

Implementation guidelines for
**Public Mental Health Services
and Private Hospitals**

2010

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The revision of the National Standards for Mental Health services and the development of the corresponding Implementation Guidelines were funded by the Australian Government.

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2010

Contents

This implementation guide for public mental health services and private hospitals accompanies the ten National Standards for Mental Health Services:

Standard 1. Rights and responsibilities

Standard 2. Safety

Standard 3. Consumer and carer participation

Standard 4. Diversity responsiveness

Standard 5. Promotion and prevention

Standard 6. Consumers

Standard 7. Carers

Standard 8. Governance, leadership and management

Standard 9. Integration

Standard 10. Delivery of care

10.1 Supporting recovery

10.2 Access

10.3 Entry

10.4 Assessment and review

10.5 Treatment and support

10.6 Exit and re-entry

The guide provides more detail about the implementation of the ten National Standards and how they apply to your service. It is one of three guideline documents developed by and for different sector groups. The other two are for:

- community (non-government) organisations
- private office based mental health services.

The guidelines were developed with input and recommendations from:

- the alcohol, tobacco and other drugs (ATOD) sector
- Aboriginal and Torres Strait Islander people
- culturally and linguistically diverse (CALD) community sector
- mental health consumers and carers.

The recommendations from these groups have been incorporated into each of the three implementation guidelines.

An electronic copy of the implementation guidelines, as well as the National Standards for Mental Health Services, can be downloaded from the Mental Health Standing Committee website:

➤ <http://www.health.gov.au/mhsc>

GUIDELINES AND SUGGESTED EVIDENCE FOR PUBLIC MENTAL HEALTH SERVICES AND PRIVATE HOSPITALS

The National Standards for Mental Health Services (the National Standards) and the supporting guidelines aim to continually improve the quality of mental health care for all Australians. They are underpinned by a recognised need to respond to the growing cultural and social diversity in the Australian community, including the needs of Aboriginal and Torres Strait Islander people. This diversity is reflected in mental health consumers and carers, as well as among professionals working in mental health services.

The National Standards and guidelines recognise that every interaction between consumers, carers, communities and service providers in the mental health care environment is influenced by a complex matrix of beliefs, values and attitudes towards health, illness and recovery.

Many of the criteria of the National Standards have similar themes or key issues. These are detailed in the cross-referencing table found at the back of this document.

Standard 1.

Rights and responsibilities

The rights and responsibilities of people affected by mental health problems and / or mental illness are upheld by the mental health service (MHS) and are documented, prominently displayed, applied and promoted throughout all phases of care.

GUIDELINES

The intent of this standard is to ensure that consumers, carers and any other people affected by mental health problems are provided with information that will assist them to understand and exercise their rights and responsibilities while accessing mental health services (MHS).

Dignity and respect (Criterion 1.1)

All consumers have the right to treatment that respects their dignity and privacy. When consumers are placed in an environment where privacy is compromised because of essential treatment, then the MHS should have processes to ensure that they are treated respectfully and that full privacy is established as soon as practicable. Private waiting space and private rooms for assessments and consultations should be available.

Legislation (Criterion 1.2)

The MHS should have access to legislation, acts and guidelines related to their service. There are many sources for this information. Current information on relevant legislation, acts and guidelines, such as an extract from the Privacy Act or fact sheets are available from:

➤ <http://www.privacy.gov.au>

Information provided includes:

- national privacy legislation
- consumer information My health my privacy my choice
- information sheet on the Privacy Act
- guidelines on health privacy
- guidelines on research privacy.

Links to privacy legislation in all states and territories and international human rights instruments can also be found at

➤ <http://www.privacy.gov.au>

There should always be evidence of a process to incorporate and monitor compliance with legislation and guidelines.

Informed consent (Criterion 1.3)

Informed consent should always be obtained before any treatment and documented in the person's health record. When treating involuntary consumers, the MHS should involve their carers.

There needs to be clear policies about consent relevant to the age of consumers of the service. Custody and issues of legal guardianship should be addressed in policies.

Under some circumstances consumers may be subject to the provisions of mental health legislation, or have a legal guardian authorised to make a decision on their behalf. Services provided must be consistent with the relevant Commonwealth, state or territory mental health legislation and related Acts.

Rights and responsibilities information (Criteria 1.4, 1.5, 1.6, 1.7)

Current information on rights and responsibilities should be provided to consumers and carers as soon as possible after entering the MHS, or as soon as the consumer's mental state allows for comprehension of the information. It should then be provided at regular intervals throughout their care. This should be documented in the health record.

Rights and responsibilities information should be provided in an age and culturally appropriate way, in languages relevant and appropriate to the defined community. It should be presented in a variety of media, stating the different rights and responsibilities of the consumer, the carers and the MHS. Young people, such as consumers in child and adolescent area mental health services (CAMHS), should have their rights and responsibilities explained to them, as well as to their parent or guardian.

The involuntary consumer should be advised of their rights and responsibilities and provided with the relevant documents soon after admission to the service and at regular intervals after that until they are well enough to understand those rights and responsibilities. Involuntary consumers should be given the same opportunities to ask questions as voluntary consumers.

Copies of the *Mental health: statement of rights and responsibilities* (1991) is available at

➤ www.health.gov.au

and links to the human rights standards that Australia has agreed to uphold are available at

➤ <http://www.hreoc.gov.au>.

Written current information on rights and responsibilities for consumers and carers should include details of:

- the National Standards for Mental Health Services
- how to access an independent advocate, cultural informant or support person, such as a peer support worker or a consumer/carer consultant
- how to obtain an independent second opinion
- complaints procedures including contact details for independent bodies
- the responsibility of consumers and carers to treat staff and volunteers of the MHS with respect
- how staff of the MHS respect the rights of consumers and carers
- the responsibility of the consumer to disclose relevant information about themselves that may affect treatment.

Rights and responsibilities should be made known to staff and volunteers, be provided at orientation and be prominently displayed in every facility of the MHS. They should be available on the MHS website and via email, fax or post on request. This could include posters or brochures and fact sheets that can be downloaded from the internet.

The MHS should use videos, sound bites and guides for family members or cultural informants in multiple formats so that information is accessible to people with different levels of literacy.

The MHS can help a consumer understand and be understood by offering the following:

- the use of interpreters
- opportunities to ask questions
- the use of consumer advocates
- involvement of important family members or supporters in the discussion of rights and responsibilities.

Evidence should be included in the health record that rights and responsibilities were discussed verbally with the consumer and carers where appropriate.

Privacy and confidentiality (Criteria 1.8, 1.9)

The consumer's right to privacy and personal space should be considered in the layout and design of accommodation in inpatient facilities, private consulting and therapy rooms. This includes adequate space for visitors.

The MHS should provide the least restrictive environment possible for individual consumers. This should enable effective treatment to occur, while ensuring the safety and protection of other consumers, staff, visitors and members of the public.

When deciding on the least restrictive and safest environment the following factors should be taken into consideration:

- cultural factors such as the relationship to the living environment
- views
- outside areas
- non air-conditioned areas
- access to family and places for them to stay in inpatient units.

Confidentiality of personal information should be in accordance with Commonwealth, state or territory legislation and staff should be made aware of policies and procedures in regard to this.

Examples of where the consumer's right to privacy and confidentiality is evident include:

- provision of private waiting space
- availability of private rooms for assessments and consultations
- lockable cupboards for personal possessions
- staff discretion when discussing consumers
- use of accredited interpreters
- anonymity in providing feedback and suggestions to the MHS.

Involvement in care (Criteria 1.10, 1.11, 1.12)

The MHS should offer the opportunity to all those affected by mental illness to learn about mental illness by providing access to relevant information and support. Any information for consumers and carers should be reviewed regularly and updated at least every 24 months, with links to current legislation and covenants. Further information can be found in Standard 6 Promotion and prevention.

The consumer should be involved in their treatment, care and recovery planning and provided with information about their illness.

Although the MHS needs to respect confidentiality this does not preclude carers being involved in discussions concerning the consumer's treatment, care and recovery plan unless the consumer has refused or withdrawn consent. In this case general discussions may take place.

While the consumer has a right to have others involved in their care, it is important that the consumer also has the right to refuse the involvement of other staff or service providers nominated by the MHS providing this refusal does not impose a risk to the consumer or other staff or service providers.

The MHS should consider family and community relationships and the need for more than one person to be involved when nominating a consumer's representative. Services should develop a list of important people in the consumer's life and show evidence of consulting appropriately with these people.

Access to records (Criteria 1.13, 1.14)

Access by consumers to their own records should be in accordance to Commonwealth and state or territory legislation. Legislative exclusions to the right of access should be appropriately applied.

Policy and procedures about use, disclosure and handling of personal and health related information should address any issues that may be relevant to the mental health service.

Advocacy (Criterion 1.15)

Posters and brochures providing information on how to access advocacy services should be prominent in the MHS. Advocacy may include legal, housing, work, benefits, welfare and family services advocacy.

The service should document evidence of access to advocacy and support services in the individual consumer health record.

The MHS should provide ongoing training to staff and consumer advocates about the applicability of privacy and confidentiality legislation to their service, to enable them to answer questions from consumers and carers about legislation.

Consumer feedback (Criterion 1.16)

Posters and brochures providing information on complaint and grievance procedures should be prominently displayed in every facility of the MHS. This information should be available on the MHS website and via email, fax or post on request. This information should include contact details of the relevant state or territory Health Care Complaints Commission.

SUGGESTED EVIDENCE

Evidence that may be provided for this standard includes:

- rights and responsibilities brochure
- Privacy Commission fact sheets
- staff training module on rights and responsibilities, privacy and confidentiality
- posters or brochures on privacy

- translation of documents provided to consumers
- availability of copies of the National Standards for Mental Health Services
- health records review
- visual evidence of private consulting rooms
- developed standards and audit tools for culturally informed design of buildings and standards for culturally informed design and operation of inpatient units
- developed measure of true family involvement which may include extended family and supporters
- quantitative and qualitative methods to obtain consumer and carer satisfaction:
 - patient surveys
 - focus groups
- policies and procedures:
 - management of health information
 - use of interpreters
 - consumer advocacy
 - voluntary and involuntary consumers
 - consent process
 - privacy and confidentiality
 - complaints and grievances
 - cultural assessment
 - compliance with legislation.

Standard 2.

Safety

The activities and environment of the MHS are safe for consumers, carers, families, visitors, staff and its community.

GUIDELINES

The intent of this Standard is to ensure that mental health services (MHS) provide a safe environment for consumers, carers, visitors and staff. This can be achieved by identification, analysis, treatment or correction, monitoring and review of risks to safety.

Promoting safety (Criterion 2.1)

The MHS must ensure the safety and wellbeing of its consumers, carers, staff and others.

Cultural beliefs form an important aspect of the consumer's understanding and response to health care. Protection of the consumer's cultural needs should be taken into consideration when reviewing safety issues. Culturally inappropriate care may result in misunderstandings, placing the consumer at risk and adversely affecting the consumer's mental health and recovery. Further requirements of culture and diversity are addressed in Standard 4 Diversity responsiveness.

Culturally safe environments are those in which:

- a consumer feels safe
- the consumer's mental health and overall health needs are understood
- the consumer's culture is viewed as an essential component of the care
- the consumer feels empowered to make decisions on their care and recovery.

Mental health services need to address the *National Safety Priorities in Mental Health: a national plan for reducing harm* (2005) and ensure that staff has access to, and comply with, relevant legislation addressing safety and the organisation's safety policies and procedures.

National safety priorities (Criteria 2.2, 2.3, 2.4, 2.5)

Criteria 2.3, 2.4, 2.5 and 2.6 should be implemented in line with the *National Safety Priorities in Mental Health: a national plan for reducing harm* (2005) and an analysis of risks specific to the individual MHS.

In most Child and Adolescent Mental Health Services (CAMHS) restraint and seclusion is not used; however, there should be documented processes on the 'firm holding technique', 'time out' or equivalent strategies.

The MHS should consider the role of family members or other cultural supporters in accompanying the consumer to promote safety and dignity especially on long journeys from rural and remote areas.

Legislation, regulations and guidelines (Criteria 2.6, 2.7)

Examples of relevant safety legislation, regulations and guidelines include:

- the Australian Health Ministers' *Mental health: statement of rights and responsibilities* (1991)
- national, state and territory working group guidelines on quality and safety
- state and territory occupational health and safety legislation
- state and territory mental health legislation and related Acts.

Information on infection control should be available to staff, consumers and visitors and the MHS should adhere to infection control standards.

The MHS must have policy and procedures to ensure the safety of all people in the service setting, particularly those who are vulnerable. The MHS must be in an appropriately designed facility that ensures the physical environment is appropriate to deliver and facilitate safe and effective care.

Policies and procedures to address safety issues for consumers, carers and staff include:

- consumer identification for appropriate delivery of care
- medication and adverse medication event management
- clinical handover and transfer of care
- seclusion and restraint
- minimisation of the risk of self harm and suicide
- safe transportation of consumers (including extended periods and air transport)
- falls prevention and skin risk assessments

- risk identification and management
- access to mobile phones, pagers, personal security alarms to staff to expedite communication during critical incidents
- security measures
- granting of leave
- infection control.

The MHS should have procedures to assist staff, consumers, their carers and other visitors when they have been exposed to a traumatic incident within the service.

Staff safety (Criteria 2.8, 2.9, 2.10)

The MHS should employ sufficient staff to ensure their safety and the safety of consumers, carers and others. If staff are required to work alone, the MHS should have written protocols that address any issues identified in a risk assessment.

The risk assessment of staff working conditions could include issues of:

- staff working alone and having access to others at all times
- personal security on and off site
- violence and aggression
- lifting and manual handling
- exposure to hazardous substances
- security of medications and other stores
- evacuation in the event of a fire or other danger
- adverse event or incident management.

Staff should be trained in workplace health and safety in accordance with relevant legislation and should participate in comprehensive, updated and revised training in the use of strategies to identify, prevent or de-escalate agitation, aggression and interpersonal violence.

The MHS should have a formal critical incident/emergency response plan to ensure the safety and security of staff and others within the MHS at any given time.

Assessment (Criterion 2.11)

The MHS should undertake regular assessments of the environment and address any issues to minimise the risk of harm including sexual abuse, self-harm and other interpersonal violence.

There should be a regular risk assessment of consumers to ensure their correct health status. This should be done in a timely manner to minimise the risk of harm to themselves and others. Consumers are at greatest risk in times of transition between settings or transfer of care. The service should carry out a risk assessment before the consumers' discharge or exit and at any significant points of transition.

In some cases risk assessment should be conducted on the carer, such as when the carer is a child or aged person or when the consumer is discharged or leaving the service.

Joint risk assessments between the MHS, non-government organisations, local communities and primary health services or Aboriginal and Torres Strait Islander medical services are often appropriate when responsibility for care is being transferred or jointly managed.

Review and analysis of risks (Criteria 2.12, 2.13)

There should be regular organisational reviews of safety within the MHS leading to a set of recommendations. Safety recommendations should be implemented and revised as part of a continuous review process. An oversight committee, such as a clinical governance committee, should review safety issues.

Services should have evidence of analysis of all critical incidents including suicide, self-harm, interpersonal violence (between consumers, carers, others and service providers) and adverse drug events. Analysis includes a health record review and an evaluation of the processes.

SUGGESTED EVIDENCE

Evidence that may be provided for this standard includes:

- staff training records
- risk management reports
- medication management and notification of adverse drug reactions
- evidence of analysis of critical events:
 - collated data and trends
 - individual cases
- recommendations from safety reviews
- evidence of action on recommendations
- infection control manuals
- visual evidence of a safe environment
- policies and procedures:
 - workplace health and safety
 - use of restraint and seclusion
 - minimisation of self-harm and suicide
 - safe transport
 - risk management
 - aggression and violence
 - infection control
 - staffing and resource management
 - staff safety
 - collection and storage of consumer belongings
- joint risk assessment between MHS and other agencies
- involvement of family and community in addressing risks
- evidence of safety considerations throughout the continuum of care.

Standard 3.

Consumer and carer participation

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

GUIDELINES

The intent of this Standard is to ensure that mental health services (MHS) engage in ongoing consultation with consumers, carers and others in its community regarding the planning, delivery, development, monitoring and evaluation of services. The MHS should ensure that support and training is given where appropriate.

Participation (Criteria 3.1, 3.2)

The MHS needs to use methods appropriate to their individual service to engage and support consumers and carers in all areas of service planning, delivery, evaluation and quality assurance activities.

Consumer and carer participation needs to reflect the cultural and social diversity of the community within which the MHS operates.

Examples of appropriate methods include:

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

Support and training (Criterion 3.3)

Consumers and carers who are involved with mental health services must have access to training and support.

Consumer and carer participation and representation in training must reflect the ethnic and racial diversity of the population served. Initiatives to ensure this occurs could include practical assistance for Aboriginal and Torres Strait Islander and culturally and linguistically diverse (CALD) consumers and carers. This could include such things as transport to meetings, payment for attendance or training sessions in rural or remote communities.

Advocacy (Criteria 3.4, 3.5)

Services should provide information on how to access advocacy services. This can be included in the rights and responsibilities document, and may include a list of organisations such as:

- The Mental Health Carers ARAFMI Australia
➤ <http://www.arafmiaustralia.asn.au>
- Children of Parents with a Mental Illness (COPMI)
➤ <http://www.copmi.net.au>
- Commonwealth Carer Resource Centre 1800 242 636 (free call).

It is essential that advocates provide culturally appropriate information and support. To ensure Aboriginal and Torres Strait Islander people and CALD perspectives are heard, MHS could hold regular forums in different locations in the community to obtain viewpoints of those from the non-dominant culture.

Where an MHS employs consumers and carers as advocates, issues of accountability to management and other consumers should be made clear.

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

Employment of consumers and carers (Criterion 3.6)

Consumers and carers can be employed in an MHS to fill roles such as consumer or carer consultants on projects, consumer or carer liaison in agencies and to conduct research.

Consumer or carer staff members should be well informed about the processes in place to protect, advise and support them. Where consumers and carers are employed the MHS should provide mentoring and supervision and ensure access to training and support as required.

Supervision and mentoring should ideally be provided in a culturally safe environment.

Documentation of participation (Criterion 3.7)

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

- the process of choosing consumers, carers and other representatives
- payment (direct or 'in kind') and reimbursement for expenses, in accordance with the consumer's preference
- ongoing skills development, such as training in peer support, advocacy, consulting, staff selection, computer skills and financial management to maximise participation on committees
- training to recognise the value of the consumer or carer's contribution
- equipment, space and budget requirements
- identifying whether consumers want collective or separate representation
- consultation with representatives of the community as required.

SUGGESTED EVIDENCE

Evidence that may be provided for this standard includes:

- evidence of service participation activities, such as plans, meeting minutes, reimbursements
- evidence on demographics of consumers and carer participation including age, gender, and ethnicity
- policies and procedures such as:
 - consumer and carer participation, including training and support
 - advocacy, including training and support, mentoring and supervision
 - representation on committees
 - terms of reference of consumer carer committees or a position description for consumer and carer consultants.

Standard 4.

Diversity responsiveness

The MHS delivers services that take into account the cultural and social diversity of its consumers and meets their needs and those of their carers and community throughout all phases of care.

GUIDELINES

The intent of this Standard is to ensure that mental health services (MHS) are culturally responsive and appropriate for the culturally and linguistically diverse population in their defined community.

Cultural competence refers to processes and practices that facilitate inclusiveness and address the inequities in health care for people from CALD backgrounds. Services that recognise and respond to the multiple levels of diversity within their community will develop cultural competence.

Cultural competence involves learning about diversity and its impact on the way services are accessed, delivered, received and promoted. This should be incorporated in all aspects of policy making, administration, practice and service delivery. It should systematically involve CALD consumers, carers, key stakeholders and communities in the planning, delivery and evaluation of services.

Aboriginal and Torres Strait Islander cultural competency refers to the ability to understand and value Aboriginal and Torres Strait Islander people's perspectives and provides the basis on which all Australians can engage positively in a spirit of mutual respect and reconciliation. MHS should recognise the right to self determination and form meaningful partnerships based on cultural respect and culturally responsive and safe practice.

The MHS should be aware of the definition:

Aboriginal health is not just the physical well being of an individual but is the social, emotional and cultural well being of the whole community in which each individual is able to achieve their full potential thereby bringing about the total well being of their community. It is a whole-of-life view and includes the cyclical concept of life-death-life. (National Aboriginal Community Controlled Health Organisation (NACCHO), 1996)

Further information on cultural safety is available in the guidelines for Standard 2 Safety.

Identification (Criterion 4.1)

The MHS should identify the diverse groups within its catchment area and their patterns of use and under-use of services. This information should be used to plan and develop culturally competent services and strategies to improve access to the service.

The MHS should provide evidence that it uses methods such as:

- analysis of census data and relevant research on CALD mental health issues
- collaborations with CALD groups and relevant community organisations
- open public forums in partnership with relevant CALD stakeholders
- collaboration with expert individuals and organisations such as the Transcultural Mental Health and Refugee Centres and networks to gain knowledge on the diversity in its community
- collaboration with community health and welfare organisations and services to develop local protocols for Aboriginal and Torres Strait Islander people
- develop relationships with local Aboriginal and Torres Strait Islander elders and peak groups.

Response to needs (Criterion 4.2)

The MHS should have documented evidence to show:

- consultations and partnerships with local CALD services
- the provision of training to all staff, including management, on the diversity of needs within its catchment and on culturally competent service delivery
- how the service's committees and working groups consult with, and represent, CALD groups
- how the service's relevant committees and working groups consult with and represent Aboriginal and Torres Strait Islander communities
- how complaints, dispute and grievance resolution procedures address diversity factors
- how the service engages with CALD community organisations and experts in transcultural mental health
- how and when the MHS engages interpreters.

Policies, procedures and work practices that recognise, and are responsive to, the needs of the MHS community include:

- identifying the social and cultural customs and values of Aboriginal and Torres Strait Islander people in the community
- identifying the social and cultural customs and values of people from culturally and linguistically diverse backgrounds in the community
- addressing issues of gender and sexual orientation

- addressing issues of age and differences in socio-economic status
- recognising physical or intellectual disabilities
- identifying the religious customs and spiritual values of people in the community.

The MHS should have documented evidence on:

- how staff access and distribute multilingual resources to consumers, carers and others on rights and responsibilities and relevant mental health topics
- how the service assessment and treatment processes are inclusive of consumers and carer's cultural and linguistic needs
- community-informed data for Aboriginal and Torres Strait Islander people.

Socioeconomic and cultural data must be in a useable form. All data should be available to staff and the community through orientation programs, cultural awareness training and ongoing updates.

Planning (Criterion 4.3)

The MHS needs to use methods that are appropriate to their individual service to engage the CALD groups and the Aboriginal and Torres Strait Islander community in all areas of service planning, delivery, evaluation and quality assurance activities. This should be part of its strategic and business plans.

All policy and development proposals need to consider the impact on Aboriginal and Torres Strait Islander and CALD communities.

Other service providers (Criterion 4.4)

The MHS needs to demonstrate that it has policies and procedures that allow access to professional services—such as interpreters, Aboriginal and Torres Strait Islander health workers, cultural consultants and transcultural mental health services and networks. It needs to demonstrate how this information has been communicated to staff, consumers and carers.

The MHS needs to show how and when it will engage interpreters or bilingual workers to facilitate culturally appropriate assessment, diagnosis and treatment. The use of interpreters or bilingual workers needs to be coordinated in consultation with the consumer and carer to ensure it is culturally sensitive.

The consumers' health record should include details of the use of liaison staff or other related service providers.

The MHS should develop appropriate partnerships with other service providers, organisations and programs with diversity experience as part of its commitment to self determination for Aboriginal and Torres Strait Islander people.

Staff (Criteria 4.5, 4.6)

The MHS needs to demonstrate that staff are skilled in accessing information about socio-cultural, linguistic and historical factors relevant to the mental health of people from CALD backgrounds, particularly those who have had traumatic or refugee experiences.

The MHS needs to demonstrate that staff can access cultural competency training in mental health, and provide statistics on the percentage of staff who annually attend this training.

The MHS, where available and appropriate, should integrate the use of culturally and linguistically diverse and Aboriginal and Torres Strait Islander liaison staff into service delivery.

The MHS should appoint cultural guides appropriate to their communities and who are accessible to all staff members.

SUGGESTED EVIDENCE

Evidence that may be provided for this standard includes:

- analysis of census data
- cultural appropriateness of services and clinical instruments
- evidence of use of interpreters
- translated documents
- evidence of percentage of staff who have completed cultural competency training in mental health
- analysis of the cultural and linguistic backgrounds of consumers and carers of the MHS
- evidence of seeking cultural input from cultural informants, bilingual workers or relevant others
- evidence of use of related service providers
- policies and procedures covering:
 - working with Aboriginal and Torres Strait Islander consumers and carers
 - working with CALD consumers and carers
 - use of interpreters
 - special needs groups
 - staff training
 - disputes and grievances

- dissemination of cultural information
- representation on committees
- evidence of implementation and regular review of policies and procedures
- evidence of partnerships with the Aboriginal and Torres Strait Islander community
- service level agreements with other providers such as Aboriginal and Torres Strait Islander medical services, divisions of general practice or Royal Flying Doctor Service
- development of measures for cultural competency of staff
- external monitoring of non-discriminatory practice by carers and consumers and Aboriginal and Torres Strait Islander community groups.

Standard 5.

Promotion and prevention

The MHS works in partnership with its community to promote mental health and address prevention of mental health problems and / or mental illness.

GUIDELINES

The intent of this Standard is to ensure that mental health services (MHS) develop appropriate and effective activities for promotion of mental health and prevention of mental health problems and / or mental illness.

This standard should be read in conjunction with Standard 8 Governance, leadership and management.

Development of activities (Criterion 5.1)

Promotion and prevention activities will be influenced by the size, scope of services provided and the sector in which the MHS operates. This includes the public and private sectors and non-government organisations.

The MHS should link their promotion and prevention strategies to the early intervention of mental health problems and mental illness in accordance with the key directions of the National Mental Health Promotion, Prevention and Early Intervention Action Plan.

It is important to understand the needs of our culturally and socially diverse population. Any mental health promotion and prevention initiatives need to be designed for culturally and socially diverse population groups.

Strategies for Aboriginal and Torres Strait Islander populations should be informed by the *National Strategic Framework for Aboriginal and Torres Strait Islander Health (2003–2013)* and based on established partnerships with Aboriginal and Torres Strait Islander stakeholders.

Appropriate activities (Criterion 5.2)

The MHS should consider the following steps when addressing this standard:

- establish and maintain partnerships with carers, consumers and relevant stakeholders, to share and combine resources
- establish and maintain mechanisms for consumer and carers to participate in the development, implementation and evaluation of promotion and prevention activities
- identify problems to be addressed based on evidence about the groups in the community, for example population health data
- identify the factors that will determine priorities for action
- ensure that planning is informed by appropriate Commonwealth, state and territory mental health legislation, as well as current national and state or territory mental health promotion, prevention and early intervention plans
- develop a plan that includes goals, objectives, actions and evaluation strategies.
- develop timelines that include start and end dates for all stages, activities and tasks.
- develop a plan for the organisation of tasks that cover the responsibilities of stakeholder organisations and individual staff
- evaluate what elements of the activities worked, what elements were less successful, who participated in the activities, whether the activities reached the intended groups and whether the goals and objectives were achieved
- prepare and disseminate reports on the activities.

This information has been adapted from the report for the Department of Human Services and VicHealth, *Evidence-based mental health promotion resource* (Keleher, H and Armstrong, R 2005).

Within Aboriginal and Torres Strait Islander populations and settings, relevant community, consumer and organisation stakeholders must be included in the developing implementation plans. These must be responsive to Aboriginal and Torres Strait Islander diversity and reflect a local, strengths-based approach, with culturally adapted training for early identification and resources and support for primary care and first contact providers.

Collaborative partnerships (Criterion 5.3)

Collaborative partnerships should be developed with a range of internal and external stakeholders. These partnerships mean resources can be shared to promote and prevent mental health issues.

Each service must demonstrate partnerships which foster promotion and prevention activities and show collaboration at all stages of development and and implementation.

Examples of sectors and settings include:

- drug and alcohol services
- the youth sector
- housing
- employers
- Centrelink
- aged-care services
- health promotion and public health services
- local government
- community services
- churches and religious groups
- schools
- the tertiary education sector
- Aboriginal and Torres Strait Islander groups
- divisions of general practice
- multicultural groups
- early childhood services
- maternal and baby health services
- media
- councils.

Examples of partnerships across a range of sectors and settings include:

- membership and participation in inter-sectoral consultative and reference groups
- project advisory groups
- memorandums of understanding (MOUs) demonstrating shared funding agreements
- MHS representation on external committees and boards involved in promotion and prevention activities.

The MHS should have links to programs aimed at preventing the development of co-morbid illness and maintaining good health in consumers, carers and staff.

Strategies to promote awareness of the relationship between mental and physical health should be culturally appropriate and include:

- depression and anxiety awareness programs
- early psychosis awareness programs
- parent and family education programs
- stress management programs
- mental health education in the workplace
- mental health education in schools
- quit smoking programs
- alcohol, tobacco and other drug services or programs
- leisure skills programs
- programs that promote social inclusion and healthy lifestyles, such as links with sporting and recreation clubs
- fact sheets, either electronic or print based, for consumers, carers and other service providers, on topics such as exercise and mental health, mental health and heart disease or sleep and mental health
- joint community education programs, such as with MHS and general practitioners
- local action groups.

Coordination of partnerships (Criterion 5.4)

The MHS should be able to demonstrate partnerships for promotion and prevention activities through:

- documented roles and responsibilities of organisations and individuals involved in the partnerships
- minutes of meetings
- terms of reference
- a plan that identifies goals, objectives, actions and evaluation strategies.

Accountability (Criterion 5.5)

The MHS should ensure that the positions identified to progress mental health promotion and prevention in Aboriginal and Torres Strait Islander settings are given sufficient information about, and links to, Aboriginal and Torres Strait Islander populations.

Workforce (Criterion 5.6)

Workforce development on mental health promotion and prevention includes:

- training programs
- networking forums and planning workshops
- attendance and presentations at conferences
- mentoring and supervision
- access to online clearing houses, journals, practical resources and training programs
- access to experts for advice
- attention to needs of Indigenous people, families and communities, and mechanisms for consultation with Indigenous stakeholders.

SUGGESTED EVIDENCE

Evidence that may be provided for this standard includes:

- partnerships with relevant sectors or settings
- promotional packages
- meeting minutes
- identification of positions responsible for promotion and prevention
- workforce development
- evidence of promotion and prevention strategies and plans
- policies and procedures covering:
 - promotion and prevention
 - workforce training programs
 - mentoring and supervision.

Standard 6.

Consumers

Consumers have the right to comprehensive and integrated mental health care that meets their individual needs and achieves the best possible outcome in terms of their recovery.

NOTE: The consumer standard is not assessable, as it contains criteria that are all assessable within the other standards.

GUIDELINES

The consumer standard is not assessable, as it contains criteria that can be assessed within the other standards. These criteria are gathered under one standard to ensure that all these elements are examined together.

Treatment of consumers (Criteria 6.1, 6.2)

Consumers of MHS have the right to be treated with the respect and dignity equal to any human. Wherever possible, consumers should be able to access a staff member of their own gender if required.

Under some circumstances consumers may be subject to the provisions of mental health and related legislation, or have a legal guardian authorised to make a decision on their behalf, which compels the consumer to receive treatment. Services provided must be consistent with the relevant legislation.

The MHS should work within a framework that supports emotional health and wellbeing. Statements of consumer rights and responsibilities should be adapted to meet local conditions. All cultural training programs emphasise the importance of history and the ongoing nature of issues of power and exploitation and sensitivity to further abuse.

Consumers rights and responsibilities (Criteria 6.3, 6.4)

The consumer statement of Rights and Responsibilities, provided on admission to the MHS and later at regular intervals, should include statements on the following:

- the consumers safety and wellbeing is upheld by the MHS
- consumers have the right to privacy and confidentiality
- consumers have the right to seek other opinions regarding their care, assessment and treatment
- relationships between consumers, carers, family and friends are respected and honoured

- consumers work in partnership with service providers
- the language and cultural needs of consumers are addressed
- consumers complaints and grievances are addressed without compromising the service provided to them
- consumers have responsibility for maintaining their own health and welfare
- consumers should respect the rights of others
- consumers should respect staff and treat them with dignity and respect
- consumers should be involved in their treatment, care and recovery plan.

Education about rights and responsibilities should occur at admission and continue until the consumer's mental state allows comprehension of the information. Discussion about the rights and responsibilities, choice of treatment and the treatment, care and recovery plan, should be clearly documented in the consumer's health record.

The MHS can assist a consumer to understand the information on their care by offering the following:

- use of interpreters
- use of cultural guides
- providing opportunities to ask questions
- use of consumer advocates
- involvement of family and community where appropriate.

The MHS should have policies and procedures for offering appropriate support to consumers, their families, staff and visitors immediately following a critical incident.

Relationships (Criterion 6.5)

Any existing relationships with carers and their capacity and willingness should be the key considerations when determining the most appropriate treatment and support for consumers. Individual consumer needs should be taken into account to determine the least restrictive environment for them. The environment should enable effective treatment to occur, while ensuring safety and protection of other consumers, staff, visitors and members of the public.

Identification of clinician (Criterion 6.6)

The clinician involved in the consumer's initial contact with the service coordinates assessment, treatment and support or a smooth transition to another service or clinician if appropriate. This position could be called a case manager, care coordinator or key worker.

Partnerships (Criterion 6.7)

Each consumer participates fully in developing their individual treatment, care and recovery plan and in the evaluating outcomes to ensure that goals are achieved. A copy of the treatment, care and recovery plan is given to the consumer wherever possible. It may be essential to involve community and family members when developing plans for ATSI people.

Informed consent (Criterion 6.8)

The MHS obtains consent to care by providing information about the choices of services and treatment available and ensuring that this information is understood. The service should support consumers to make informed choices.

Care plans (Criterion 6.9)

Each consumer should have an individual comprehensive treatment, care and recovery plan based on the consumer's assessment and developed by the interdisciplinary team with the consumer and their nominated carer.

Access to information (Criterion 6.10)

Consumers should have access to information on the mental illness, treatment options, risks and benefits, effects and side-effects and ongoing care and rehabilitation arrangements. This information should be discussed with consumers by an appropriate member of the care team, and evidence of the discussion recorded in the health record.

Right to involve (Criterion 6.11)

Consumers have the right to nominate who is involved in their treatment, care and recovery planning. This does not just include carers and family members. It can mean the right to choose which staff or service providers are involved where this does not impose a risk to the consumer, carer or MHS staff.

Exit plans (Criterion 6.12)

The consumers' exit plan should include details of:

- a nominated health care provider such as a general practitioner or private psychiatrist
- shared care arrangements with general practitioners, private psychiatrists and non-government organisations, if applicable
- the earliest possible involvement of the consumer's nominated service provider and arrangements for ongoing follow-up
- community resources likely to be required
- other people likely to be involved

- other details identified by the consumer or carers
- the preferred method of evaluating the outcomes for the consumer
- a plan for identifying early warning signs of relapse
- how to re-enter the MHS
- a clear point of contact in the MHS regarding the most recent episode of treatment or support.

The MHS should assist consumers and their carers in identifying early warning signs of relapse. Symptoms of pending relapse and an accompanying relapse management plan should be included in the exit plan.

Continuity of care (Criterion 6.13)

Arrangements for follow-up should be planned and in place before consumers leave the service and these arrangements should be documented in the individual health record.

The consumer is given formal introductions to various community agencies where necessary. Community based agencies and programs may include education providers, community recreation programs, paid or voluntary work, supported or other employment and consumer run support services.

Consumer records (Criteria 6.14, 6.15)

Consumers are provided with information about how to access their own health records. This should include information on who can access records on the consumers' behalf in accordance with relevant legislation. Consumer information sheets on privacy legislation are available from

➤ <http://www.privacy.gov.au>.

Contact (Criterion 6.16)

Adequate meeting areas, flexible visiting times and access to family and friends all contribute to making it easier for the consumer to maintain contact.

Service planning (Criteria 6.17, 6.18)

The MHS needs to use methods that are appropriate to their individual service to engage consumers and carers in all areas of service planning, delivery, evaluation and quality assurance activities.

Providing training will maximise consumer participation in the MHS.

Standard 7.

Carers

The MHS recognises, respects, values and supports the importance of carers to the wellbeing, treatment, and recovery of people with a mental illness.

GUIDELINES

Where there is relevant legislation services should ensure compliance. eg. *Carer Recognition Act (NSW, SA, WA, Qld, NT)*.

The intent of this Standard is to ensure that carers are informed and involved in the treatment, care and recovery planning of the consumer when the carer has an ongoing role to support the consumer.

In the context of this standard 'carer' refers to family members or friends of people with a mental illness whose life is affected by the mental illness and includes the partner, parent, friend or child of the consumer.

Identification of carers (Criterion 7.1)

Carers can be parents, partners, brothers, sisters, friends or children of any age. A carer can also be a state or territory guardianship board or tribunal or an appointed guardian or administrator. The MHS should have policies to address these possibilities. CAMHS sometimes works more with carers than other services and may deal exclusively with the parent or carer, depending on the consumer's age. The MHS should address issues of custodial and non-custodial parents and legal guardianship. It should also take into account whether the carer is a consumer within another MHS. Policies and service delivery protocols should address these situations.

In Indigenous communities carers can include individual members of a family who may not necessarily be blood relatives, and skin groups can embrace entire communities. This can make identifying carers difficult, and there should be some flexibility when recording carer information.

Partnerships (Criteria 7.2, 7.3)

Care should be delivered in partnership with consumers, carers and clinicians. Meetings provide a critical component of care.

The role of the extended family and the wider community must also be taken into account when working with Aboriginal and Torres Strait Islander and CALD communities. Culture influences Aboriginal and Torres Strait Islander people's decisions about when and why they seek services, whether they accept or reject treatment and how likely they are to continue treatment and follow-up. It can also affect success of prevention and health promotion strategies, the client's assessment of the quality of care and their views about the health service and its staff. Aboriginal health workers and cultural 'guides' are vital in establishing meaningful contact with Indigenous families from rural and remote communities.

Carers should be engaged as soon as possible in the episode of care with clear and open communication. The MHS should routinely seek information from carers that contributes to care. The MHS should try to identify the carer if this did not happen when the consumer was admitted.

Provision of information (Criterion 7.4)

The MHS should provide written material on rights and responsibilities in languages other than English and in a variety of media. This should be reviewed regularly. The material should be prominently displayed in every facility of the MHS and also made available on the MHS website and via email, fax or post on request.

The MHS should look at alternative means of engaging the general population in remote communities on mental health issues. Examples include using 'talking' posters and books in various languages or displaying information in Aboriginal and Torres Strait Islander organisations and facilities.

Information could include:

- where to access a copy of the *National Standards for Mental Health Services* (2010) such as through the web address*
- a brochure on rights and responsibilities, which could be a photocopy of the organisation's statements
- where to access the *Mental health statement of rights and responsibilities* (1991)*
- where to access human rights instruments and statements.*

*Information on where to access these documents is found in the guidelines for Standard 1 Rights and responsibilities.

The carer statement of rights and responsibilities should include statements such as these:

- the carer's wellbeing is supported by the MHS
- the service will provide information about the consumer's mental health condition, treatment, ongoing care and if applicable, rehabilitation
- carers can access mental health staff to provide them with information that may assist in care, assessment and treatment of the consumer

- carers are entitled to access the consumer during care, assessment and treatment processes and should be consulted by mental health staff about those processes
- the relationship between a carer and the person they care for is respected and honoured.
- carers have the opportunity to work in partnership with service providers
- carers are respected for the critical role they play
- carers have the rights, choices and opportunities to enjoy optimum health, social, spiritual and economic wellbeing and to participate in family, social and community life, employment and education
- carers are supported to balance their caring role with their own needs
- the MHS staff are trained to communicate effectively with carers regarding issues of confidentiality
- the language and cultural needs of carers are considered.

Opportunities for carers to ask questions about their rights and responsibilities are provided throughout all phases of the consumer's care.

Diversity of carers (Criterion 7.5)

Carers of Aboriginal and Torres Strait Islander people, CALD people, people with intellectual or physical disabilities should be specifically identified and supported by the MHS within and outside their communities.

Each MHS must develop a policy that provides guidelines, details requirements and refers to relevant legislation and guidelines for providing services to people from diverse backgrounds.

Staff of the MHS need to have a sound understanding of the implications of this issue.

Age of carers (Criterion 7.6)

The MHS should consider the needs of carers who are children or aged persons and provide information on how to access support for these age groups. Support organisations include:

- The Mental Health Carers ARAFMI Australia
➤ <http://www.arafmiaustralia.asn.au>
- Children of Parents with a Mental Illness (COPMI)
➤ <http://www.copmi.net.au>

Contact and discussion with carers should be clearly documented in the consumer's health record.

Confidentiality (Criterion 7.7)

Staff of the MHS require a sound understanding of the confidentiality principles of the Mental Health Act and Commonwealth, state or territory legislation, which defines what information can be conveyed to families and other carers and under what circumstances. These issues should be addressed in documented policies and procedures.

MHS staff need to be aware of the different attitude to information sharing among remote Indigenous communities. Communal sharing of responsibilities and information relating to individuals is the norm.

Posters in appropriate languages outlining the legal rights of consumer and carers should be placed in all MHS services, hospitals and primary health care services.

Consultation (Criteria 7.8, 7.9, 7.10)

Carers need access to information on the mental illness of the consumer, treatment options, ongoing care and rehabilitation arrangements. Any discussions with the carer about the personal aspects of the consumer's care should be in accordance with Commonwealth, state or territory privacy legislation. The service's primary duty of care is to the consumer and this should be considered when the consumer has not provided consent to disclose information to the carer. The MHS should have policies and procedures to address these issues and staff should have access to these and be provided with relevant training.

The consumer's health record should show when a nominated carer seeks information. All liaisons with carers should be documented in the health record.

Exit information (Criteria 7.11, 7.12, 7.13)

Carers should have access to information on respite services, counselling, crisis support, education and training to maximise their wellbeing and ability to care and advocate for the consumer.

Information is available on services and support for carers, including children and adolescents at:

- the Australian Government site on mental health:
➤ www.mentalhealth.gov.au
- Department of Health and Ageing:
➤ www.health.gov.au

Posters and brochures with information on respite services, carer respite centres, resource centres and counselling programs should be prominently displayed in every facility of the MHS and made available on the MHS website and via email, fax or post on request.

Participation (Criterion 7.14)

Involving Aboriginal and Torres Strait Islander carers in the delivery of mental health services helps a service learn about what Aboriginal people value and how staff and carers can work with these values to achieve better services for clients.

Examples of how to ensure Aboriginal and Torres Strait Islander people are involved as carers include:

- providing financial and other practical assistance to attend
- holding meetings
- ensuring participation in interview panels
- reviewing draft policies
- providing input at orientation programs
- participating in service planning days
- participating in anonymous reviews of complaints.

It may be necessary to actively reach out to communities to involve Aboriginal and Torres Strait Islander carers who live in rural and remote Australia. This engagement with rural and remote communities will ultimately be productive.

Training (Criteria 7.15, 7.16, 7.17)

There should be evidence that staff have undergone appropriate training to assess a carer's capacity to provide care for the consumer after they are discharged. In some cases the carer could be a child, aged person or a person from a remote community and this should be considered in discharge planning.

The MHS should provide training to staff on the use of carer assessment tools for measuring a carer's capacity to provide care to the consumer.

The MHS should provide training and education to help carers in their role as representatives within the MHS. This could include topics such as OH&S, governance, the responsibilities of committee and board representations and computer training. Evidence that carers are provided with information on available training and how to access that training should also be provided.

Policies and procedures should guide the MHS on how to work with carers and should recognise the importance of the carer to the consumer, the health care provider, the MHS and the community.

SUGGESTED EVIDENCE

Evidence that may be provided for this standard includes:

- information on rights and responsibilities
- health records and treatment, care and recovery plan reviews
- posters and brochures
- staff training records
- policies and procedures covering:
 - working with carers
 - identifying carers
 - privacy and confidentiality
 - training programs
 - advocacy training and support, mentoring and supervision.

Standard 8.

Governance, leadership and management

The MHS is governed, led and managed effectively and efficiently to facilitate the delivery of quality and coordinated services.

GUIDELINES

The intent of this Standard is to ensure that structures are in place to facilitate effective governance of the mental health service (MHS).

Integration and coordination (Criterion 8.1)

There should be evidence of integration with both internal and external stakeholders.

Mental health services can be stand-alone psychiatric units, community-based services, or services co-located with psychiatric general hospitals. The MHS organisational structure should identify it as a discrete entity within the larger organisation where this is applicable.

There should be clear links between the MHS and the wider organisation in the organisation's operational and strategic plans. The MHS should be able to identify a single point of accountability for the MHS in all settings and programs.

The MHS should address both corporate and clinical governance responsibilities.

The governing body of the MHS delegates authority to senior executives and managers and defines their responsibility in operating clinical and non-clinical services to achieve the MHS goals and ensure service integration, coordination and effective outcomes for its consumers.

Promotion and prevention (Criterion 8.2)

The MHS should develop a plan for the organisation that identifies the position responsible for developing promotion and prevention strategies for the organisation and individual staff.

Development and review of strategic plan (Criterion 8.3)

The MHS should have documented evidence of participation of staff, consumers, carers and representatives of key groups in the community, in the developing and reviewing the strategic plan.

The strategic plan includes the following components:

- a needs analysis of consumers and the community
- a service evaluation plan, including measuring health outcomes for individual consumers and consumer groups with specific needs
- a plan for maximising consumer and carer participation in the MHS
- a plan for promoting mental health and addressing early identification and prevention of mental health problems
- a staff development plan.

The differences and values of the MHS community should be reflected in the strategic plan. The plan also needs to be consistent with legislative requirements, and national and state or territory mental health policies and related documents.

Compliance with legislation and related Acts (Criterion 8.4)

Commonwealth and state or territory legislation guides the development of policies and procedures. There should be a policy and procedure framework for the MHS.

There should systems for disseminating information when changes are made to mental health legislation and for monitoring and evaluating compliance with the organisations' policies and procedures.

These systems should include:

- identification and dissemination of new or amended standards
- codes of practice
- guidelines and legislation.

Resources (Criterion 8.5)

The MHS should be able to demonstrate sound financial management practices and a clear budget allocation for the delivery of services.

Recruitment, selection and staff development (Criteria 8.6, 8.7)

Policies, procedures and staff records should show evidence of the following:

- professional development
- regular performance review
- supervision and staff support programs
- statement of roles and responsibilities
- diversity of backgrounds in staff recruitment
- completion of an orientation program based on the National Standards.

The MHS should identify the professional development needs of staff and ensure ongoing staff participation in education, performance review and professional development programs.

Formal orientation programs for new staff should:

- incorporate information on the National Standards and their implementation
- reflect the National Practice Standards for the *Mental Health Workforce* (2002)
- are based on the needs of the MHS
- are based on the needs of the target population
- include comprehensive competency training.

The MHS should ensure that staff have access to formal supervision. Depending on the setting, supervision of staff can be multidisciplinary, discipline specific, individual or group, through peer and case review.

Formal structures and delegations should be identified and regularly reviewed.

Critical incidents (Criterion 8.8)

The MHS should have a formal process to review critical incidents. The process should support staff and others within the MHS affected by the critical incident. The outcomes of the review of incidents should be used to guide ongoing prevention plans. Further information on critical incidents is available in the guidelines for Standard 2 Safety.

Information management (Criterion 8.9)

Information management includes health records in both individual and aggregated formats that is understandable to those involved in the delivery of care.

The MHS should collect outcomes data as identified in the National Outcomes and Casemix Classifications (for public mental health services) and Centralised Data Management Service Model (for private mental health services).

The MHS should also collect the relevant administrative and statistical data in all settings as appropriate to the service including National Minimum Data Sets (NMDS), Hospital Casemix Protocols (HCP) and nationally agreed Key Performance Indicators (KPIs). The MHS should adopt the Australian Bureau of Statistics' *Standards for Statistics on Cultural and Language Diversity*, (1999).

Public mental health services are required to collect information as identified in the agreed national key performance indicators for Australian public mental health services and use this for quality improvement.

Data management systems provide evidence of:

- compliance with legislative requirements
- achievement of reporting requirements.

Risk management (Criterion 8.10)

Information gathered through feedback, complaints, incidents and adverse reporting should be part of clinical and corporate governance, including risk management processes.

The MHS must have documented systems that are evaluated to ensure corporate and clinical risks are:

- identified
- analysed
- evaluated
- treated
- continuously monitored and reviewed
- communicated.

Further information on risk management is available from the guidelines for Standards 2 Safety and 4 Diversity responsiveness.

Formal quality improvement program (Criterion 8.11)

The MHS analyses data to promote effective care for consumers and their carers, to assist with evaluating service delivery and developing staff training programs. Data management systems provide evidence of quality improvement activities as a result of data evaluation.

The MHS should have documented systems that are evaluated to ensure complaints, adverse events, critical incidents and near misses reporting are used for quality improvement activities. Information gathered for this reporting should be part of clinical governance, including risk management processes.

The quality improvement program should include evaluation of services and individual health outcomes, using information from staff, consumers, carers, other service providers and the community. This should result in improvements in services.

Staff, consumers, carers, key groups within the community and other service providers, should be involved in service evaluation.

SUGGESTED EVIDENCE

Evidence that may be provided for this standard includes:

- a strategic plan showing:
 - how the MHS is aligned with the wider organisation if this is applicable
 - staff, consumer and carer participation in developing the plan
- the current operational plan
- evidence of stakeholder involvement in plans
- staff records
- details of data management systems
- outcomes data and indicators
- evidence of compliance systems
- policies and procedures covering:
 - framework for the development of policies
 - schedules for policy review
 - evaluation of compliance to policies and procedures
 - regular review and update of policies
 - human resources.

Standard 9.

Integration

The MHS collaborates with and develops partnerships within its own organisation and with other service providers to facilitate coordinated and integrated services for consumers and carers.

GUIDELINES

The intent of this standard is to ensure that mental health services (MHS) are integrated and provide continuity of care for consumers and carers at several levels, from the individual consumer level, to the person coordinating the care, the team and organisational levels, through to that involving other service providers.

Continuity and coordination of care (Criterion 9.1)

The person responsible for coordination of care helps consumers, carers and service providers to work together by facilitating links in and outside the organisation. They ensure consumers are matched with the most appropriate provider so that the consumers' transition to other levels of service in the continuum is seamless and timely and there is no duplication in assessment, service planning and delivery.

The person responsible coordinating care is identified on admission or soon after and the consumer and carer, where appropriate, should be informed that this person is responsible for:

- coordinating assessment
- coordinating treatment and support
- facilitating a smooth transition of care to other services and between case managers as required
- planning collaboratively with the consumer and carer
- communicating with the consumer and carers where appropriate regarding all aspects of care
- coordinating the interdisciplinary care team.

Support for interdisciplinary care teams (Criterion 9.2)

The MHS should schedule regular interdisciplinary care team meetings to ensure a shared focus on the consumer's care.

The MHS should audit treatment, care and recovery plans regularly during each episode of care to identify evidence of input from interdisciplinary care teams.

Members of the interdisciplinary care team contribute their particular expertise. The team should share information and work interdependently. Leadership of the interdisciplinary care team should be task-dependent with tasks defined by the individual consumer's situation. The person responsible for coordinating the consumer's care should be a member of the interdisciplinary care team and have been responsible for coordinating the activities of the interdisciplinary care team to achieve the best possible outcome for consumers.

Collaborative planning (Criterion 9.3)

The MHS should inform staff, consumers and carers about the range of health care and related services that are available.

The MHS can provide treatment and support to a consumer at several sites including inpatient, community-based rehabilitation or recovery centres or at home.

For organisations with many sites, the process of engagement with the service and / or transfer between services should be standardised and consumers need to be informed where services will be provided.

To promote integration and continuity of care between MHS programs and sites there needs to be regular team leader meetings and service wide meetings that include inpatient and community staff.

The MHS should ensure that staff are familiar with policy and procedures relating to contact with internal and external services and providers. Contacts with internal and external services and providers, including referrals, should be documented.

The MHS should have an up-to-date resource folder in hard and soft copy to inform staff, consumers and carers about the range of other health and related services.

There should be regular meetings with other service providers to maintain or establish links and partnerships that facilitate continuity of care for the consumer.

Links with primary health care providers (Criterion 9.4)

Shared care arrangements between general practitioners (GPs), private psychiatrists, non-government organisations and other relevant agencies should be used to facilitate consumer recovery.

Examples of models of shared care arrangements include:

- GPs and other mental health care providers, such as the Better Access Initiative and the Access to Allied Health Professionals (ATAPS) which aim to increase community access to mental health professionals
- Community Mental Health Case Manager, the Mental Health Intake and Assessment Team and the Acute Mental Health Unit.

When clinical supervision for the patient is transferred to the primary care provider, such as the GP, the MHS should provide feedback that will assist the GP. This feedback should contain:

- notification of discharge from hospital and what has happened to the consumer
- any change in legal status of the consumer, for example, community treatment orders (CTO) or community care orders (CCO), changes in treatment, medication, physical health or pathology results
- recommendations for the GP in the treatment of the consumer
- details of the contact person and process for re-entry to the MHS if the consumer relapses.

Interagency and intersectoral links (Criterion 9.5)

The MHS works with other service providers, including welfare services, primary care practitioners, disability support services, emergency departments, aged-care providers and transcultural and multicultural mental health agencies.

Links and partnerships with external services, such as alcohol, tobacco and other drug services (ATODS), should be supported by formal service agreements. Where there is no formal agreement the MHS should have clear procedures on how to establish and maintain contact with these services.

The MHS needs to develop links between child and adolescent, adult and older person programs and other service providers, to ensure a smooth transition to age-appropriate services as required.

Examples of partnership agreements could include links with:

- drug and alcohol services
- the youth sector
- housing providers
- employment providers

- Centrelink
- aged-care services:
 - health promotion/public health services
 - local government
 - community services
 - churches and religious groups
 - schools
 - the tertiary education sector
 - Aboriginal and Torres Strait Islander groups
 - divisions of general practice
 - multicultural groups
 - early childhood services
 - maternal and baby health services.

SUGGESTED EVIDENCE

Evidence that may be provided for this standard includes:

- audit of treatment, care and recovery plans
- evidence of team leader meetings
- discharge summaries supplied to primary health care providers
- evidence of shared care arrangements
- partnerships with other service providers, such as alcohol, drug and tobacco services
- policies and procedures covering:
 - contact with internal and external services
 - process of transfer between services
 - orientation program
 - supervision and training programs.

Standard 10. Delivery of care

10.1 SUPPORTING RECOVERY

The MHS incorporates recovery principles into service delivery, culture and practice providing consumers with access and referral to a range of programs that will support sustainable recovery.

GUIDELINES

The intent of this Standard is to ensure that mental health services (MHS) facilitate the recovery journey for consumers by assisting consumers to achieve wellness, rather than just treating the illness.

Recovery-oriented culture and practices (Criterion 10.1.1)

In recovery-oriented services, recovery values are reflected in the organisation, administration and staffing. Examples include:

- a mission statement identifying recovery processes and outcomes
- policy statements and guidelines providing recovery-based principles for service delivery
- quality improvement that is developed, implemented and monitored in collaboration with consumers and carers
- staff selection, training and supervision according to recovery values and with consumer and carer involvement
- whole-of-service commitment to responding to cultural differences and Indigenous uniqueness
- stigma and discrimination free practices.

Principles of Recovery Oriented Mental Health Practice include:

- uniqueness of the individual
- real choices
- attitudes and rights
- dignity and respect
- partnership and communication
- evaluating recovery.

(Details of these principles can be found at the back of the National Standards.)

Dignity and respect (Criterion 10.1.2)

Every individual has worth and deserves respect, dignity and effective care. A focus on the consumer's recovery and participation in their own care can facilitate this. Respect and dignity is mandatory regardless of culture, social context, residence or the service setting, particularly in remote Australia.

Recognition and support (Criterion 10.1.3)

In a recovery model, the aim is to have consumers take responsibility for themselves. This can be achieved by instilling hope, re-establishing a positive identity and self esteem, healing, empowerment, and connection by applying the principles of human rights, providing a positive culture of healing, and culturally informed recovery-oriented services.

Responsibility for self can be achieved by supporting the consumer to:

- develop their own goals
- work with other healthcare providers, carers, family and friends, to make plans for reaching these goals
- take on decision-making tasks
- engage in self-care.

It is important that practitioners working in Aboriginal and Torres Strait Islander settings know how to access appropriate information and identify consumers' strengths and abilities.

The MHS should give consumers and their carers simple and easy to understand information in the appropriate language. This should include information on:

- the consumer's condition including how to care for themselves after they exit the service
- how to follow the treatment, care and recovery plan and achieve the expected results
- improving and maintaining the consumer's overall health and wellbeing
- peer-based support programs and services that promote recovery
- appropriate inpatient activity programs.

Self (Criteria 10.1.4, 10.1.6)

10.1.4 The MHS should encourage and support consumer and carer autonomy.

Autonomy should be understood in a social and cultural context, particularly for Indigenous consumers and carers. Services and practitioners should have access to training resources which explore autonomy in contexts appropriate to Aboriginal and Torres Strait Islander people and suggest ways to support this in local practice.

10.1.6 The MHS can assist consumers to develop independence and regain self direction, understanding and control of their illness through:

- using advance-care directives and treatment and care and recovery plans
- helping consumers to develop connections with communities
- establishing relationships with community organisations beyond the mental health service system
- establishing policy and procedures that give consumers opportunities for choice and control
- educating staff about special interest groups and community activities for consumers.

Social inclusion and citizenship (Criterion 10.1.5)

Examples of strategies that the MHS can use to promote the rights of individuals with mental illness to social inclusion and citizenship include:

- asking consumers about what worked and what didn't work for them in their own recovery, including how the treatment, care and recovery plans supported or hindered their progress
- encouraging and supporting consumers to participate in all aspects of service planning, development and implementation (further information on consumer participation is available in Standard 3 Consumer and carer participation)

- encouraging and supporting consumers to become advocates (further information on advocacy is available in Standards 1 Rights and responsibilities and 3 Consumer and carer participation)
- providing information to consumers that is easy to understand about how they are protected by disability and mental health legislation
- ensuring practitioners know about, and can engage with, relevant work, recreational and family-focused agencies and activities in Aboriginal and Torres Strait Islander settings, including both conventional and traditional activities and practices.

Positive connections—social, family and friends (Criterion 10.1.7)

Re-connection to the community should be viewed as a primary goal of the MHS and reflected in the MHS mission statement. The MHS should support and encourage consumers to develop or re-establish appropriate connections with family, friends and community support networks.

The responsibility for leading community integration activities should be designated to specific MHS staff.

The MHS should work collaboratively with consumers to develop and review the consumer's goals for re-connecting with the community, consistent with cultural processes and social constraints.

The culture of the MHS should value and foster the use of peer support and consumer self-help.

Education should be provided to staff and consumer and carer advocates about the range of support networks that are available in the community such as local civic and volunteer groups, faith communities and educational institutions.

Location should not compromise efforts and resources to support social inclusion in rural and remote settings.

Participation of consumers (Criterion 10.1.8)

This criterion is covered by the guidelines in Standard 3 Consumer and carer participation.

In Aboriginal and Torres Strait Islander settings the MHS must ensure individual participation of consumers and carers, and provide support for developing and running consumer and carer representative groups at regional and local levels.

Community services and resources (Criterion 10.1.9)

The MHS should be aware of community services that may support consumers. These could include:

- drug and alcohol services
- youth services
- housing services
- employment services
- Centrelink
- aged-care services
- health promotion/public health
- local government
- churches and religious groups
- educational institutions
- Aboriginal and Torres Strait Islander services and groups
- multicultural groups
- early childhood services
- volunteer groups.

Carer centred approaches (Criterion 10.1.10)

Carer centered approaches may include:

- involving the carer in treatment and support
- providing culturally informed carer education regarding the relevant mental illness
- training the carer in family communication and problem solving skills
- providing counselling and ongoing support for the carer
- offering support for children of parents with a mental illness
- facilitating contact with relevant support or self-help groups.

Relationships with family, carers, sexual partners, friends, peers, cultural groups and the community are encouraged.

SUGGESTED EVIDENCE

Evidence that may be provided for this standard includes:

- an organisational mission statement
- evidence of the organisation's commitment to cultural competence and cultural safety
- information and education being provided to consumers and carers
- links with other service providers
- consumer and carer satisfaction surveys
- treatment, care and recovery plans
- consumer and carer interviews
- evidence of access to consumer-run groups
- evidence of referrals to recovery support programs
- evidence of follow-up
- policies and procedures covering:
 - principles for service delivery
 - cultural safety
 - staff selection
 - training and supervision
 - working with carers
 - education programs
 - referral processes
 - consumer and carer support systems.

10.2 ACCESS

The MHS is accessible to the individual and meets the needs of its community in a timely manner.

GUIDELINES

The intent of this Standard is to ensure that access to mental health services is reasonable and equitable.

Identified needs (Criterion 10.2.1)

The MHS needs to pay particular attention to the diversity of its consumers including Aboriginal and Torres Strait Islander persons, culturally and linguistically diverse (CALD) persons, religious and spiritual beliefs, gender, sexual orientation, physical and intellectual disability, age, legal status and socio-economic status.

Further information on culture and diversity is available in the guidelines of Standard 4 Diversity responsiveness.

Access should be regularly monitored to ensure that it is timely, equitable and meets the identified needs of its community. The monitoring process includes seeking feedback from consumers, carers and the community regarding access to the MHS.

Data on waiting times to access the MHS should be analysed and strategies should be developed and implemented to reduce the number of consumers on the waiting list.

The MHS can provide evidence of facilitating access to services through such means as:

- formal links with relevant community groups and other service providers
- use of appropriately trained interpreters or cultural brokers
- staff orientation and ongoing training that includes training about the access process and relevant cultural considerations
- liaison services
- use of technology to improve access (such as Telehealth which provides online medical services).

The MHS should facilitate access to transport where necessary taking into account the capacity of the service and the consumer / carer needs in accordance with relevant legislation and guidelines. The location of services, such as the proximity to transport hubs and / or shopping centres should also be considered.

Provision of information on access (Criterion 10.2.2)

The process of access should be made known to consumers, carers, relevant stakeholders, other agencies and service providers. There should be a documented procedure for disseminating information on the access process to consumers, carers and other service providers.

The MHS should provide information on access to services through prominently displayed posters, brochures and video or multimedia. This information should also be available through the website or via email, fax or post on request. In Indigenous settings this information should be culturally informed and appropriately written for the target population.

After-hours care (Criterion 10.2.3)

Information should be available about how consumers can access after-hours care.

Evidence of efforts to provide after-hours emergency contact information for consumers includes:

- an information pamphlet with after-hours emergency contact numbers and location of after-hours mental health services in a format that is understandable to consumers and carers
- information on availability of tele-psychiatry or an after-hours telemedicine service provided by a mental health nurse for remote locations
- national or state telephone-based services capable of providing culturally appropriate advice.

Physical access (Criterion 10.2.4)

The MHS should have clear signage, disabled access and sufficient waiting areas.

Service settings in Indigenous communities should be designed with an understanding of local cultural expectations.

The MHS should facilitate access to transport where necessary, taking into account the capacity of the service and consumer needs.

The MHS transport assistance policy and procedure should outline options for accessing assistance based on individual consumer needs and risks.

SUGGESTED EVIDENCE

Evidence that may be provided for this standard includes:

- consumer survey results
- information sheets, brochures or posters
- clear signage, accessible physical entry points
- consideration of cultural factors in the built, clinical environment
- data on waiting times
- use of technology, such as multimedia information kiosks and telehealth services
- evidence of provision of after-hours emergency contact information for consumers
- Policies and procedures covering:
 - after-hours access
 - transport assistance
 - dissemination of information on access to the service.

10.3 ENTRY

The entry process to the MHS meets the needs of its community and facilitates timeliness of entry and ongoing assessment.

GUIDELINES

The intent of this Standard is to ensure that entry processes to the mental health service (MHS) are made known to the community it serves and that entry processes are efficient.

Documented entry policy and process (Criterion 10.3.1)

The MHS should have a documented entry policy and procedure which includes:

- the system of on call, entry and assessment
- how to ensure the needs of Aboriginal and Torres Strait Islander persons, culturally and linguistically diverse (CALD) persons are met and that religious and spiritual beliefs, gender, sexual orientation, physical and intellectual disability, age and socio-economic status are addressed in the entry process

- the use of interpreters
- assessing the specific needs of the consumer in terms of the type of services required
- the process of making alternative arrangements and a smooth transition of care to a more appropriate MHS if the MHS accessed cannot provide this service.

Provision of information on the entry process (Criterion 10.3.2)

The MHS should have a procedure for disseminating information on the entry process to consumers, carers, and other service providers. This can be done through such activities as mail outs of posters and brochures, providing online information, interagency liaison and regular liaison with referral sources.

Posters and brochures that provide information on the entry process should be prominently displayed in every facility of the MHS and also made available on the MHS website and via email, fax or post on request.

Prioritisation of referrals (Criterion 10.3.3)

Prioritisation of referrals varies, depending on the service and the sector. The MHS can routinely monitor its 'non-accepted' referrals and review procedures where necessary.

The MHS needs to be able to formally identify who is responsible for monitoring and evaluating compliance with entry policies and procedures.

Defined pathway for entry into the MHS (Criterion 10.3.4)

The MHS should have one entry point for each service it delivers.

For mental health services that have multiple sites, the system of on call, entry and assessment needs to be coordinated by the appropriate staff or governing body.

Minimise delay and duplication (Criterion 10.3.5)

The MHS should be able to provide evidence that the individual consumer health record and treatment, care and recovery plan was started when the consumer entered the service. The means of entry to the service should be recorded in the consumer's health record.

The MHS contacts health professionals involved in earlier episodes of care to obtain relevant information as soon as practicable after the consumer enters the MHS. Evidence that the MHS attempted to obtain information on any earlier episodes of care should be documented in the consumer's individual health record.

Wherever possible the MHS should access the consumer's previous health record to eliminate duplication.

Involuntary admission (Criteria 10.3.6, 10.3.7)

For some consumers, voluntary or involuntary status can change within the same admission period to an inpatient facility. The MHS should have protocols available that encourage voluntary status where this does not pose a risk to the consumer, carer, visitors or staff.

The MHS should offer counselling and debriefing for consumers and carers who are admitted as involuntary patients.

Providing a counselling and debriefing service to consumers and carers may not always be appropriate during the admission stage but it is imperative that this occurs during the period of care.

The MHS and relevant evacuation agencies operating in rural and remote settings (such as police, ambulance or the Royal Flying Doctor Service) should ensure they have clear guidelines consistent with the relevant legislation. Whenever involuntary evacuation of a consumer is undertaken carers and other relevant community members should be engaged as early in the process as possible to ensure understanding and cooperation. Feedback to this group should also be guaranteed.

Care management on entry (Criterion 10.3.8)

On entry to the MHS an interim or permanent person responsible for the coordination of care is appointed to the consumer. The consumer and the carer should be advised of who this person is and any changes should be made known to the consumer and the carer.

The MHS must ensure that in Indigenous settings where there are no resident MH practitioners, there is an identified person (usually within the primary care centre) and a process to ensure that all case management issues and decisions can be directly and appropriately conveyed to consumers and carers.

SUGGESTED EVIDENCE

Evidence that may be provided for this standard includes:

- information on entry criteria
- evidence of dissemination of information
- posters and brochures
- a health record review, including referrals and previous treatment
- evidence of coordination with other sites

- treatment, care and recovery plans
- policies and procedures covering:
 - the referral process
 - triage
 - the entry process, including inclusion and exclusion criteria
 - safe transport
 - evacuation protocols
 - mechanisms for review.

10.4 ASSESSMENT AND REVIEW

Consumers receive a comprehensive, timely and accurate assessment and a regular review of progress is provided to the consumer and their carer(s).

GUIDELINES

The intent of this Standard is to ensure that the mental health service (MHS) provides evidence that appropriate information is collected, reviewed and recorded in the individual consumer's health record as part of the assessment, review, treatment and recovery process.

Examples of appropriate information include:

- history of previous mental health problems
- medical history
- details of present health
- functional and emotional status, including the consumer's ability to communicate and care for themselves
- cultural and social history and cultural formulation of diagnosis when required
- level of risk the consumer presents to themselves and others
- the consumer's perception of their needs, desired outcomes and their expectations of service delivery
- details of available carer support after the consumer exits the MHS

- consumer's knowledge of how to maintain a healthy lifestyle and reduce the risk of mental health problems
- consumer's economic situation, social circumstances and level of education
- individual needs of the consumer and carers that may affect service delivery
- diagnosis
- education about the disease
- range of treatments available
- information about alcohol, tobacco and other drug (ATOD) services
- crisis intervention plan
- available treatment settings (wherever possible treatment should be administered in a setting of the consumer's choice)
- evaluation of treatment options
- treatment consent forms signed by the consumer and appropriate MHS staff
- details of integration of care with other providers
- service exit plan.

Assessment tools and methods (Criterion 10.4.1)

Assessment tools and methods appropriate to the individual MHS include diagnosis, functional assessment, family input, suicide and other risk assessment, problem-oriented assessment, formulation and mental status examination. The MHS should be able to provide evidence of using culturally appropriate assessment tools and methods.

Owing to the high rates of clients with ATOD concerns, services could benefit from using a self-audit baseline assessment such as COMPASS, to address co-morbid ATOD issues in a more comprehensive, integrated manner. A further self audit could be carried out after 12 months, for example. Services could also benefit from using a validated screening tool related to ATOD use.

Conduct of assessments (Criteria 10.4.2, 10.4.3)

Evidence that assessments are conducted during the consumer's first contact with the MHS is recorded in the consumer's individual health record. There should be evidence of who was involved, including other service providers or the carer.

The consumer's preferred setting for assessment could be a home visit rather than in the community mental health centre, emergency department or psychiatric unit. The MHS may use the telephone or video to conduct assessments in situations where face-to-face assessment is not possible due to distance or the consumer's preference.

The MHS should consider using, and documenting, the use of an interpreter, particularly in remote Indigenous settings. Collateral informants should regularly be consulted and their use documented.

Information on informed consent is available in the guidelines for Standard 1 Rights and responsibilities.

Planning discharge (Criterion 10.4.4)

When discharge planning begins early in the admission to inpatient care, the planning is more efficient. Time to communicate and consult with the consumer, the carer and other health care professionals will facilitate continuity of care after the consumer is discharged.

Discharge planning for Indigenous clients must involve inpatient staff, relevant outpatient MHS staff, representatives of the primary care service in the community to which the consumer will return and relevant carers or family.

Review (Criteria 10.4.5, 10.4.6)

Assessment is reviewed regularly. A complete assessment depends on many factors, such as the type or complexity of the services provided, so information should be updated regularly.

Crisis intervention should be included in treatment, care and recovery plans both for this episode and for future presentations.

Evidence of an assessment review should be recorded in the consumer's individual health record.

Information on risk assessment is provided in the guidelines for Standard 2 Safety.

Follow-up (Criterion 10.4.7)

Risk assessment is conducted and documented for people who decline to participate in an assessment. An appropriate form of contact is planned with the referring agent and support is offered to carers where relevant.

Interdisciplinary care plan (Criterion 10.4.8)

The treatment, care and recovery plan is developed with input from the consumer, carer, the person responsible for the coordination of care and other service providers. It should contain the details of treatment provided and the expected outcomes. It should ensure continuity of care and complement

treatment, care and recovery plans developed by other service providers. The plan should be consistent with the consumer's culture and education. Involvement of carers or cultural brokers should be documented.

Existing carer relationships and the capacity, willingness and needs of the carer should be considered when developing the treatment, care and recovery plan. This ensures that the necessary supports are put in place for the consumer.

The MHS should be able to provide evidence that the consumer and their carer have received a copy of the current treatment, care and recovery plan and that steps have been taken to ensure that the content of the treatment, care and recovery plan is understood by the consumer and their carer.

The age of consumers and carers will affect the degree to which they are involved in the development of their care and recovery plans. Care and recovery plans should be age appropriate especially where there are young carers. Child and adolescent consumers who experience problems within their family may have a legal guardian or others involved in their care and support who may need to be involved in the care plan.

The consumer participates fully in the development of the individual treatment, care and recovery plan and in the evaluation of outcomes.

SUGGESTED EVIDENCE

Evidence that may be provided for this standard includes:

- assessment methods and tools
- health record review of treatment, care and recovery plans
- consumer survey results
- policies and procedures covering:
 - follow-up procedures
 - assessments, including risk assessments
 - development of treatment, care and recovery plans
 - appropriate culturally adapted protocols and resources.

10.5 TREATMENT AND SUPPORT

The MHS provides access to a range of evidence-based treatments and facilitates access to rehabilitation and support programs which address the specific needs of consumers and promotes their recovery.

GUIDELINES

The intent of this Standard is to ensure that the defined community has access to high quality treatment and support.

The person responsible for the coordination of the consumers care is involved in the admission, treatment and discharge planning.

Best available evidence (Criterion 10.5.1)

In conjunction with the treating clinician, the MHS delivers treatment consistent with current evidence-based guidelines and legislation. The MHS can facilitate access to continuing professional development to help service providers stay knowledgeable and skilled. It should also provide access to resources and current clinical practice guidelines.

Treatment and services (Criterion 10.5.2)

Treatment options need to address Aboriginal and Torres Strait Islander persons, culturally and linguistically diverse (CALD) persons, and take into account religious and spiritual beliefs, gender, sexual orientation, physical and intellectual disability, age profile and socio-economic status.

Treatment and support systems should be applicable to the consumers' age, stage of development, physical health, and stage in their recovery process.

In rural and remote settings practitioners must ensure processes for frequent monitoring (through primary care or wellbeing services) to identify and respond to Aboriginal and Torres Strait Islander consumer needs.

Further information on culture and diversity is available in the guidelines for Standard 4 Diversity responsiveness.

Information on therapies (Criterion 10.5.3)

Information about the purpose, importance, benefits and risks of proposed treatments needs to be provided to the consumer. This information should be delivered in an appropriate language and media, such as verbal and written information in the relevant language. The service should use family or cultural brokers when necessary.

In private MH services, this information is usually provided by the treating clinician. Where this has occurred, the consumer's health record should show that the treating clinician has provided this information to the consumer.

Consumers should be given opportunities to ask questions about the therapies offered throughout the treatment process.

Informed consent must be obtained before treatment. The MHS must have a consent form or access to a copy of a consent form that has information about:

- the type of treatment
- steps in the treatment process.

The MHS should obtain consent or see evidence that consent has been obtained:

- before any treatment or intervention commences
- when services are changed
- when services are added
- when the consumer makes an informed decision about changing their treatment.

This should be documented in the consumer's health record.

Clinical trials and experimental treatments (Criterion 10.5.4)

Appropriate ethical authorisations need to be obtained before consumer's can participate in clinical trials and experimental treatments. In the case of Aboriginal and Torres Strait Islander consumers, this should include the NHMRC guidelines for research in Indigenous populations and clearance by state-based Indigenous research ethics committees.

Least restrictive (Criterion 10.5.5)

Individual consumer needs should be taken into account when determining the least restrictive environment. The environment should enable effective treatment to occur, while ensuring safety and protection of other consumers, staff, visitors and members of the public.

Further information on the least restrictive environment is available from the guidelines of Standards 1 Rights and responsibilities and 6 Consumers.

Because restrictive practices (Mental Health Authority provisions and depot medications) are used more frequently in Indigenous populations, particularly in rural and remote settings, all such decisions should be regularly reviewed and explained to both the consumer and relevant carers.

Medication management (Criterion 10.5.6)

The MHS should have a process in place for a pharmaceutical review of prescribing, storage, transport and administration of medications. There should be a system in place for the use of personal medications during transit situations, such as on admission to hospital and transfer from one service to another.

Adherence to evidence-based treatment (Criteria 10.5.7, 10.5.8)

Strategies to promote adherence to treatment include:

- establishing and maintaining shared care arrangements between the MHS and the primary health care provider
- monitoring the consumer's psychiatric state through collaboration with the consumer, carer and the primary health care provider
- providing ongoing education to the consumer and carers, with the consumer's informed consent, about the consumer's illness and options for treatment
- establishing an overall treatment plan in collaboration with the consumer, their carers and their primary health care provider
- enhancing adherence to the treatment plan—this requires accepting psychosocial intervention, vocational goals and addressing relationship issues. An atmosphere of tolerance in which the consumer feels free to discuss treatment critically improves adherence
- increasing the understanding of the effects of the illness
- assisting consumers to cope with their interpersonal relationships, work, and other physical health needs
- identifying stressors and early warning signs that could initiate relapse. Early warning signs are often non-specific and may just present as a change in mood, anxiety or social withdrawal.

The strategies detailed above are adapted from *MJA Practice Essentials: Managing schizophrenia in the community* (Harry H Hustig and Peter D Norrie, 1998).

Continuity of care (Criterion 10.5.9)

The MHS should have in place systems for dual case management with alcohol and other drug services, collaborative treatment with other service providers such as aged care, psychiatric disability support, disability services and court liaison services.

The MHS should ensure the involvement of other related service providers when making decisions regarding individual treatment of consumers.

Because of the burden of social adversity and comorbidity in some Aboriginal and Torres Strait Islander communities, diverse agencies and organisations are involved in ongoing care. The MHS should ensure coordination and communication across the services and sectors.

Use of medication and / or other therapies (Criterion 10.5.10)

Medication forms part of the treatment strategies provided by the MHS and is intended to allow the consumer to function as well as possible while reducing their specific symptoms. Each prescription is documented. Each medication should be reviewed regularly including its appropriateness and any effects due to multiple medications and drug interactions.

Any other therapies used are reviewed regularly to ensure their appropriateness to the consumers' age, stage of development, physical health, and stage in their recovery process.

Evaluation of treatment (Criterion 10.5.11)

There should be written evidence of appropriate treatment information including:

- information about the illness or disorder
- the range of treatments available
- potential benefits and possible adverse effects
- the length of time before treatment will begin to have an effect
- costs and choices of therapy, medication and other technologies
- options for the treatment setting—wherever possible treatment should be administered in a setting of the consumer's choice
- likely consequences in the event of refusal of treatment
- evaluation of treatment and support outcomes
- consent process.

Range of agencies and programs (Criterion 10.5.12)

Consumers should have the opportunity to be involved in joint programs developed with other agencies. Community based agencies and programs may include education providers, community recreation programs, paid or voluntary work, supported or other employment, and consumer run support services.

Self-care programs (Criteria 10.5.13, 10.5.14 and 10.5.15)

Self-care, independence, health and wellbeing should be part of the education program provided by the MHS. Peer workers and consumer educators are important contributors to the education program.

Relationships with family, carers, sexual partners, friends, peers, cultural groups and the community are encouraged.

When applicable the MHS provides a range of treatment and support, or referral to the appropriate services and programs so that consumers can live independently in their own accommodation, shared accommodation, supervised or supported residences and public refuges. These services need to be relevant to the age of the consumer, for example necessary skills required by CAMHS consumers may include 'risk-safe behaviours'.

A range of programs based on individual needs should be available. It is recognised that some people will require ongoing care while others will require a brief episode of care. All programs should attempt to maximise a person's independence and involvement with their community.

In Aboriginal and Torres Strait Islander communities, practitioners should be aware of culturally informed self-care and allied programs (such as men's groups) and be able to help consumer access these resources. Practitioners should also be aware of the resources and services available for the wider community and how to access these programs when appropriate for specific Aboriginal and Torres Strait Islander consumers.

The MHS should provide consumers and their carers simple and easy to understand information and education on:

- the consumer's condition, including how to care for themselves after they leave the service
- how to follow the service plan and achieve the expected results
- how to use medications, supplies, and equipment in a safe and effective way
- how to develop the skills necessary to meet their own needs and become as independent as possible through self-care programs
- self care resources available from the MHS, other service providers and the internet
- improving and maintaining the consumer's overall health and wellbeing
- accommodation options

- employment options such as apprenticeships and traineeships
- peer-based support programs and services that promote recovery
- appropriate inpatient activity programs.

The MHS must ensure that access to appropriate programs is available and that this is in settings where consumers are not isolated. This is particularly relevant for rural and remote Aboriginal and Torres Strait Islander populations. This may require that carers are present or able to visit, or additional resources may be required for Aboriginal and Torres Strait Islander consumers to maintain community contact.

Accommodation options (Criterion 10.5.16)

The MHS should explore accommodation options that suit the individual needs of the consumer. Factors to be considered include:

- proximity to primary care providers, family members and carers
- mobility
- visual and hearing impairment
- single sex accommodation
- space for family members where children are concerned.

Where supported accommodation is not provided by the MHS, there should be close collaboration between the MHS and the accommodation provider to facilitate access to other treatment and support programs.

MH services operating in areas with significant Aboriginal and Torres Strait Islander populations should ensure that supported and transitional accommodation options appropriate to Indigenous consumers are available. This includes flexible options in regional centres close to specialist and tertiary services, which are connected with in-community options.

Support systems (Criterion 10.5.17)

Whenever possible the MHS should work with the consumer to find ways to access support programs. These programs should reflect the identified needs of each consumer taking into account their age, stage of development, physical health, and stage in their recovery process. Consumers should be able to choose support programs that are most suitable to them. Practitioners working in rural and remote settings should be aware of the available resources and ways to overcome any problems of location or social disadvantage.

Support programs include:

- residential and supported housing
- vocational support systems
- education programs
- employment programs
- family programs and family interventions.

SUGGESTED EVIDENCE

Evidence that may be provided for this standard includes:

- completed consent forms or copies of consent forms
- evidence treatment, care and recovery plans that diversity has been considered
- medication management and notification of adverse drug reactions
- access to, and availability of, evidence-based guidelines
- evidence that consumers and carers received treatment, care and recovery plans
- details on available support programs
- a review of the consumer's health record
- policies and procedures covering:
 - consent
 - research or clinical trials
 - medication management
 - guardianship
 - discharge planning
 - referral
 - shared care arrangements.

10.6 EXIT AND RE-ENTRY

The MHS assists consumers to exit the service and ensures re-entry according to the consumer's needs.

GUIDELINES

The intent of this criterion is to ensure that mental health services (MHS) have policy and procedures on how to assist consumers when they exit the service and that consumers are provided with sufficient information on how to re-enter the service if / and / or when required.

The consumer's exit from, follow-up and re-entry to the service is the joint responsibility of the private mental health service, the private psychiatrist and the general practitioner.

In rural and remote settings this responsibility demands involvement of the mental health service, the primary care service or Aboriginal and Torres Strait Islander community controlled organisation, and other relevant providers. This may include general practitioners.

Access and information on services (Criteria 10.6.1, 10.6.2)

The consumer should be given formal introductions to various community agencies. Information provided could be in the form of a booklet in a language understood by the consumer and carer, or verbal information relayed with the assistance of interpreters. Any information or introductions should be given before the consumer leaves the service.

Given the limited services available in some rural and remote settings the MHS must keep an updated list of available services and activities and details of how they can help the consumer. This information should be easily accessible and understandable.

Development of exit plans (Criteria 10.6.3, 10.6.4)

The exit plan should contain details of:

- the change in the consumer's health status
- the consumer's satisfaction with the service
- perception of quality of life
- a review of the goals in individual treatment, care and recovery plans

- a peer review
- case discussion and methods used to evaluate outcomes (including the consumer's preferred evaluation methods).

Where appropriate these approaches should use culturally adapted processes and resources.

Exit plans for child and adolescent and aged consumers need to consider issues specific to their demographic. For example, aged-care consumers transferring to a nursing home on leaving the MHS and exit plans for child and adolescent consumers are not usually discussed at entry to the MHS.

The MHS should help consumers and their families and carers identify early warning signs of a relapse. The exit plan should include details of symptoms of a pending relapse, sometimes called 'relapse signatures' and a relapse management plan.

Information in the exit plan should include details on:

- the preferred health care provider, for example the general practitioner or private psychiatrist
- the earliest possible involvement of the consumer's nominated service provider and arrangements for ongoing follow-up
- community resources likely to be required
- other people likely to be involved
- the preferred method of evaluating outcomes for the consumer
- follow-up arrangements with the consumer
- plans for identifying early warning signs of relapse
- how to re-enter the MHS
- a clear point of contact in the MHS regarding the most recent episode of treatment or support
- shared care arrangements with GPs, private psychiatrists and non-government organisations if applicable.

Re-entering the service (Criteria 10.6.5, 10.6.6, 10.6.7)

At the time of discharge ongoing arrangements for treatment and support should be reviewed by the MHS.

To assist in the delivery of care detailed in the exit plan in shared care arrangements, information on the consumer should be provided in a timely manner and should include details of:

- treatment, medication, physical health and any pathology results
- any requirements or recommendations for the GP in future treatment of the consumer
- the process of returning care to the MHS provider in the case of relapse
- contact information of the person responsible.

Follow-up of consumers (Criterion 10.6.8)

For the purposes of criterion 10.6.8 discharge is defined as discharge from an inpatient unit or discharge from an episode of care. The criterion does not apply to final discharge of the consumer from the mental health service.

Due to the relatively high risk of suicide in the first four weeks after discharge and to prevent relapse, the MHS, in conjunction with the treating clinician, is required to follow-up wherever possible within seven days of the consumer being discharged from the service. Consumers flagged for follow-up are identified by a risk assessment performed prior to exiting the service.

There is a clear and documented follow-up process, which identifies the responsible agency and crisis service for the period following the consumer's exit from the service.

Despite the greater likelihood of consumer mobility and remote residence, the MHS is responsible for ensuring timely and comprehensive follow up, regardless of location or circumstances, in collaboration with primary care and community controlled organisations.

SUGGESTED EVIDENCE

Evidence that may be provided for this standard includes:

- exit plans, showing evidence of relapse management
- shared care arrangements
- evidence of risk assessments and follow-up
- dissemination of information to primary health care providers
- policies and procedures covering:
 - the development of exit plans
 - access
 - exit and re-entry
 - follow-up procedures.

CROSS REFERENCING OF NATIONAL STANDARDS FOR MENTAL HEALTH SERVICES

Standard 1. Rights and responsibilities

The rights and responsibilities of people affected by mental health problems and / or mental illness are upheld by the mental health service and are documented, prominently displayed, applied and promoted throughout all phases of care.

Criteria	Cross referenced with:
1.1	6.1 and 10.1.2
1.2	7.9 and 8.4
1.3	6.8 and 10.4.3
1.4	4.1, 6.3, 7.4, 7.5 and 7.6
1.7	4.1
1.8	7.7
1.9	6.5 and 10.5.5
1.10	6.7, 10.4.7, 10.4.8 and 10.5.11
1.11	1.12, 6.11, 7.3, 10.4.3, 10.4.8 and 10.6.4
1.12	1.11, 6.11, 7.1, 7.2, 10.4.3, 10.4.8 and 10.6.4
1.13	6.14
1.14	6.15 and 7.7
1.15	3.4

Standard 2. Safety

The activities and environment of the mental health service are safe for consumers, carers, families, visitors, staff and its community.

Criteria	Cross referenced with:
2.1	4.1 and 6.2
2.4	10.5.6
2.5	10.3.7
2.8	8.6
2.11	8.10 and 10.4.5

Standard 3. Consumer and carer participation

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

Criteria	Cross referenced with:
3.1	6.17, 7.14 and 10.1.8
3.3	6.18 and 7.15
3.4	1.15
3.5	6.18 and 7.15

Standard 4. Diversity responsiveness

The mental health service delivers services that take into account the cultural and social diversity of its consumers and meets their needs and those of their carers and community throughout all phases of care.

Criteria	Cross referenced with:
4.1	1.4, 7.5 and 7.6
4.3	5.2 and 8.3
4.4	5.1 and 8.3
4.5	5.6 and 8.7

Standard 5. Promotion and prevention

The mental health service works in partnership with its community to promote mental health and address prevention of mental health problems and / or mental illness.

Criteria	Cross referenced with:
5.1	4.4 and 8.2
5.2	4.3 and 8.3
5.3	3.1, 6.17 and 7.14
5.6	8.7

Standard 6. Consumers

Consumers have the right to comprehensive and integrated mental health care that meets their individual needs and achieves the best possible outcome in terms of their recovery.

Criteria	Cross referenced with:
6.1	1.1 and 10.1.2
6.2	2.1
6.3	1.4
6.4	1.4
6.5	1.9 and 10.5.5
6.6	9.1 and 10.3.8
6.7	1.10 and 10.5.11
6.8	1.3 and 10.4.3
6.9	10.4.8
6.10	10.5.2
6.11	1.12, 10.4.3 and 10.4.8
6.12	10.6.4
6.13	10.6.5
6.14	1.13

6.15	1.14
6.16	1.9, 7.7 and 10.5.3
6.17	3.1, 5.3 and 7.14
6.18	3.3, 3.5 and 7.17

Standard 7. Carers

The mental health service recognises, respects, values and supports the importance of carers to the wellbeing, treatment, and recovery of people with a mental illness.

Criteria	Cross referenced with:
7.1	1.12
7.2	1.12, 10.4.3 and 10.4.8
7.3	1.11
7.4	1.4
7.5	4.1
7.6	4.1
7.7	1.8, 8.4 and 1.14
7.9	1.2 and 10.5.3
7.10	10.5.8 and 10.5.11
7.12	10.4.4 and 10.6.4
7.13	10.6.2
7.14	3.1, 6.17 and 10.1.8
7.15	3.3 and 3.5

Standard 8. Governance, leadership and management

The mental health service is governed, led and managed effectively and efficiently to facilitate the delivery of quality and coordinated services.

Criteria	Cross referenced with:
8.2	4.4, 5.1 and 5.5
8.3	4.3 and 5.2
8.6	2.8
8.7	4.5 and 5.6
8.9	1.14, 6.5 and 7.7
8.10	2.11 and 10.4.5

Standard 9. Integration

The mental health service collaborates with and develops partnerships within its own organisation and externally with other service providers to facilitate coordinated and integrated services for consumers and carers.

Criteria	Cross referenced with:
9.1	6.6 and 10.3.8
9.4	10.5.9 and 10.6.5
9.5	10.1.9

Standard 10. Delivery of care

10.1 SUPPORTING RECOVERY

The mental health service incorporates recovery principles into service delivery, culture and practice providing consumers with access and referral to a range of programs that will support sustainable recovery.

Criteria	Cross referenced with:
10.1.2	1.1 and 6.1
10.1.4	10.5.13
10.1.6	10.5.11
10.1.7	10.5.12
10.1.8	3.1 and 7.14
10.1.9	9.5, 10.5.16 and 10.5.17

10.2 ACCESS

The mental health service is accessible to the individual and meets the needs of its community in a timely manner.

Criteria	Cross referenced with:
10.2.2	10.3.2
10.2.4	10.3.4

10.3 ENTRY

The entry process to the mental health service meets the needs of its community and facilitates timeliness of entry and ongoing assessment.

Criteria	Cross referenced with:
10.3.2	10.2.2
10.3.3	9.4 and 10.5.9
10.3.4	10.2.4
10.3.7	2.5
10.3.8	9.1

10.4 ASSESSMENT AND REVIEW

Consumers receive a comprehensive, timely and accurate assessment and a regular review of progress is provided to the consumer and their carer(s).

Criteria	Cross referenced with:
10.4.1	10.5.1
10.4.3	1.3, 1.11, 1.12, 6.8, 6.11, 7.2, 10.4.8, 10.5.3 and 10.6.4
10.4.4	10.6.3
10.4.5	2.11
10.4.8	1.3, 1.11, 1.12, 6.9, 6.11, 7.2, 10.4.8 and 10.6.4

10.5 TREATMENT AND SUPPORT

The mental health service provides access to a range of evidence-based treatments and facilitates access to rehabilitation and support programs which address the specific needs of consumers and promote their recovery.

Criteria	Cross referenced with:
10.5.1	10.4.1
10.5.2	6.10
10.5.3	7.9 and 10.4.3
10.5.4	1.3
10.5.5	1.9 and 6.5
10.5.6	2.4
10.5.8	7.10
10.5.9	9.4 and 10.3.3
10.5.11	1.10, 6.7, 7.10, 10.1.6 and 10.4.8
10.5.12	10.1.7
10.5.13	10.1.4
10.5.15	9.5 and 10.1.9
10.5.16	10.1.9
10.5.17	10.1.9

10.6 EXIT AND RE-ENTRY

The mental health service assists consumers to exit the service and ensures re-entry according to the consumer's needs.

Criteria	Cross referenced with:
10.6.2	7.13
10.6.3	10.4.4
10.6.4	1.11, 1.12, 6.12, 7.12 and 10.4.8
10.6.5	6.13 and 9.4



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All information in this publication is correct as of October 2010