as hard to reach is to assume that the consultative approach used should extend beyond standard techniques. It should feature greater consideration of who is targeted for consultation, how they are asked to participate, their potential motivations for participating and any barriers to participation.

Developing new relationships and identifying innovative ways to engage the target group(s) may also be needed, as well as additional effort and resources. Without such efforts, participation may simply reinforce existing patterns of social exclusion and disadvantage.

The report makes some useful comments about the techniques that Victorian councils use to address this gap in their consultation processes.

Their approach fits with a broader emphasis within many consultation strategies on making participation as enjoyable and easy as possible for people, and ‘going to them’ rather than expecting citizens to visit council at a time that is suitable for staff.

On-site consultation methods such as “think tents” or “listening posts” use a similar logic: engaging people at a more relevant place for the issue under discussion and away from council chambers.

New technologies such as email and text messaging have also created easy ways to engage some citizens. Furthermore, ongoing consultative mechanisms such as Nillumbik’s Community Planning ThinkTank and Boroondara’s new Community Voice reference panel provide many citizens with opportunities to be consulted in a manner that suits their circumstances.

Some councils mentioned that adapting information to different needs was central to reaching some groups, particularly those from CALD backgrounds and those with hearing or vision impairment.

Other strategies to reduce participation barriers included using accessible venues and providing childcare and council transport. Incentives such as cash or prizes were used sometimes.

However, the report also noted that practical barriers prevented councils achieving best practice consultation processes in some situations:

Although the above represents an impressive list of strategies for engaging hard to reach groups, the focus groups and surveys also revealed that often councils do not have the time, resources or, in some cases, expertise to consult as well as they would like to do. Effective community consultation around some issues and with particular groups often proves time consuming and is resource-intensive, meaning the practices are sometimes recognised as second best.

The report found the main difficulty was time and resources, and for this reason more traditional, less complex techniques such as surveys and face-to-face meetings remain the key strategies for council consultative processes.

The United Nations’ Convention on the Rights of the Child Article 12 (to which Australia is a signatory) provides a basis in law for the right of children to be consulted in matters that affect them.

This consultation process seeks views on how we might more effectively engage children and young people in discussions about their care and support and in planning.

DHHS will need to balance system capacity with its commitment to inclusion in its consumer and community engagement techniques.
8. Engagement enablers

The best intentions for consumer and community engagement are not realised without a range of support mechanisms.

Many countries have established significant infrastructure to support effective consumer and community engagement. For example, the United Kingdom Department of Health has set up a Patient and Public Empowerment division to support this agenda.

While the term “patient” relates primarily to health services and general practice, the intention is broad, encompassing all health and social care services. As its name suggests, there are two main thrusts to its engagement work. One is the individual level of care and support and the other is public engagement in planning services and developing policy.

The UK’s National Health Service has established a Centre for Involvement to support and encourage patient and public involvement in health and social care decision-making. It aims to give staff and the public the tools to turn patient and public involvement into everyday practice.

The UK also has specific legislation governing the duty of health and social care bodies to involve and consult with patients and the public in service planning and operation, and in the development of proposals for change. This is set out in Section 11 of the Health and Social Care Act 2001.

The Consumer Participation and Information Program of the Quality and Safety Branch of the Victorian DHS funds the Health Issues Centre to provide agreed support for the 19 Victorian Community Advisory Committees, the Consumer Nominee Program, one or two discussion papers a year and staff involvement on DHS advisory committees.

In Tasmania, the peak bodies within the community sector play an important role in representing the views of their members and consumers.

However, there is no peak body that reflects broad consumer and community interests across the health and human services sector.

DHHS will consider the value of such an organisation as part of this consultation process.
9. How consumer and community engagement will work

DHHS, consumers and the community must build a shared commitment to the values that underpin effective consumer engagement. This will involve:

- **Trust** based on productive working relationships and mutual agreement about processes
- **Respect** for each other and our contributions
- **Openness** and willingness to consider the views of others. These will lead to shared ownership of processes and outcomes.

We must ensure:

- **Equal opportunity** to participate – this means engaging at the earliest possible time, ensuring those affected know about process and have access to information that will help them engage
- **Leadership** and **advocacy** from the top
- **Flexibility** in approach so we can **respond** to the needs of different groups
- **A process** for **reporting** how the consumer input influenced decisions
- **Evaluation** of outcomes and communication of the lessons learned.

We need to think about how we will:

- learn new listening skills and ways of responding
- provide training for service providers and consumers, too
- make sure that what is put in place is achievable and sustainable
- work with community sector organisations that are funded by DHHS and what will be expected of them
- consider whether new legislation is necessary to ensure consumer and community engagement remains a priority
- consider whether a non-government organisation (such as a Peak Body) should be set up to represent consumers and the community and to support engagement.
We are interested in what you think about consumer and community engagement and your ideas about how we can best involve you in decisions about our services. In particular we would value your feedback on the following:

• Is consumer and community engagement important?

• What do you think are the benefits of consumer and community engagement in decisions about health and human services?

• What principles do you think should underpin engagement?

• Does our approach to engagement make sense for Tasmania?

• What do you think needs to be in place for consumer and community engagement to work?

Please email your comments and ideas to susan.stipcevic-webb@dhhs.tas.gov.au or post to: 

Susan Stipcevic-Webb
Consumer and Community Engagement Manager
PO Box 125
Hobart, Tasmania 7001

If posting, please include your address if you wish us to acknowledge receipt of your contribution or if you wish us to keep you informed on consumer and community engagement.

Please provide your feedback by Tuesday 12 May 2009.

Once DHHS receives your response it will develop a draft consumer and community engagement strategy that will go to a project reference group for consideration. This reference group will help DHHS develop the strategy by providing advice and expertise.

The group includes representatives from peak bodies that advocate for consumer and community interests in Tasmania as well as local government, community representatives from Tasmania’s Health Plan regional forums and DHHS staff.

DHHS will then circulate the draft strategy for public comment in June 2009. Comments from this stage will inform the final consumer and community engagement strategy, which will go to the State Government in August 2009.
### Attachment A: Victorian DHS engagement types and tools

<table>
<thead>
<tr>
<th>Participation type</th>
<th>Objective</th>
<th>Key tools</th>
<th>Make sure</th>
</tr>
</thead>
</table>
| **Information**    | • To support participation  
                    • To convey facts  
                    • To educate | • Public information campaigns  
                    • Individual treatment or support session | • There is a distribution strategy with target consumers, carers or community  
                    • Try hard to use common words and pictures for medical and technical works  
                    • Train and educate staff in person-centred communication |
| **Consultation**   | • To gauge reaction to a proposal/care plan/treatment plan and invite feedback  
                    • Consultation is only engagement when information gathered can influence subsequent policy, care and treatment choices | • Key contacts  
                    • Surveys  
                    • Interest group meetings, focus groups  
                    • Public meetings  
                    • Discussion papers  
                    • Public hearings  
                    • Consumer and carer family or advocate meetings  
                    • Health and social care consultations | • Let all stakeholders know how their input will be used and the outcomes of their participation  
                    • If input has not been used, let stakeholders know why  
                    • When clinical decisions have been made quickly, explain why and how as soon as possible  
                    • Educate staff in person-centred communication skills |
| **Partnership**    | • To engage consumers, carers and community representatives in aspects of government or health and human services organisational decision-making  
                    • To involve consumers, carers and representatives in care, support or treatment decision-making | • Advisory boards  
                    • Community advisory committees  
                    • Policy community forum  
                    • Shared decision making  
                    • Community development  
                    • Person-centred care | • Talk with stakeholders and decide if you should have members, representatives or nominees  
                    • Consider having a balance between community organisations and individuals  
                    • Can you use a variety of partnership opportunities to achieve your aim?  
                    • Alternate meetings to suit the range of stakeholder needs  
                    • Educate and train staff in shared decision-making and person-centred care |
## Attachment A: Victorian DHS engagement types and tools (continued)

<table>
<thead>
<tr>
<th>Participation type</th>
<th>Objective</th>
<th>Key tools</th>
<th>Make sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delegation</td>
<td>• To hand control to a board of community representatives within a specified framework</td>
<td>• Public enquiries</td>
<td>• Hold briefing sessions for new members to meet and learn the systems</td>
</tr>
<tr>
<td></td>
<td>• To ensure policy options are formulated at arms length from party politics</td>
<td>• Impact assessment studies</td>
<td>• For people from a diverse range of backgrounds to feel confident to participate, have a long term training and mentor program in place</td>
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<td>• Health and human services boards</td>
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<td>• Ethics committees</td>
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<td></td>
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<td>• Quality and safety committees</td>
<td></td>
</tr>
<tr>
<td>Control</td>
<td>• To hand control of an issue to the electorate</td>
<td>• Referenda</td>
<td>• Develop budgets but leave time for planning</td>
</tr>
<tr>
<td></td>
<td>• To hand control of care, support or treatment decisions to the consumer</td>
<td>• Community elected Boards of Management</td>
<td>• Provide a wide range of information on the issue to the public</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Advance care planning</td>
<td>• Regularly advertise the processes to check for advance care plans and for staff to respect consumer choices</td>
</tr>
</tbody>
</table>
Attachment B: Health Canada glossary of terms

Citizen - an individual who is neither a delegate nor a representative of any government, organisation, association or interest group.

Citizen engagement - the techniques that facilitate an informed dialogue among citizens and government officials, elected and/or non-elected, and encourage participants to share ideas or options and undertake collaborative decision-making, sometimes as partners.

Communications - the techniques that inform the public about policies, programs and services.

Consultations - the techniques involving a two-way flow of information that offer options for consideration and encourage feedback, such as additional ideas or options from the public.

Continuum of public involvement - the full range of public involvement in issues of public concern. This document refers to five levels of public involvement and pinpoints an array of public involvement techniques along a continuum. Communications techniques are at the “low end”, consultation is in the “mid range” and citizen engagement is at the “high end” of the public involvement continuum.

Governance - the set of processes and traditions that determine how a society steers itself, how citizens are accorded a voice on issues of public concern and how decisions are made on these issues.

Involvement - the level of participation by the public, or the extent to which the public is actively involved in understanding, assessing or resolving issues of public concern.

Partner - an individual, group or organisation that participates in, or is responsible for sharing responsibility for the implementation of various aspects of policy or program decisions.

Public - individuals, consumers, citizens, special interest groups and/or stakeholders.

Public involvement techniques - a broad range of strategies and methods used to inform citizens and/or accord them a voice on issues of public concern and/or include citizens in decision-making processes relating to these issues.

Social cohesion - refers to building shared values, reducing disparities in wealth and income and enabling people to have a sense of engagement in a common enterprise and face shared challenges as members of the same community.

Stakeholder - an individual, group or organisation having a stake in an issue and its outcome (e.g. specific matters around health, environment, consumers, volunteers, industry, science).

Sustainable community development - communities empower themselves to achieve a hopeful and common future vision. Effectively responds to change through community-based decision-making, economic self-reliance and environmental sustainability.

Public - individuals, consumers, citizens, special interest groups and/or stakeholders.

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Endnotes

1: If you would like a better understanding of DHHS activities please visit our website at www.dhhs.tas.gov.au


7: Victoria, Department of Human Services. Doing it with us not for us: Strategic Direction. 2006.


11: See for example Neighbourhood Renewal project undertaken by the Victorian Department of Human Services, www.neighbourhoodrenewal.vic.gov.au. Here community members have been heavily involved in renewal initiatives deliberating about diverse social factors impinging on their neighbourhoods and this has contributed significantly to both community need personal outcomes. See also Stoke-on-Trent Carers Strategy developed through extensive carer and community involvement and resulted in carers having a direct impact on the priorities adopted in the strategy, www.stoke.gov.uk/ccm/navigation/social-care/adult-social-care/carer-support-and-assessments/carer-s-strategy/carers-strategy-document/


15: Victorian Government Department of Human Services, Doing it with us not for us: Strategic Direction 2006.


18: Queensland Council of Social Service DRAFT 1: Consultation and Participation Practice: Engaging with Homeless People in Queensland May 2006 S.


